HealthPartners Dental Plan

www.healthpartners.com/fedvip

(844) 440-1900

HealthPartners

2023

A Regional Dental PPO Plan

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

IMPORTANT
- Rates: Back Cover
- Changes for 2023: Page 4
- Summary of Benefits: Page 40

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

FEDVIP
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
844-440-1900
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, 2023 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 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 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.

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, 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 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

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.com. 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 2022 Open Season, your coverage will begin on January 1, 2023. Premium deductions will start with the first full pay period beginning on/after January 1, 2023. 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 14, 2022 through midnight EST December 12, 2022. 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 is no waiting period associated with this plan.

How We Have Changed For 2023

Changes to High Option only

- The Plan is adding a $5,000 in-network annual implant maximum.

Changes to both High Option and Standard Option plans

- The Plan increased coverage for fluoride varnish for children under age 19 to twice per calendar year.
- See page 42 for 2023 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 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 or a Health Insurance Marketplace (Exchange) plan is not required.

Federal Annuitants

You are eligible to enroll if you:

- 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.

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 Program.

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.

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 compensationer 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 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 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 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).

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) 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 2023.

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 BENEFEDS.

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, you may enroll in a dental and/or vision plan during the November 14, 2022 through midnight EST December 12, 2022, Open Season. Coverage is effective January 1, 2023.

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 BENEFEDS 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.

Generally, 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.

Cancelling an enrollment

You may cancel your enrollment only during the annual Open Season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date.

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.

If you have an HCFSA or LEX HCFSA FSAFEDS account and you haven't exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over up to $610 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 31. You must also actively reenroll in a health care or limited expense account during the NEXT Open Season to be carryover eligible. Your reenrollment must be for at least the minimum of $100. If you do not reenroll, 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 period permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

For a health care or limited expense account, each participant must contribute a minimum of $100 to a maximum of $3,050.

Current FSAFEDS participants must re-enroll to participate 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 can use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

You may be required to submit your claims to the FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA) to claim reimbursement.

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 healthpartners.com/fedvip or call us at 844-440-1900.
Where You Get Covered Care	You can find a current list of dentists online at healthpartners.com/fedvip. You can also call us at 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 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 First Payor	When you visit a provider who participates with both, your FEHB plan and your FEDVIP plan, the FEHB 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 and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the primary FEHB 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 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 identification cards to every dental appointment because most FEHB 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.com 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 FederalDentalPlans.com or by contacting us at 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	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. Example: In our High Option plan, the out-of-network calendar year deductible for an individual is $50
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Standard Option plan, you pay 20% for in-network minor restorative services.
Annual Benefit Maximum	The maximum annual benefit that you can receive per enrollee. 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. 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.
Lifetime Benefit Maximum	Both the Standard Option plan and the High Option plan include a lifetime benefit maximum limit for orthodontic care. 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. 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.
In-Network Services	The coinsurance amounts listed in the benefit schedule represent your total cost for in-network services subject to any plan maximums or limitations.
Out-of-Network Services	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.
Emergency Services	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.
Plan Allowance	The amount we use to determine our payment for out-of-network services.
In-Progress Treatment	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 2023 plan year; regardless of any current plan exclusion for care initiated prior to the enrollee's effective date. 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 2023 plan year such as crowns and implants.

This is not a requirement for carriers to provide in-progress coverage for orthodontia in a plan where an enrollee must meet a waiting period.

FEDVIP carriers will not cover in-progress treatment if you enroll in a FEDVIP plan that has a waiting period, or does not cover the service. Several FEDVIP dental plans have options that offer orthodontia coverage without a 12-month waiting period, and without age limits.

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 – 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 child under three years of age and counseling with the primary caregiver – Limited to two per calendar year

D0150 Comprehensive oral evaluation – Limited to two per calendar year – see benefit limitations

D0180 Comprehensive periodontal evaluation – Limited to two per calendar year

D0210 Intraoral – complete series (including bitewings) – Limited to one set every three years. (Full Mouth series or panoramic images)

D0220 Intraoral – periapical – first film

D0230 Intraoral – periapical – each additional images

D0240 Intraoral – occlusal images

D0250 Extraoral - first radiographic image

D0251 Extraoral - Posterior Dental Radiographic Image

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

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

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

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

Diagnostic and treatment services - continued on next page

Diagnostic and treatment services (cont.)
D0330 Panoramic film – Limited to one set every three years. (Full Mouth series or panoramic images)
D0425 Caries susceptibility tests
Preventive Services
D1110 Prophylaxis (dental cleaning) – adult – Limited to twice per calendar year
D1120 Prophylaxis (dental cleaning) – child – Limited to twice per calendar year
D4910 Periodontal maintenance following active periodontal therapy – Limited to a combination of two periodontal maintenance or dental cleanings (prophylaxis) per year.
D1206 Topical application of fluoride varnish - Limited to children under age 19 and twice per calendar year
D1208 Topical application of fluoride - Limited to children under age 19 and twice per calendar year
D1351 Sealant – per tooth – One sealant per permanent molar in a three year period
D1352 Preventive resin restoration in a moderate caries risk – permanent tooth
D1353 Sealant Repair (Per Tooth)
D1354 Interim caries arresting medicament application – Limited to one application per tooth, per lifetime
D1510 Space maintainer – fixed – unilateral – 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 – 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
D1550 Recementation of space maintainer – Limited to children under age 19
D1551 Recement or re-bond bilateral space maintainer - maxillary – Limited to children under age 19
D1552 Recement or re-bond bilateral space maintainer – mandibular – Limited to children under age 19
D1575 Distal shoe space maintainer – fixed – unilateral - Limited to children under age 19 and one per lifetime
Additional Procedures
D9110 Palliative treatment of dental pain – minor procedure
D9310 Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician)
D9311 Consultation with a medical health care professional
D9440 Office visit after regularly scheduled hours
Prevention Reward

Other benefit enhancements included on both plans:

Little Partners℠
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 planning and scaling.

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 or involving incisal angle (anterior)

D2390 Resin based composite crown - anterior

D2391 Resin-based composite - one surface posterior

D2392 Resin-based composite - two surface posterior

D2393 Resin-based composite - three surface posterior

D2394 Resin-based composite - four or more surface posterior

D2910 Re-cement inlay - Limited to once per 6 month period per tooth

D2915 Recement cast or prefab post and core

D2920 Recement 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)

D3221 Pulpal debridement, primary and permanent teeth

D3222 Partial pulpotomy for apexogenesis

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

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration). Incomplete endodontic treatment when you discontinue treatment.

D3355 Pulpal regeneration - initial visit

Endodontic Services - continued on next page

Endodontic Services (cont.)
D3356 Pulpal regeneration - interim medication replacement
D3357 Pulpal regeneration - completion of treatment
Periodontal Services
D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to once per quadrant every two years
D4342 Periodontal scaling and root planning-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
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 (each 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 clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
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 (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory)
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report

Oral Surgery
D7111 Extraction, coronal remnants - deciduous tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
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 – complete bony complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy – intentional partial tooth removal – Limited to one per lifetime
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
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 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 substrate
D2750 Crown - porcelain fused to high noble metal
D2751 Crown - porcelain fused to predominately base metal
D2752 Crown - porcelain fused to noble metal
D2780 Crown - 3/4 cast high noble metal
D2781 Crown - 3/4 cast predominately base metal
D2782 Crown - 3/4 noble metal
D2783 Crown - 3/4 porcelain/ceramic
D2790 Crown - full cast high noble metal
D2791 Crown - full cast predominately base metal
D2792 Crown - full cast noble metal
D2794 Crown - titanium
D2950 Core buildup, including any pins
D2954 Prefabricated post and core, in addition to crown
D2980 Crown repair, by report
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 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3410 Apicoectomy/periradicular surgery - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)
D3427 Periradicular surgery without apioectomy
D3430 Retrograde filling – per root
D3450 Root amputation - per root
D3920 Hemisection (including any root removal) - not including root canal therapy

Periodontal Services
D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces, per quadrant - limited to once in a 24 month period
D4211 Gingivectomy or gingivoplasty - one to three teeth, per quadrant - limited to once in a 24 month period
D4212 Gingivectomy or gingivoplasty - with restorative procedures, per tooth
D4240 Gingival flap procedure, including root planing, four of more contiguous teeth or bounded teeth spaces per quadrant
D4241 Gingival flap procedure, including root planning - one to three teeth per quadrant
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant - limited to once in a 24 month period
D4261 Osseous surgery (including flap entry and closure) - one to three teeth per quadrant - limited to once in a 24 month period
D4268 Surgical revision procedure, per tooth
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4276 Combined connective tissue and double pedicle graft, per tooth
D4277 Free soft tissue graft procedure, first tooth or edentulous tooth position in a graft
D4278 Free soft tissue graft procedure, each additional contiguous tooth or edentulous tooth position in a graft
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 comprehensive evaluation and diagnosis - Limited to once per lifetime
D4999 Periodontal procedure, unspecified 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 base (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)
D5220 Mandibular partial denture, flexible base
D5221 Immediate maxillary partial denture - resin base
D5222 Immediate mandibular partial denture - resin base
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases
D5225 Maxillary partial denture, flexible base
D5226 Mandibular partial denture, flexible base
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)
D5282 Removable unilateral partial denture one piece cast metal (including clasps and teeth), maxillary
D5283 Removable unilateral partial denture one piece cast metal (including clasps and teeth), mandibular

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D5284 Removable unilateral partial denture – one piece flexible base (including clasps and teeth), per quadrant (limited to 1 per quadrant every 5 years)
D5286 Removable unilateral partial denture – one piece resin (including clasps 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), by report. Charges submitted without a report will be denied as non-covered benefits.
D5899 Unspecified removable prosthodontic procedure, by report
D6010 Endosteal implant - surgical placement
D6011 Second Stage Implant - Surgery
D6012 Surgical Placement of Interim Implant Body
D6013 Surgical placement of mini implant
D6040 Subperiosteal implant
D6050 Transosseous mandibular implant
D6052 Semi-precision attachment abutment
D6053 Implant/Abutment supported removable denture for complete edentulous arch
D6054 Implant/Abutment supported removable denture for partial edentulous arch
D6055 Implant supported or abutment supported connecting bar
D6056 Prefabricated abutment - includes placement
D6057 Custom abutment - includes placement
D6058 Implant/abutment supported single porcelain/ceramic crown
D6059 Implant/abutment supported single porcelain fused to metal crown high noble
D6060 Implant/abutment supported single porcelain fused to metal crown predominantly base metal
D6061 Implant/abutment supported single porcelain fused to metal crown noble metal
D6062 Implant/abutment supported single cast metal crown high noble metal
D6063 Implant/abutment supported single cast metal crown predominantly base metal
D6064 Implant/abutment supported single cast metal crown noble metal
D6065 Implant supported single porcelain/ceramic crown
D6066 Implant supported single porcelain fused to metal crown titanium, titanium alloy, high noble metal.
D6067 Implant supported single metal crown titanium, titanium alloy, high noble metal
D6068 Implant/abutment supported fixed partial denture retainer for porcelain/ceramic
D6069 Implant/abutment supported fixed partial denture retainer for porcelain fused to metal high noble metal
D6070 Implant/abutment supported fixed partial denture retainer for porcelain fused to metal predominantly base metal
D6071 Implant/abutment supported fixed partial denture retainer for porcelain fused to metal noble metal
D6072 Implant/abutment supported fixed partial denture retainer for cast metal high noble metal
D6073 Implant/abutment supported fixed partial denture retainer for cast metal predominantly base metal
D6074 Implant/abutment supported fixed partial denture retainer for cast metal noble metal
D6075 Implant supported fixed partial retainer for ceramic
D6076 Implant supported fixed partial retainer for porcelain fused to metal titanium, titanium alloy, high noble metal
D6077 Implant supported fixed partial retainer for cast metal titanium, titanium alloy, high noble metal
D6080 Implant maintenance procedures
D6081 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

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
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 or titanium alloy
D6085 Provisional implant crown
D6086 Implant supported crown - predominantly base alloys
D6087 Implant supported crown - noble alloys
D6088 Implant supported crown - titanium/titanium alloys
D6090 Repair Implant Prosthesis
D6091 Replacement of Semi-Precision or Precision Attachment
D6092 Recement Implant/abutment supported crown
D6093 Recement Implant/abutment supported fixed partial denture
D6094 Abutment supported crown - titanium
D6095 Repair implant abutment, by report
D6096 Remove broken implant retaining screw
D6097 Abutment supported crown - porcelain fused to titanium or titanium alloys
D6098 Implant supported retainer for metal FPD - porcelain fused to predominantly base alloys
D6099 Implant supported retainer for metal FPD - porcelain fused to noble alloys
D6100 Implant removal, by report
D6101 Debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure – Limit 1 per lifetime
D6102 Debridement of peri-implant defect
D6103 Bone graft for repair of peri-implant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologi materials to aid in osseous regeneration
D6104 Bone graft at the time of implant placement
D6110 Implant/abutment supported removable denture for completely edentulous arch-maxillary
D6111 Implant/abutment supported removable denture for completely 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 completely edentulous arch - maxillary
D6115 Implant/abutment supported fixed denture for completely 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 or titanium alloy
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 or titanium alloy
D6190 Implant Index
D6194 Abutment supported retainer crown for FPD-titanium
D6195 Abutment supported retainer - porcelain fused to titanium or titanium alloy
D6205 Pontic - indirect resin based composite
D6210 Pontic - cast high noble metal
D6211 Pontic - cast predominately base metal
D6212 Pontic - cast noble metal
D6214 Pontic - titanium
D6240 Pontic - porcelain fused to high noble metal

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6241 Pontic - porcelain fused to predominately base metal
D6242 Pontic - porcelain fused to noble metal
D6243 Pontic – porcelain fused to titanium or 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 Provisional pontic
D6519 Inlay/onlay – porcelain/ceramic
D6520 Inlay – metallic – two surfaces
D6530 Inlay – metallic – three or more surfaces
D6543 Onlay – metallic – three surfaces
D6544 Onlay – metallic – four or more surfaces
D6545 Retainer - cast metal for resin bonded fixed prosthesis
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6549 Resin retainer - for resin-bonded fixed prosthesis
D6600 Retainer inlay – porcelain/ceramic, two surfaces
D6601 Inlay/onlay - porcelain/ceramic, three or more surfaces
D6602 Inlay-cast high noble metal, two surfaces
D6603 Inlay-cast high noble metal, three or more surfaces
D6604 Inlay - cast predominantly base metal, two surfaces
D6605 Inlay - cast predominantly base metal, three or more surfaces
D6606 Inlay - cast noble metal, two surfaces
D6607 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 Onlay - cast high noble metal, two surfaces
D6611 Onlay - cast high noble metal, three or more surfaces
D6612 Retainer onlay - indirectly fabricated predominantly base metal, two surfaces
D6613 Onlay - cast predominantly base metal, three or more surfaces
D6614 Onlay - cast noble metal, two surfaces
D6615 Onlay - cast noble metal, three or more surfaces
D6624 Inlay – cast titanium metal
D6634 Onlay - cast titanium metal
D6710 Crown - indirect resin based composite
D6720 Crown - resin with high noble metal
D6721 Crown - resin with predominantly base metal
D6722 Crown - resin with noble metal
D6740 Crown - porcelain/ceramic
D6750 Crown - porcelain fused to high noble metal
D6751 Crown - porcelain fused to predominately base metal
D6752 Crown - porcelain fused to noble metal
D6753 Retainer crown - porcelain fused to titanium or titanium alloys
D6780 Crown - 3/4 cast high noble metal

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6781 Crown - 3/4 cast predominately base metal
D6782 Crown - 3/4 cast noble metal
D6783 Crown - 3/4 porcelain/ceramic
D6784 Retainer crown ¾ - titanium and titanium alloys
D6785 Retainer crown ¾ - titanium and titanium alloys
D6790 Crown - full cast high noble metal
D6791 Crown - full cast predominately base metal
D6792 Crown - full cast noble metal
D6794 Retainer crown – titanium or titanium alloys
D6920 Connector bar
D6930 Recement fixed partial denture
D6940 Stress breaker
D6950 Precision attachment
D6973 Core buildup for retainer, including any pins
D7999 Unspecified oral surgery
D9222 Deep sedation/general anesthesia – first 15 minutes
D9223 Deep sedation/general anesthesia - each 15 minutes.
D9239 Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes
D9243 Intravenous moderate (conscious) sedation/anesthesia - each subsequent 15 minutes
D9610 Therapeutic drug injection, by report – Therapeutic drug injections are not covered if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication. Charges submitted without a report will be denied as non-covered benefits.
D9612 Therapeutic parenteral drugs, two or more administrations, and different medications – Therapeutic drug injections are not covered if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication. Charges submitted without a report will be denied as non-covered benefits.
D9613 Infiltration of sustained release therapeutic drug – single or multiple sites – Limited to third molar extractions only, children up to age 22 and once per lifetime
D9930 Treatment of complications (post-surgical) unusual circumstances, by report – Coverage determined by review of report. Charges submitted without report are not covered.
D9931 Cleaning and inspection of a removable appliance
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 – Limited to once per enrollee per 12 consecutive month period
D9942 Repair/reline occlusal guard-1 every two years for patients 13 and older.
D9943 Adjustment of occlusal guard - Limit 1 every six months for patients 13 and older
D9944 Occlusal guard – hard appliance, full arch - Limit 1 every year for patients 13 and older
D9945 Occlusal guard – soft appliance, full arch - Limit 1 every year for patients 13 and older
D9946 Occlusal guard – hard appliance, partial arch, by report – Occlusal guards which includes D9944, D9945, & D9946 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.
D9974 Internal bleaching – per tooth – 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.
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 maximum. You are responsible for all charges that exceed the lifetime maximum.
- **Out-of-Network:** 50% of the plan allowance up to the lifetime maximum and any difference between the plan allowance and the billed amount. You are responsible for all charges that exceed the lifetime maximum.

Standard Option

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

Orthodontic Services

D0340 Cephalometric film
D0350 Oral/facial images (including intra and extraoral images)
D0351 3D photographic image
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 adult dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of adult dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit

Orthodontic Services - continued on next page

Orthodontic Services (cont.)
D8670 Periodic orthodontic treatment visit (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8681 Removable orthodontic retainer adjustment
D8690 Orthodontic treatment (alternative billing to a contract fee)

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
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 minutes
D9239 Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minutes
D9310 Consultation (diagnostic service provided by dentist or physician other than the requesting dentist or physician)
D9440 Office visit – after regular scheduled hours
D9610 Therapeutic parental drug - single administration
D9612 Therapeutic parental drugs - two or more administrations, different drugs
D9613 Infiltration of sustained release therapeutic drug – single or multiple sites
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 healthpartners.com/fedvip. You may also contact us by phone at 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.

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) 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, D2931) 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) 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) or asynchronous (D9996), 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 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 plan). If you need to send in a paper claim you may download a claim form from healthpartners.com/fedvip. Mail completed claim form to:

HealthPartners Claims
P.O. Box 1289
Minneapolis, MN 55440-1289

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
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 844-440-1900

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
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 844-440-1900

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

Annual Benefit Maximum	The maximum annual benefit that you can receive per enrollee. 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. 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.
Annuitants	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.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Class A Services	Basic services, which include oral examinations, dental cleanings (prophylaxis), diagnostic evaluations, sealants and x-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
Class C Services	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.
Class D Services	Orthodontic services.
Complainant	This is an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant or former enrollee, who submits a complaint.
Complaint	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.
Emergency Services	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.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Generally Accepted Dental Protocols	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.
In-Progress Treatment	Dental services that initiated in 2022 that will be completed in 2023.

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 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.com 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% implants subject to $5,000 Annual Maximum	60%
Annual Maximum (excludes orthodontics)	Unlimited	$3,000 combined in- and out-of-network
Class D Services – Orthodontics • No age limit • No waiting period • No deductible	50% Up to $3,500 Lifetime Maximum	50% Up to $2,000 Lifetime 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.com 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 • No age limit • No waiting period • No deductible	50% Up to $2,000 Lifetime Maximum	50% Up to $1,000 Lifetime 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.

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	**$15.94**	**$31.88**	**$47.81**	**$34.54**	**$69.07**	**$103.59**
2	**$18.19**	**$36.38**	**$54.57**	**$39.41**	**$78.82**	**$118.24**

Rating Area	High - Bi-Weekly			High - Monthly		
	Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
1	**$22.14**	**$44.28**	**$66.42**	**$47.97**	**$95.94**	**$143.91**
2	**$23.24**	**$46.49**	**$69.73**	**$50.35**	**$100.73**	**$151.08**