

HealthPartners Dental Plan

www.healthpartners.com/fedvip

1 (844) 440-1900



HealthPartners®

2025

A Regional Dental PPO Plan

Serving: Minnesota, North Dakota, South Dakota, parts of Iowa and parts of Wisconsin.

IMPORTANT

- Rates: Back Cover
- Changes for 2025: Page 4
- Summary of Benefits: Page 39

This plan has two enrollment regions; please see the end of this brochure to determine your region and corresponding rates.

Options:

High Option - Self Only

High Option - Self Plus One

High Option - Self and Family

Standard Option - Self Only

Standard Option - Self Plus One

Standard Option - Self and Family



Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:



United States
Office of Personnel Management

Healthcare and Insurance
<http://www.opm.gov/insure>

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The law directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-38, expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits of HealthPartners Dental under HealthPartners contract OPM02-FEDVIP-02AP-09 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

HealthPartners
8170 33rd Avenue South
Bloomington, MN 55424
1-844-440-1900
www.healthpartners.com/fedvip

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits. You and your family members do not have a right to benefits that were available before January 1, 2025 unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits, if they are also listed on the coverage.

OPM negotiates benefits and rates with each carrier annually. Rates are shown at the end of this brochure.

HealthPartners is responsible for the selection of in-network providers in your area. Contact us at 1-844-440-1900 for the names of participating providers or to request a provider directory. You may also request or view the most current directory via our website www.healthpartners.com/fedvip. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not for a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you may nominate them to join by calling Member Services. You cannot change plans, outside of open season, because of changes to the provider network.

Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance.

The HealthPartners Dental plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program/Postal Service Health Benefits (PSHB) Program.

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website, www.healthpartners.com/fedvip and click on the "Private Policies" link at the bottom of the page. If you do not have access to the internet or would like further information, please contact us by calling 1-844-440-1900.

Discrimination is Against the Law

HealthPartners complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, HealthPartners does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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FEDVIP Program Highlights

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|--|---|
| A Choice of Plans and Options | You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Some TRICARE beneficiaries may not be eligible to enroll in both. Visit www.opm.gov/dental or www.opm.gov/vision for more information. |
| Enroll Through BENEFEDS | You enroll online at www.BENEFEDS.gov . Please see Section 2, Enrollment, for more information. |
| Dual Enrollment | If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans. |
| Coverage Effective Date | If you sign up for a dental and/or vision plan during the 2024 Open Season, your coverage will begin on January 1, 2025. Premium deductions will start with the first full pay period beginning on/after January 1, 2025. You may use your benefits as soon as your enrollment is confirmed. |
| Pre-Tax Salary Deduction for Employees | Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars. TRICARE enrollees automatically pay premiums through payroll deduction or automatic bank withdrawal (ABW) using post-tax dollars. |
| Annual Enrollment Opportunity | Each year, an open season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, open season runs from November 11, 2024 through midnight EST December 9, 2024. You do not need to re-enroll each open season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual open season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment for more information. |
| Continued Group Coverage After Retirement | Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information. |
| Waiting Period | There are no waiting periods associated with our plan options. |
| Compliance with the American Dental Association (ADA) | FEDVIP abides by the Current Dental Terminology (CDT) codification system in accordance with standards set by the American Dental Association (ADA). <i>Current Dental Terminology (CDT)</i> , Copyright © American Dental Association. All rights reserved. |

How We Have Changed For 2025

Changes to the High Option include:

- There are no plan changes for 2025.

Changes to the Standard Option include:

- There are no plan changes for 2025.

See page 42 (Standard & High Rates) for 2025 rates.

Section 1 Eligibility

| | |
|-------------------------------------|--|
| Federal Employees | If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program, the Postal Service Health Benefits (PSHB) Program, or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation, you are eligible to enroll in FEDVIP. Enrollment in the FEHB Program, PSHB Program, or a Health Insurance Marketplace (Exchange) plan is not required. |
| Temporary/Seasonal Employees | Certain temporary, intermittent, and seasonal Federal and U.S. Postal Service employees are now eligible to enroll in FEDVIP. To be eligible, these employees must be expected to work 130 hours per calendar month for at least 90 days. In addition, certain firefighters hired under a temporary appointment and intermittent emergency response personnel are eligible to enroll in FEDVIP. The employing agency must determine and notify these employees of their eligibility. |
| Federal Annuitants | <p>You are eligible to enroll if you:</p> <ul style="list-style-type: none">• retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS) or another retirement system for employees of the Federal Government;• retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government. <p>Your FEDVIP enrollment will continue into retirement if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB/PSHB Program.</p> <p>Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again when you begin to receive your annuity.</p> |
| Survivor Annuitants | If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment. |
| Compensationers | A compensationner is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status. |
| TRICARE-eligible individual | An individual who is eligible for FEDVIP dental coverage based on the individual's eligibility to previously be covered under the TRICARE Retiree Dental Program or an individual eligible for FEDVIP vision coverage based on the individual's enrollment in a specified TRICARE health plan. Retired members of the uniformed services and National Guard/Reserve components, including "gray-area" retirees under age 60 and their families are eligible for FEDVIP dental coverage. These individuals, if enrolled in a TRICARE health plan, are also eligible for FEDVIP vision coverage. In addition, uniformed services active duty family members who are enrolled in a TRICARE health plan are eligible for FEDVIP vision coverage. |

Family Members

Except with respect to TRICARE-eligible individuals, family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support. FEDVIP rules and FEHB/PSHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in your legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

The following persons are not eligible to enroll in FEDVIP, regardless of FEHB/PSHB eligibility or receipt of an annuity or portion of an annuity:

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB/PSHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member
- Active duty uniformed service members. **Note:** If you are an active duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).
- Temporary/seasonal employees who does not meet the 130 hours per calendar month for 90 days.

Section 2 Enrollment

Enroll Through BENEFEDES

You must use BENEFEDES to enroll or change enrollment in a FEDVIP plan. BENEFEDES is a secure enrollment website (www.BENEFEDES.gov) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans your enrollment will continue automatically. Please Note: Your plans' premiums may change for 2025.

Note: You cannot enroll or change enrollment in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDES.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family; however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee, annuitant, or TRICARE-eligible individual (TEI), you may enroll in a dental and/or vision plan during the November 11, 2024 through midnight EST December 9, 2024, Open Season. Coverage is effective January 1, 2025.

During future annual open seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these open season enrollments and changes will be set by OPM. **If you want to continue your current enrollment, do nothing. Your enrollment carries over from year to year, unless you change it.**

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.
- a TRICARE-eligible individual

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDES receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an open season.

The following chart lists the QLEs and the enrollment actions you may take.

Qualifying Life Event: Marriage

From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Acquiring an eligible family member (non-spouse)

From Not Enrolled to Enrolled: No
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing a covered family member

From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: Yes
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing other dental/vision coverage (eligible or covered person)

From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Moving out of regional plan's service area

From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Going on active military duty, non- pay status (enrollee or spouse)

From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from active military duty (enrollee or spouse)

From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from Leave without pay

From Not Enrolled to Enrolled: Yes (if enrollment cancelled during LWOP)
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes (if enrollment cancelled during LWOP)

Qualifying Life Event: Annuity/ compensation restored

From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Transferring to an eligible position*

From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

*Position must be in a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium and you elect to enroll.

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plan's service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either plan, you cannot change or cancel that particular enrollment until the next open season, unless you experience a QLE that allows such a change or cancellation.

VA Exception for Cancellation

Generally, you may cancel your enrollment only during the annual open season. However, if you are a FEDVIP enrollee paying premiums on a **post-tax basis**, and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may** change your enrollment type or cancel your enrollment within 60 days of receiving notification of VA dental or vision eligibility. This 60-day period may fall outside of open season. VA dental or vision eligibility documentation must be submitted to OPM via the BENEFEDS mailbox (benefedsportal@opm.gov) within 60 days of notification to support the FEDVIP enrollment change or cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the open season effective date. An eligible family member's coverage also ends upon the effective date of the cancellation.

If you are a FEDVIP enrollee paying premiums on a **pre-tax basis**, and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may not** change or cancel your FEDVIP enrollment until the next open season.

FEDVIP enrollees can verify if they are paying their premiums on a pre- or post- tax basis by contacting BENEFEDS at 1-877-888-3337, TTY number 1-877-889-5680.

When Coverage Stops

Coverage ends for active and retired Federal, U.S. Postal employees, and TRICARE-eligible individuals when you:

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;

- as sponsor or primary enrollee leaves active duty
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments;
- cancel the enrollment during open season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under FEDVIP plans:

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA), you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

Please review IRS - Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (www.irs.gov/forms-pubs/about-publication-969) for additional information about carryover and contribution amounts for the upcoming tax year. If you have an HCFSA or LEX HCFSA FSAFEDS account and you have not exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over a set maximum amount of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st. You must also actively re-enroll in a health care or limited expense account during the next open season to be carryover eligible. Your re-enrollment must meet the minimum contribution amount for the plan year. If you do not re-enroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

Current FSAFEDS participants must re-enroll to participate in the program next year.

See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058. Note: FSAFEDS is not open to retired employees or to TRICARE eligible individuals.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB/PSHB and/or FEDVIP plans.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You should present your ID card whenever you receive services from an assigned plan provider.

If you do not receive your ID card within 30 days after the effective date of your enrollment or if you need replacement cards, you may request one through our website at www.healthpartners.com/fedvip or call us at 1-844-440-1900.

Where You Get Covered Care

You can find a current list of dentists online at www.healthpartners.com/fedvip. You can also call us at 1-844-440-1900 to request that a list be mailed to you.

Plan Providers

A current list of participating dentists is available on our online provider search at www.healthpartners.com/fedvip.

In-Network

Providers who have agreed to participate in the HealthPartners dental network.

Out-of-Network

Only providers listed with their corresponding locations are in network. Not all dentists at a location may be in network and the same provider at a different location may not be in network. It is your responsibility to ensure that the listed provider is active and in network at the time and location at which you receive services. You may obtain care from any licensed dentist. If the dentist you use is not part of our network, benefits will be determined based on the out-of-network benefit level. Because these providers are out of our network, payment will be based on the lesser of the provider's actual charge or the maximum allowed amounts established by HealthPartners for services rendered by out-of-network providers. You are responsible for the difference between our payment and the amount billed. If a member chooses to go out of network, payment will be made directly to the member.

Emergency Services

All expenses for emergency services are payable as any other expense, subject to plan provisions. If you receive emergency services from an out-of-network dentist, benefits will be paid under the out-of-network plan provisions. You are responsible for the difference between the maximum allowed amount and the billed charge.

FEHB/PSHB First Payor

When you visit a provider who participates with both, your FEHB/PSHB plan and your FEDVIP plan, the FEHB/PSHB plan will pay benefits first. The FEDVIP plan allowance will be the prevailing charge, in these cases. You are responsible for the difference between the FEHB/PSHB and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the primary FEHB/PSHB first payor. You can assist with this process and also ensure that you are receiving the maximum allowable benefit under each program by presenting both your FEDVIP and FEHB/PSHB ID cards at the time of your dental appointment. The dentist should include both ID numbers when submitting the claim to the plans.

It is important to bring your FEDVIP and FEHB/PSHB identification cards to every dental appointment because most FEHB/PSHB plans offer some level of dental benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.

Coordination of Benefits

We will coordinate benefit payments with the payment of benefits under other group health benefits coverage you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault.

We may request that you verify/identify your health insurance plan(s) annually or at time of service.

Service Area To enroll in this plan, you must live in our service area. This is where our providers are located. Our service area is: Minnesota, North Dakota, South Dakota, parts of Iowa and parts of Wisconsin.

If you move outside of our service area, you may enroll in another plan at that time. You do not have to wait until open season to change plans.

Contact BENEFEDS at www.benefeds.gov or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to change plans.

Rating Areas Your rates are determined based on where you live. This is called a rating area. If you move, you must update your address through BENEFEDS. Your rates might change because of the move.

Limited Access Areas If you live in a limited access area and you receive covered services from an out-of-network provider, we will pay in accordance with our plan allowance. You are responsible for any difference between the amount billed and our payment. You can find a list of our limited access areas at www.FederalDentalPlans.com or by contacting us at 1-855-836-6337.

Alternate Benefit There are no alternate benefits associated with this plan.

Maximum Amount Allowed The maximum amount of reimbursement we allow for a specific procedure. When you use an in-network provider, the provider cannot bill you for the difference between the Maximum Allowed Amount and the billed charge. When you use an out-of-network provider, you are responsible for the difference between the Maximum Allowed Amount and the billed charge in addition to applicable coinsurance and deductible amounts.

Precertification 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 precertification 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 precertification 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 precertification 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 precertification 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 8 “Claims Filing and Disputed Claims Processes” for a description of how to proceed.

Call Member Services for more information on precertification of benefits.

We will notify the dentist of the precertification, 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.

Precertification for services to be performed is limited to services performed within 90 days from the date such course of treatment was approved by us. Additional services required after 90 days may be submitted in writing, as a new course of treatment, and approved on the same basis as the prior plan.

Section 4 Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

| | |
|---------------------------------|--|
| Deductible | <p>A deductible is a fixed expense you must incur for certain out-of-network covered services and supplies before we start paying benefits for them.</p> <p>Example: In our High Option plan, the out-of-network calendar year deductible for an individual is \$50</p> |
| Coinsurance | <p>Coinsurance is the percentage of our allowance that you must pay for your care.</p> <p>Example: In our Standard Option plan, you pay 20% for in-network minor restorative services.</p> |
| Annual Benefit Maximum | <p>The maximum annual benefit that you can receive per enrollee.</p> <p>The High Option annual benefit maximum for in-network implant services is \$5,000. There is no annual benefit maximum on the High Option plan for all other in-network services, the annual benefit maximum for non-orthodontic out-of-network services is \$3,000 per enrollee. Benefits received in-network will count toward the out-of-network annual maximum benefit.</p> <p>The Standard Option annual benefit maximum for non-orthodontic services is \$2,000 per enrollee for in-network services, and \$1,000 per enrollee for out-of-network services. In no instance will the Standard Option allow more than \$2,000 per enrollee in combined benefits in any calendar year.</p> |
| Lifetime Benefit Maximum | <p>Both the Standard Option plan and the High Option plan include a lifetime benefit maximum limit for orthodontic care.</p> <p>The High Option lifetime benefit maximum for orthodontic care is \$3,500 per enrollee in-network and \$2,000 per enrollee out-of-network. The lifetime benefit maximum for orthodontic care is combined for in-network and out-of-network services.</p> <p>The Standard Option lifetime benefit maximum for orthodontic care is \$2,000 per enrollee in-network and \$1,000 per enrollee out-of-network. The lifetime benefit maximum for orthodontic care is combined for in-network and out-of-network services.</p> |
| In-Network Services | <p>The coinsurance amounts listed in the benefit schedule represent your total cost for in-network services subject to any plan maximums or limitations.</p> |
| Out-of-Network Services | <p>The coinsurance amounts listed in Section 5, along with any deductible and billed amounts that exceed the maximum allowed fee (plan allowance), represent your cost for out-of-network services.</p> |
| Emergency Services | <p>An emergency is treatment due to injury, accident or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically or physically possible for you to be treated by a plan provider.</p> |
| Plan Allowance | <p>The amount we use to determine our payment for out-of-network services.</p> |
| In-Progress Treatment | <p>In-progress treatment for dependents of retiring active duty service members who were enrolled in the TRICARE Dental Program (TDP) will be covered for the 2025 plan year; regardless of any current plan exclusion for care initiated prior to the enrollee's effective date.</p> <p>This requirement includes assumption of payments for covered orthodontia services up to the FEDVIP policy limits, and full payment where applicable up to the terms of FEDVIP policy for covered services completed (but not initiated) in the 2025 plan year such as crowns and implants.</p> |

Section 5 Dental Services and Supplies Class A Basic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is \$0 in-network. The out-of-network deductible is \$50 per enrollee on the High Option and \$75 per enrollee on the Standard Option. The deductible does not apply to Class A services.
- The High Option annual benefit maximum for non-orthodontic in-network services is unlimited and \$3,000 per enrollee for non-orthodontic out-of-network services.
- The Standard Option annual benefit maximum for non-orthodontic in-network services is \$2,000 per enrollee, and \$1,000 per enrollee for out-of-network services. In no instance will the Standard Option allow more than \$2,000 per enrollee in combined benefits in any calendar year.
- The following is an all-inclusive list of covered services. HealthPartners will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.
- There is no waiting period for basic services.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

- **High Option**
 - **In-Network:** Nothing for covered services as defined by the plan subject to plan maximums.
 - **Out-of-Network:** Any difference between the plan allowance and the billed amount.
- **Standard Option**
 - **In-Network:** Nothing for covered services as defined by the plan subject to plan maximums.
 - **Out-of-Network:** Any difference between the plan allowance and the billed amount.

Diagnostic and treatment services

D0120 Periodic oral evaluation - established patient – *Limited to two per calendar year – see benefit limitations*

D0140 Limited oral evaluation – problem focused – *Limited to one per calendar year – see benefit limitations*

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver – *Limited to two per calendar year*

D0150 Comprehensive oral evaluation - new or established patient – *Limited to two per calendar year – see benefit limitations*

D0180 Comprehensive periodontal evaluation - new or established patient – *Limited to two per calendar year*

D0210 Intraoral – comprehensive series of radiographic images – *Limited to one set every three years. (Full Mouth series or panoramic images)*

D0220 Intraoral - periapical first radiographic image

D0230 Intraoral - periapical each additional radiographic image

D0240 Intraoral - occlusal radiographic image

D0250 Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector

D0251 Extra-oral posterior dental radiographic image

D0270 Bitewing - single radiographic image - *Limited to one set per calendar year*

D0272 Bitewings - two radiographic images – *Limited to one set per calendar year*

D0273 Bitewings - three radiographic images – *Limited to one set per calendar year*

Diagnostic and treatment services - continued on next page

Diagnostic and treatment services (cont.)

D0274 Bitewings - four radiographic images – *Limited to one set per calendar year*

D0277 Vertical bitewings - 7 to 8 radiographic images – *Limited to one set every three years.*

D0330 Panoramic radiographic image – *Limited to one set every three years. (Full Mouth series or panoramic images)*

D0425 Caries susceptibility tests

Preventive Services

D1110 Prophylaxis - adult – *Limited to twice per calendar year*

D1120 Prophylaxis - child – *Limited to twice per calendar year*

D1206 Topical application of fluoride varnish - *Limited to children under age 19 and twice per calendar year*

D1208 Topical application of fluoride – excluding varnish - *Limited to children under age 19 and twice per calendar year*

D1351 Sealant – per tooth – *Limited to one sealant per permanent molar in a three year period*

D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth

D1353 Sealant repair – per tooth

D1354 Application of caries arresting medicament – per tooth – *Limited to one application per tooth, per lifetime*

D1510 Space maintainer - fixed, unilateral – per quadrant – *Limited to children under age 19*

D1516 Space maintainer – fixed – bilateral, maxillary – *Limited to children under age 19*

D1517 Space maintainer – fixed – bilateral, mandibular – *Limited to children under age 19*

D1520 Space maintainer - removable, unilateral - per quadrant – *Limited to children under age 19*

D1526 Space maintainer – removable – bilateral, maxillary – *Limited to children under age 19*

D1527 Space maintainer – removable – bilateral, mandibular – *Limited to children under age 19*

D1551 Re-cement or re-bond bilateral space maintainer - maxillary – *Limited to children under age 19*

D1552 Re-cement or re-bond bilateral space maintainer – mandibular – *Limited to children under age 19*

D1553 Re-cement or re-bond unilateral space maintainer - per quadrant – *Limited to children under age 19*

D1575 Distal shoe space maintainer - fixed, unilateral - per quadrant - *Limited to children under age 19 and one per lifetime*

D4910 Periodontal maintenance – *Limited to a combination of two periodontal maintenance or dental cleanings (prophylaxis) per year.*

Additional Procedures

D9110 Palliative treatment of dental pain – per visit

D9311 Consultation with a medical health care professional

Prevention Reward

Other benefit enhancements included on both plans:**Little PartnersSM**

Any service covered on the FEDVIP plan is covered at no cost with no annual maximum limit or frequency limits for children 12 years and younger when they see a network dentist. The goal is to eliminate any financial barriers from kids receiving the care they need to put them on a path to a lifetime of good oral health. Little Partners does not apply to orthodontics or dental implants.

MouthWise Matters

Members who are pregnant or living with diabetes will receive coverage at in-network providers at no cost for a set of services that help control or prevent gum disease (annual maximum and frequency limits do not apply). These services include extra dental checkups, cleanings, root planing and scaling.

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is \$0 in-network. The out-of-network deductible is \$50 per enrollee on the High Option and \$75 per enrollee on the Standard Option.
- The High Option annual benefit maximum for non-orthodontic in-network services is unlimited and \$3,000 per enrollee for out-of-network services.
- The Standard Option annual benefit maximum for non-orthodontic in-network services is \$2,000 per enrollee, and \$1,000 per enrollee for out-of-network services. In no instance will the Standard Option allow more than \$2,000 per enrollee in combined benefits in any calendar year.
- There is no waiting period for basic services.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

Minor Restorative Services

High Option

- **In-Network:** Nothing for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$50 deductible. You pay 40% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount

Standard Option

- **In-Network:** You pay 20% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$75 deductible. You pay 60% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

Endodontics

High Option

- **In-Network:** You pay 50% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$50 deductible. You pay 60% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

Standard Option

- **In-Network:** You pay 50% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$75 deductible. You pay 60% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

Periodontal, Prosthodontic and Oral Surgery Services

High Option

- **In-Network:** You pay 30% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$50 deductible. You pay 40% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

Standard Option

- **In-Network:** You pay 45% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$75 deductible. You pay 60% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

Minor Restorative Services

D2140 Amalgam - one surface, primary or permanent

D2150 Amalgam - two surfaces, primary or permanent

D2160 Amalgam - three surfaces, primary or permanent

D2161 Amalgam - four or more surfaces, primary or permanent

D2330 Resin-based composite - one surface, anterior

D2331 Resin-based composite - two surfaces, anterior

D2332 Resin-based composite - three surfaces, anterior

D2335 Resin-based composite - four or more surfaces (anterior)

D2390 Resin-based composite crown, anterior

D2391 Resin-based composite - one surface, posterior

D2392 Resin-based composite - two surfaces, posterior

D2393 Resin-based composite - three surfaces, posterior

D2394 Resin-based composite - four or more surfaces, posterior

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration - *Limited to once per 6 month period per tooth*

D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core

D2920 Re-cement or re-bond crown - *Limited to once per 6 month period per tooth*

D2921 Reattachment of tooth fragment, incisal edge or cusp

D2930 Prefabricated stainless steel crown - primary tooth - *Limited to one per patient, per tooth, per lifetime*

D2931 Prefabricated stainless steel crown - permanent tooth - *Limited to one per patient, per tooth, per lifetime*

D2951 Pin retention - per tooth, in addition to restoration

Endodontic Services

D3110 Pulp cap - direct (excluding final restoration)

D3120 Pulp cap - indirect (excluding final restoration)

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament

D3221 Pulpal debridement, primary and permanent teeth

D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development

D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)

Endodontic Services - continued on next page

Endodontic Services (cont.)

D3355 Pulpal regeneration - initial visit

D3356 Pulpal regeneration - interim medication replacement

D3357 Pulpal regeneration - completion of treatment

Periodontal Services

D4341 Periodontal scaling and root planing - four or more teeth per quadrant – *Limited to once per quadrant every two years*

D4342 Periodontal scaling and root planing - one to three teeth per quadrant – *Limited to once per site every two years*

D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth

Prosthodontic Services

D5410 Adjust complete denture - maxillary

D5411 Adjust complete denture - mandibular

D5421 Adjust partial denture - maxillary

D5422 Adjust partial denture - mandibular

D5511 Repair broken complete denture base, mandibular

D5512 Repair broken complete denture base, maxillary

D5520 Replace missing or broken teeth – complete denture – per tooth

D5611 Repair resin partial denture base, mandibular

D5612 Repair resin partial denture base, maxillary

D5621 Repair cast partial framework, mandibular

D5622 Repair cast partial framework, maxillary

D5630 Repair or replace broken retentive clasping materials – per tooth

D5640 Replace missing or broken teeth – partial denture – per tooth

D5650 Add tooth to existing partial denture – per tooth

D5660 Add clasp to existing partial denture - per tooth

D5670 Replace all teeth and acrylic on cast metal framework (maxillary)

D5671 Replace all teeth and acrylic on cast metal framework (mandibular)

D5710 Rebase complete maxillary denture

D5711 Rebase complete mandibular denture

D5720 Rebase maxillary partial denture

D5721 Rebase mandibular partial denture

D5730 Reline complete maxillary denture (direct)

D5731 Reline complete mandibular denture (direct)

D5740 Reline maxillary partial denture (direct)

D5741 Reline mandibular partial denture (direct)

D5750 Reline complete maxillary denture (indirect)

D5751 Reline complete mandibular denture (indirect)

D5760 Reline maxillary partial denture (indirect)

D5761 Reline mandibular partial denture (indirect)

D5850 Tissue conditioning, maxillary

D5851 Tissue conditioning, mandibular

D6980 Fixed partial denture repair necessitated by restorative material failure

Oral Surgery

D7111 Extraction, coronal remnants – primary tooth

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated

D7220 Removal of impacted tooth - soft tissue

D7230 Removal of impacted tooth - partially bony

D7240 Removal of impacted tooth - completely bony

D7241 Removal of impacted tooth - completely bony, with unusual surgical complications

D7250 Removal of residual tooth roots (cutting procedure)

D7251 Coronectomy – intentional partial tooth removal, impacted teeth only – *Limited to one per lifetime*

D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth

D7280 Exposure of an unerupted tooth

D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant

D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant

D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant

D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant

D7471 Removal of lateral exostosis (maxilla or mandible)

D7510 Incision and drainage of abscess - intraoral soft tissue

D7910 Suture of recent small wounds up to 5 cm

D7956 Guided tissue regeneration, edentulous area - resorbable barrier, per site

D7957 Guided tissue regeneration, edentulous area - non-resorbable barrier, per site

D7971 Excision of pericoronal gingiva

D7999 Unspecified oral surgery procedure, by report

Class C Major

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is \$0 in-network. The out-of-network deductible is \$50 per enrollee on the High Option and \$75 per enrollee on the Standard Option.
- The High Option annual implant maximum for in-network services is \$5,000. The High Option annual benefit maximum for all other non-orthodontic in-network services is unlimited.
- The High Option annual benefit maximum for non-orthodontic out-of-network services is \$3,000 per enrollee.
- The Standard Option annual benefit maximum for non-orthodontic in-network services is \$2,000 per enrollee, and \$1,000 per enrollee for out-of-network services. In no instance will the Standard Option allow more than \$2,000 per enrollee in combined benefits in any calendar year.
- The following is an all-inclusive list of covered services. HealthPartners will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.
- There is no waiting period for basic services.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

Major Restorative, Endodontic, Periodontal and Prosthodontic Services

High Option

- **In-Network:** You pay 50% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$50 deductible. You pay 60% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

Standard Option

- **In-Network:** You pay 50% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$75 deductible. You pay 60% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

Major Restorative Services

D0160 Detailed and extensive oral evaluation - problem focused, by report

D2510 Inlay - metallic - one surface

D2520 Inlay - metallic - two surfaces

D2530 Inlay - metallic - three or more surfaces

D2542 Onlay - metallic - two surfaces

D2543 Onlay - metallic - three surfaces

D2544 Onlay - metallic - four or more surfaces

D2610 Inlay - porcelain/ceramic - one surface

D2620 Inlay - porcelain/ceramic - two surfaces

Major Restorative Services - continued on next page

Major Restorative Services (cont.)

D2630 Inlay - porcelain/ceramic - three or more surfaces

D2740 Crown - porcelain/ceramic

D2750 Crown - porcelain fused to high noble metal

D2751 Crown - porcelain fused to predominantly base metal

D2752 Crown - porcelain fused to noble metal

D2780 Crown - 3/4 cast high noble metal

D2781 Crown - 3/4 cast predominantly base metal

D2782 Crown - 3/4 cast noble metal

D2783 Crown - 3/4 porcelain/ceramic

D2790 Crown - full cast high noble metal

D2791 Crown - full cast predominantly base metal

D2792 Crown - full cast noble metal

D2794 Crown - titanium and titanium alloys

D2950 Core buildup, including any pins when required

D2954 Prefabricated post and core in addition to crown

D2980 Crown repair necessitated by restorative material failure

D2981 Inlay repair necessitated by restorative material failure

D2982 Onlay repair necessitated by restorative material failure

D2983 Veneer repair necessitated by restorative material failure

D2990 Resin infiltration of incipient smooth surface lesions

Endodontic Services

D3310 Endodontic therapy, anterior tooth (excluding final restoration)

D3320 Endodontic therapy, premolar tooth (excluding final restoration)

D3330 Endodontic therapy, molar tooth (excluding final restoration)

D3346 Retreatment of previous root canal therapy - anterior

D3347 Retreatment of previous root canal therapy - premolar

D3348 Retreatment of previous root canal therapy - molar

D3351 Apexification/recalcification – initial visit (apical closure/calccific repair of perforations, root resorption, etc.)

D3352 Apexification/recalcification – interim medication replacement

D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calccific repair of perforations, root resorption, etc.)

D3410 Apicoectomy - anterior

D3421 Apicoectomy - premolar (first root)

D3425 Apicoectomy - molar (first root)

D3426 Apicoectomy (each additional root)

D3430 Retrograde filling – per root

D3450 Root amputation - per root

D3920 Hemisection (including any root removal), not including root canal therapy

Periodontal Services

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|---|
| D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - <i>Limited to once in a 24 month period</i> |
| D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - <i>Limited to once in a 24 month period</i> |
| D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth |
| D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant |
| D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant |
| D4249 Clinical crown lengthening - hard tissue |
| D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant - <i>Limited to once in a 24 month period</i> |
| D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant - <i>Limited to once in a 24 month period</i> |
| D4268 Surgical revision procedure, per tooth |
| D4270 Pedicle soft tissue graft procedure |
| D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft |
| D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft |
| D4276 Combined connective tissue and pedicle graft, per tooth |
| D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft |
| D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site |
| D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site |
| D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site |
| D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>Limited to once per lifetime</i> |
| D4999 Unspecified periodontal procedure, by report |

Prosthodontic Services

| |
|---|
| D5110 Complete denture - maxillary |
| D5120 Complete denture - mandibular |
| D5130 Immediate denture - maxillary |
| D5140 Immediate denture - mandibular |
| D5211 Maxillary partial denture – resin base (including, retentive/clasping materials, rests, and teeth) |
| D5212 Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth) |
| D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) |
| D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) |
| D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) |
| D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) |
| D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) |

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

| |
|---|
| D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) |
| D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) |
| D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) |
| D5282 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary |
| D5283 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular |
| D5284 Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant - <i>Limited to 1 per quadrant every 5 years</i> |
| D5286 Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant |
| D5863 Overdenture – complete maxillary |
| D5864 Overdenture – partial maxillary |
| D5865 Overdenture – complete mandibular |
| D5866 Overdenture – partial mandibular |
| D5876 Add metal substructure to acrylic full denture (per arch) - <i>Charges submitted without a report will be denied as non-covered benefits.</i> |
| D5899 Unspecified removable prosthodontic procedure, by report |
| D6010 Surgical placement of implant body: endosteal implant |
| D6011 Surgical access to an implant body (second stage implant surgery) |
| D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant |
| D6013 Surgical placement of mini implant |
| D6040 Surgical placement: eosteal implant |
| D6050 Surgical placement: transosteal implant |
| D6055 Connecting bar – implant supported or abutment supported |
| D6056 Prefabricated abutment – includes modification and placement |
| D6057 Custom fabricated abutment – includes placement |
| D6058 Abutment supported porcelain/ceramic crown |
| D6059 Abutment supported porcelain fused to metal crown (high noble metal) |
| D6060 Abutment supported porcelain fused to metal crown (predominantly base metal) |
| D6061 Abutment supported porcelain fused to metal crown (noble metal) |
| D6062 Abutment supported cast metal crown (high noble metal) |
| D6063 Abutment supported cast metal crown (predominantly base metal) |
| D6064 Abutment supported cast metal crown (noble metal) |
| D6065 Implant supported porcelain/ceramic crown |
| D6066 Implant supported crown - porcelain fused to high noble alloys |
| D6067 Implant supported crown - high noble alloys |
| D6068 Abutment supported retainer for porcelain/ceramic FPD |
| D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal) |
| D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) |
| D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal) |
| D6072 Abutment supported retainer for cast metal FPD (high noble metal) |
| D6073 Abutment supported retainer for cast metal FPD (predominantly base metal) |
| D6074 Abutment supported retainer for cast metal FPD (noble metal) |

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

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| D6075 Implant supported retainer for ceramic FPD |
| D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys |
| D6077 Implant supported retainer for metal FPD - high noble alloys |
| D6080 Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments |
| D6081 Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure |
| D6082 Implant supported crown - porcelain fused to predominantly base alloys |
| D6083 Implant supported crown - porcelain fused to noble alloys |
| D6084 Implant supported crown - porcelain fused to titanium and titanium alloys |
| D6085 Interim implant crown |
| D6086 Implant supported crown - predominantly base alloys |
| D6087 Implant supported crown - noble alloys |
| D6088 Implant supported crown - titanium and titanium alloys |
| D6090 Repair of implant/abutment supported prosthesis |
| D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment |
| D6092 Re-cement or re-bond implant/abutment supported crown |
| D6093 Re-cement or re-bond implant/abutment supported fixed partial denture |
| D6094 Abutment supported crown - titanium and titanium alloys |
| D6096 Remove broken implant retaining screw |
| D6097 Abutment supported crown - porcelain fused to titanium and titanium alloys |
| D6098 Implant supported retainer - porcelain fused to predominantly base alloys |
| D6099 Implant supported retainer for FPD - porcelain fused to noble alloys |
| D6100 Surgical removal of implant body |
| D6101 Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure – <i>Limit 1 per lifetime</i> |
| D6102 Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure |
| D6103 Bone graft for repair of peri-implant defect – does not include flap entry and closure |
| D6104 Bone graft at time of implant placement |
| D6110 Implant /abutment supported removable denture for edentulous arch – maxillary |
| D6111 Implant /abutment supported removable denture for edentulous arch – mandibular |
| D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary |
| D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular |
| D6114 Implant /abutment supported fixed denture for edentulous arch – maxillary |
| D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular |
| D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary |
| D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular |
| D6120 Implant supported retainer – porcelain fused to titanium and titanium alloys |
| D6121 Implant supported retainer for metal FPD - predominantly base alloys |
| D6122 Implant supported retainer for metal FPD - noble alloys |
| D6123 Implant supported retainer for metal FPD – titanium and titanium alloys |
| D6190 Radiographic/surgical implant index, by report |
| D6194 Abutment supported retainer crown for FPD – titanium and titanium alloys |

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

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| D6195 Abutment supported retainer - porcelain fused to titanium and titanium alloys |
| D6205 Pontic - indirect resin based composite |
| D6210 Pontic - cast high noble metal |
| D6211 Pontic - cast predominantly base metal |
| D6212 Pontic - cast noble metal |
| D6214 Pontic - titanium and titanium alloys |
| D6240 Pontic - porcelain fused to high noble metal |
| D6241 Pontic - porcelain fused to predominantly base metal |
| D6242 Pontic - porcelain fused to noble metal |
| D6243 Pontic - porcelain fused to titanium and titanium alloys |
| D6245 Pontic - porcelain/ceramic |
| D6250 Pontic - resin with high noble metal |
| D6251 Pontic - resin with predominantly base metal |
| D6252 Pontic - resin with noble metal |
| D6253 Interim pontic - further treatment or completion of diagnosis necessary prior to final impression |
| D6545 Retainer - cast metal for resin bonded fixed prosthesis |
| D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis |
| D6549 Retainer - resin bonded fixed prosthesis |
| D6600 Retainer inlay - porcelain/ceramic, two surfaces |
| D6601 Retainer inlay - porcelain/ceramic, three or more surfaces |
| D6602 Retainer inlay - cast high noble metal, two surfaces |
| D6603 Retainer inlay - cast high noble metal, three or more surfaces |
| D6604 Retainer inlay - cast predominantly base metal, two surfaces |
| D6605 Retainer inlay - cast predominantly base metal, three or more surfaces |
| D6606 Retainer inlay - cast noble metal, two surfaces |
| D6607 Retainer inlay - cast noble metal, three or more surfaces |
| D6608 Retainer onlay - porcelain/ceramic, two surfaces |
| D6609 Retainer onlay - porcelain/ceramic, three or more surfaces |
| D6610 Retainer onlay - cast high noble metal, two surfaces |
| D6611 Retainer onlay - cast high noble metal, three or more surfaces |
| D6612 Retainer onlay - cast predominantly base metal, two surfaces |
| D6613 Retainer onlay - cast predominantly base metal, three or more surfaces |
| D6614 Retainer onlay - cast noble metal, two surfaces |
| D6615 Retainer onlay - cast noble metal, three or more surfaces |
| D6624 Retainer inlay - titanium |
| D6634 Retainer onlay - titanium |
| D6710 Retainer crown - indirect resin based composite |
| D6720 Retainer crown - resin with high noble metal |
| D6721 Retainer crown - resin with predominantly base metal |
| D6722 Retainer crown - resin with noble metal |
| D6740 Retainer crown - porcelain/ceramic |
| D6750 Retainer crown - porcelain fused to high noble metal |
| D6751 Retainer crown - porcelain fused to predominantly base metal |
| D6752 Retainer crown - porcelain fused to noble metal |

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)

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| D6753 Retainer crown - porcelain fused to titanium and titanium alloys |
| D6780 Retainer crown - 3/4 cast high noble metal |
| D6781 Retainer crown - 3/4 cast predominantly base metal |
| D6782 Retainer crown - 3/4 cast noble metal |
| D6783 Retainer crown - 3/4 porcelain/ceramic |
| D6784 Retainer crown ¾ - titanium and titanium alloys |
| D6790 Retainer crown - full cast high noble metal |
| D6791 Retainer crown - full cast predominantly base metal |
| D6792 Retainer crown - full cast noble metal |
| D6794 Retainer crown - titanium and titanium alloys |
| D6920 Connector bar |
| D6930 Re-cement or re-bond fixed partial denture |
| D6940 Stress breaker |
| D6950 Precision attachment |
| D9932 Cleaning and inspection of removable complete denture, maxillary |
| D9933 Cleaning and inspection of removable complete denture, mandibular |
| D9934 Cleaning and inspection of removable partial denture, maxillary |
| D9935 Cleaning and inspection of removable partial denture, mandibular |
| D9941 Fabrication of athletic mouthguard – <i>Limited to once per enrollee per 12 consecutive month period</i> |
| D9942 Repair and/or reline of occlusal guard - <i>Limited to 1 every two years for patients 13 and older.</i> |
| D9943 Occlusal guard adjustment - <i>Limit 1 every six months for patients 13 and older</i> |
| D9944 Occlusal guard – hard appliance, full arch - <i>Limit 1 every year for patients 13 and older</i> |
| D9945 Occlusal guard – soft appliance, full arch - <i>Limit 1 every year for patients 13 and older</i> |
| D9946 Occlusal guard – hard appliance, partial arch – <i>Occlusal guards which includes D9944 Occlusal guard – hard appliance, full arch, D9945 Occlusal guard – soft appliance, full arch, and D9946 Occlusal guard - hard appliance, partial arch are limited to once per calendar year for enrollees age 13 or older and treatment is for bruxism or to protect the teeth from grinding, chipping or fracture. An occlusal guard for temporomandibular joint dysfunction or other non-dental related treatment is not covered. Charges submitted without a report will be denied as non-covered benefits.</i> |
| D9974 Internal bleaching – per tooth – <i>Internal bleaching of discolored teeth is covered for endodontically treated anterior teeth once per enrollee per tooth every three calendar years. External bleaching of discolored teeth is not covered.</i> |
| D9999 Unspecified adjunctive procedure, by report |

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The High Option lifetime benefit maximum is \$3,500 in-network and \$2,000 out-of-network per enrollee. The lifetime benefit maximum for orthodontic care is combined for in-network and out-of-network services.
- The Standard Option lifetime benefit maximum is \$2,000 in-network and \$1,000 out-of-network per enrollee. The lifetime benefit maximum for orthodontic care is combined for in-network and out-of-network services.
- There is no waiting period for basic services.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

High Option

- **In-Network:** 50% of the plan allowance up to the lifetime benefit maximum. You are responsible for all charges that exceed the lifetime benefit maximum.
- **Out-of-Network:** 50% of the plan allowance up to the lifetime benefit maximum and any difference between the plan allowance and the billed amount. You are responsible for all charges that exceed the lifetime benefit maximum.

Standard Option

- **In-Network:** 50% of the plan allowance up to the lifetime benefit maximum. You are responsible for all charges that exceed the lifetime benefit maximum.
- **Out-of-Network:** 50% of the plan allowance up to the lifetime benefit maximum and any difference between the plan allowance and the billed amount. You are responsible for all charges that exceed the lifetime benefit maximum.

Orthodontic Services

D0340 2D cephalometric radiographic image – acquisition, measurement and analysis

D0350 2D oral/facial photographic image obtained intra-orally or extra-orally

D0470 Diagnostic casts

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8040 Limited orthodontic treatment of the adult dentition

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8090 Comprehensive orthodontic treatment of the adult dentition

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment examination to monitor growth and development

D8670 Periodic orthodontic treatment visit

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))

D8681 Removable orthodontic retainer adjustment

General Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is \$0 in-network. The out-of-network deductible is \$50 per enrollee on the High Option and \$75 per enrollee on the Standard Option.
- The High Option annual benefit maximum for non-orthodontic in-network services is unlimited and \$3,000 per enrollee for out-of-network services.
- The Standard Option annual benefit maximum for non-orthodontic in-network services is \$2,000 per enrollee, and \$1,000 per enrollee for out-of-network services. In no instance will the Standard Option allow more than \$2,000 per enrollee in combined benefits in any calendar year.
- The following is an all-inclusive list of covered services. HealthPartners will provide benefits for these services, subject to the exclusions and limitations shown in this section and Section 7.
- There is no waiting period for basic services.
- **See Section 7 of this brochure for plan limitations.**

You Pay:

High Option

- **In-Network:** You pay 30% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$50 deductible. You pay 40% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

Standard Option

- **In-Network:** You pay 45% of the plan allowance for covered services as defined by the plan subject to plan maximums.
- **Out-of-Network:** \$75 deductible. You pay 60% of the plan allowance for covered services as defined by the plan subject to plan maximums and any difference between the plan allowance and the billed amount.

General Services

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| D9219 Evaluation for moderate sedation, deep sedation or general anesthesia |
| D9222 Deep sedation/general anesthesia – first 15 minutes |
| D9223 Deep sedation/general anesthesia – each subsequent 15 minute increment |
| D9230 Inhalation of nitrous oxide/analgesia, anxiolysis - <i>Nitrous oxide and oral sedation are not covered unless dentally necessary and required to perform a covered dental procedure.</i> |
| D9239 Intravenous moderate (conscious) sedation/analgesia- first 15 minutes |
| D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment |
| D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician |
| D9440 Office visit - after regularly scheduled hours |
| D9610 Therapeutic parenteral drug, single administration |
| D9612 Therapeutic parenteral drugs, two or more administrations, different medications |
| D9613 Infiltration of sustained release therapeutic drug, per quadrant |
| D9930 Treatment of complications (post-surgical) - unusual circumstances, by report |

Section 6 International Services and Supplies

International Claims Payment

This plan provides a benefit for emergency services when overseas. Emergency services are defined as treatment due to injury, accident or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically or physically possible for you to be treated by an in-network assigned plan provider. We will reimburse you for emergency services up to \$100 per member per year.

Finding an International Provider

This plan provides a benefit for international emergency services when services are received from a licensed dentist. The HealthPartners Dental Network does not extend outside of the United States. You have the right to choose any licensed dental practitioner; you do not need to contact HealthPartners first.

Note: Because international claims do not have the consideration of stateside cost containment, members must be cautious to guard against inappropriate/excessive services.

Filing International Claims

The following should be provided when submitting a claim for International emergency services:

- Name of country where services were received
- American Dental Association procedure codes
- Translation of language to English
- Translation into US currency or accurate day rate
- Tooth number(s) and/or quadrants
- Date(s) of service
- Dentist name

Customer Service Website and Phone Numbers

Our plan website is www.healthpartners.com/fedvip. You may also contact us by phone at 1-844-440-1900.

Section 7 General Exclusions – Things We Do Not Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition.**

We do not cover the following:

Plan Exclusions

- Services which are covered under Medicare, worker's compensation or employer's liability laws.
- Services which are not necessary for the patient's dental health as determined by the Plan.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Plan.
- Oral surgery requiring the setting of fractures or dislocations.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, anodontic, mandibular prognathism or development malformations where, in the opinion of the Plan, such services should not be performed in a dental office.
- Dispensing of drugs.
- Hospitalization for any dental procedure.
- Treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared.
- Replacement due to loss or theft of prosthetic appliance.
- Procedures not listed as covered benefits under this Plan.
- Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Plan (with the exception of out-of-area emergency dental services).
- Services related to the treatment of TMD ((Temporomandibular Disorder).
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
- Plaque control programs and dietary instructions.
- Nitrous oxide and oral sedation are not covered unless dentally necessary and required to perform a covered dental procedure.
- Out-of-network dental services related to the replacement of any teeth missing prior to your effective date. An existing dental implant will be treated as an existing tooth and will not be considered a missing tooth.

Plan Limitations

Little Partners: Frequency limits for children 12 years and younger do not apply when they see a network dentist. Little Partners does not apply to orthodontics or dental implants.

MouthWise Matters: To help control or prevent gum disease, frequency limits for dental checkups, cleanings, root planing and scaling at in-network providers do not apply to enrollees who are pregnant or living with diabetes.

- Two evaluations are covered per calendar year. All oral evaluations will be considered integral when provided on the same date of service by the same dentist.
- One problem focused exam is covered per calendar year, per patient.
- Two teeth cleanings (prophylaxis) are covered per calendar year, per patient.
- Periodontal maintenance after active therapy is covered two times per calendar year, within two years after definitive periodontal therapy. A combination of two periodontal maintenance or dental cleanings (prophylaxis) are allowed per year.
- Two applications of topical fluorides or fluoride varnishes are covered per calendar year, per patient to age 19.

- One set of bitewing x-rays are covered per calendar year, per patient.
- One set of full mouth x-rays or panoramic film is covered every three years, per patient.
- One sealant per tooth is covered per 36 months (limited to permanent 1st and 2nd molars). Sealants with a restoration on same date of service are considered integral.
- One interim caries arresting medicament application per primary tooth per lifetime.
- Distal shoe space maintainer limited to once per lifetime to age 19.
- 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.
- Benefit for replacement of a prosthetic appliance will be provided only (a) if the existing appliance cannot be made serviceable, and (b) after a five year period measured from the date on which it was installed.
- 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.
- Repair, relining and rebasing of dentures more than six months after installation of an initial or replacement denture is covered .
- Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
- Pulpotomies are considered integral when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
- One root planing or scaling is covered every two years per quadrant, per patient. Periodontal scaling and root planing provided within two years of periodontal scaling and root planing, or periodontal surgical procedures, in the same area of the mouth is not covered.
- One full mouth debridement is covered per lifetime, per patient.
- Localized delivery of antimicrobial agents (D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth) is limited to one benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per year. Must have pocket depths of five millimeters or greater.
- One periodontal surgery of any type, including any associated material, is covered every two years per quadrant or surgical site.
- Stainless steel crowns (D2930 Prefabricated stainless steel crown - primary tooth, D2931 Prefabricated stainless steel crown - permanent tooth) are covered one per tooth, per lifetime.
- Posts are eligible only when provided as part of a crown buildup or implant and are considered integral to the buildup or implant.
- Surgical periodontal procedures or scaling and root planing in the same area of the mouth within two years of a gingival flap procedure are not covered.
- Osseous surgery is not covered when provided within two years of osseous surgery in the same area of the mouth.
- Surgical revision procedure (D4268 Surgical revision procedure, per tooth) is considered integral to all other periodontal procedures.
- One (1) scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two (2) years.
- Coronectomy, intentional partial tooth removal, one (1) per lifetime.
- Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) when determined to be medically or dentally necessary for documented handicapped or uncontrollable patients or justifiable medical or dental conditions
- Occlusal guards are covered by report for patients 13 years of age or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period.

- Athletic mouth guards are limited to one (1) per 12 consecutive month period.
- Teledentistry, synchronous (D9995 Teledentistry – synchronous; real-time encounter) or asynchronous (D9996 Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review), limited to two (2) per calendar year.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To avoid delay in the payment of your dental claims, please have your dental provider submit your claims directly to your FEHB/PSHB plan (Should you be enrolled), then to HealthPartners. Pretreatment estimates can be submitted directly to HealthPartners (exception: If accidental injury occurs, pretreatment estimates should be submitted to your FEHB/PSHB plan). If you need to send in a paper claim you may download a claim form from www.healthpartners.com/fedvip. Mail completed claim form to:

HealthPartners
PO Box 211532
Eagan, MN 55121

Deadline for Filing Your Claim

For emergency and international claims, you have 90 days from the date of service to file your claim.

Disputed Claims Process

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 below. 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.

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.

First Level Appeal. You or your authorized representative must file your appeal within 180 days of the denial. 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
Riverview Member Rights and Benefits
PO Box 21662
Eagan, MN 55121
Telephone: 1-888-525-2125

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.

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.

All notification described above will comply with applicable law.

If you file a first level appeal and it is denied, wholly or in part, you have further appeal options, as described below.

Second Level Appeal. If your appeal is regarding an administrative or benefit determination and does not involve a determination of dental necessity (a clinical dental review), you or your authorized representative may, within 180 days of the denial, submit a written request for a second level appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

HealthPartners
Riverview Member Rights and Benefits
PO Box 21662
Eagan, MN 55121
Telephone: 1-888-525-2125

The Member Services department will provide the complainant with the option of either a written reconsideration, or a hearing before the HealthPartners Appeals Committee 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.

This completes your internal appeals process with HealthPartners.

Independent External Review.

If you do not agree with the prior dental necessity decision, you or your authorized representative may request an external review with an Independent Review Organization (IRO), as described below, within four months of the date of the adverse decision.

- To initiate the external review process, you may submit a written request for an external review to HealthPartners.
- Upon receipt of the request for external review, the IRO must provide immediate notice of the review to the complainant and to HealthPartners. Within 10 business days, the complainant and HealthPartners must provide the reviewer with any information they wish to be considered. The complainant (who may be assisted or represented by an authorized representative) 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 professional with expertise in the dental issue being reviewed.
- An external review must be made as soon as possible, but no later than 45 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 complainant and HealthPartners.
- The result of the external review is the final review of your claim and is binding on the complainant and HealthPartners.

The FEDVIP law does not provide for OPM to review disputed claims.

Section 9 Definitions of Terms We Use in This Brochure

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| Annual Benefit Maximum | <p>The maximum annual benefit that you can receive per enrollee.</p> <p>There is no annual benefit maximum on the High Option plan for non-orthodontic in-network services, the annual benefit maximum for non-orthodontic out-of-network services is \$3,000 per enrollee.</p> <p>The Standard Option annual benefit maximum for non-orthodontic in-network services is \$2,000 per enrollee, and \$1,000 per enrollee for out-of-network services. In no instance will the Standard Option allow more than \$2,000 per enrollee in combined benefits in any calendar year.</p> |
| Annuitants | <p>Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.</p> |
| BENEFEDS | <p>The enrollment and premium administration system for FEDVIP.</p> |
| Benefits | <p>Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.</p> |
| Class A Services | <p>Basic services, which include oral examinations, dental cleanings (prophylaxis), diagnostic evaluations, sealants and x-rays.</p> |
| Class B Services | <p>Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.</p> |
| Class C Services | <p>Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.</p> |
| Class D Services | <p>Orthodontic services.</p> |
| Complainant | <p>This is an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant or former enrollee, who submits a complaint.</p> |
| Complaint | <p>This is any grievance by a complainant, 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.</p> |
| Emergency Services | <p>Treatment due to injury, accident or severe pain requiring the services of a dentist which occurs under circumstances where it is neither medically or physically possible for you to be treated by an assigned plan provider.</p> |
| Enrollee | <p>The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.</p> |
| FEDVIP | <p>Federal Employees Dental and Vision Insurance Program.</p> |
| Generally Accepted Dental Protocols | <p>The standards set by the American Dental Association or which are customarily used for dental care. HealthPartners reserves the right to determine the level of necessary treatment.</p> |
| In-Progress Treatment | <p>Dental services that initiated in 2024 that will be completed in 2025.</p> |

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|--|---|
| Missing Tooth Clause | The exclusion of any service or supply rendered to replace a tooth lost prior to the effective date of coverage. When the procedure/appliance is to replace only the tooth lost prior to the member's effective date, the procedure/appliance is not covered out-of-network. When the missing tooth is repaired in conjunction with other extractions after the effective date, the procedure/appliance is covered. |
| Plan Allowance | The amount we use to determine our payment for out-of-network services. |
| Preexisting Condition | Any disease or condition of the teeth or supporting structures which existed on the effective date of coverage. |
| Sponsor | Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves). |
| TEI certifying family member | Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members |
| TRICARE-eligible individual (TEI) family member | TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity. |
| We/Us | HealthPartners |
| You | Enrollee or eligible family member. |

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-855-836-6337 and explain the situation.
- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless they are disabled and incapable of self- support).

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Summary of Benefits

High Option

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover; please review the individual sections of this brochure, for more detail.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.gov or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.

| High Option Benefits | You Pay In-Network | You Pay Out-of-Network (Class B and C subject to \$50 individual deductible) |
|--|--|--|
| Class A (Basic) Services – preventive and diagnostic Deductible does not apply to preventive and diagnostic services | 0% | 0% |
| Class B (Intermediate) Services – includes: fillings | 0% | 40% |
| Class B (Intermediate) Services – includes: non-surgical periodontics | 30% | 40% |
| Class B (Intermediate) Services – includes: oral surgery | 30% | 40% |
| Class B (Intermediate) Services – includes: endodontics | 50% | 60% |
| Class C (Major) Services – includes: major restorative, prosthodontic and surgical periodontic services | 50% | 60% |
| Annual Maximum (excludes orthodontics) | Unlimited | \$3,000 combined in- and out-of-network |
| Class D Services – Orthodontics <ul style="list-style-type: none"> • No age limit • No waiting period • No deductible | 50% | 50% |
| | Up to \$3,500 Lifetime Benefit Maximum | Up to \$2,000 Lifetime Benefit Maximum |

When you use an out-of-network provider, you are responsible for the difference between the Maximum Allowed Amount and the billed charge in addition to applicable coinsurance and deductible amounts.

Kids age 12 and under get 100% coverage at in-network providers. This benefit does not apply toward orthodontics and implants.

Members who are at risk for gum disease and are pregnant or living with diabetes get extra coverage for exams and cleanings.

Standard Option

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover; please review the individual sections of this brochure, for more detail.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.gov or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.

| Standard Option Benefits | You Pay In-Network | You Pay Out-of-Network (Class B & C subject to \$75 individual deductible) |
|--|---|---|
| Class A (Basic) Services – preventive and diagnostic Deductible does not apply to preventive and diagnostic services | 0% | 0% |
| Class B (Intermediate) Services – includes: fillings | 20% | 60% |
| Class B (Intermediate) Services – includes: non-surgical periodontics | 45% | 60% |
| Class B (Intermediate) Services – includes: oral surgery | 45% | 60% |
| Class B (Intermediate) Services – includes: endodontics | 50% | 60% |
| Class C (Major) Services – includes: major restorative, prosthodontic and surgical periodontic services | 50% | 60% |
| Annual Maximum (excludes orthodontics) | \$2,000 | \$1,000 |
| Class D Services – Orthodontics <ul style="list-style-type: none"> • No age limit • No waiting period • No deductible | 50% Up to \$2,000 Lifetime Benefit Maximum | 50% Up to \$1,000 Lifetime Benefit Maximum |

When you use an out-of-network provider, you are responsible for the difference between the Maximum Allowed Amount and the billed charge in addition to applicable coinsurance and deductible amounts.

Kids age 12 and under get 100% coverage at in-network providers. This benefit does not apply toward orthodontics and implants.

Members who are at risk for gum disease and are pregnant or living with diabetes get extra coverage for exams and cleanings.

Notes

Rate Information

How to find your monthly and bi-weekly rates:

- In the first chart below, look up your state or zip code to determine your Rating
- In the second chart below, match your Rating Area to your enrollment type for a Standard Option plan
- In the third chart below, match your Rating Area to your enrollment type for a High Option plan

| Premium Rating Areas by State/Zip Code (first three digits) | | | | | | | | |
|---|--------------|---------------|-------|---------------|---------------|-------|--------------|---------------|
| State | Zip | Rating Region | State | Zip | Rating Region | State | Zip | Rating Region |
| IA | Entire state | 1 | MN | Rest of state | 1 | SD | Entire state | 1 |
| MN | 550-555, 563 | 2 | ND | Entire state | 1 | WI | Entire state | 2 |

Standard & High Rates

| Rating Area | Standard - Bi-Weekly | | | Standard - Monthly | | |
|-------------|----------------------|----------------|-----------------|--------------------|----------------|-----------------|
| | Self Only | Self Plus One | Self and Family | Self Only | Self Plus One | Self and Family |
| 1 | \$18.39 | \$36.79 | \$55.18 | \$39.85 | \$79.71 | \$119.56 |
| 2 | \$20.99 | \$41.98 | \$62.98 | \$45.48 | \$90.96 | \$136.46 |

| Rating Area | High - Bi-Weekly | | | High - Monthly | | |
|-------------|------------------|----------------|-----------------|----------------|-----------------|-----------------|
| | Self Only | Self Plus One | Self and Family | Self Only | Self Plus One | Self and Family |
| 1 | \$25.54 | \$51.07 | \$76.61 | \$55.34 | \$110.65 | \$165.99 |
| 2 | \$26.82 | \$53.64 | \$80.46 | \$58.11 | \$116.22 | \$174.33 |