Rates | Pediatric Dental Plan B

Metal Level | High

Age	Individual Monthly Rate
0-20	$30.45

(Product ID# 26825MN0250001)

Information about this plan's rates:

- **Age determined for rating and eligibility is age of insured person on effective date**
- **Pediatric benefits are only covered for dependents under age 19**
- **Total monthly premiums are calculated by adding together the rate for each**
- **A maximum of 3 dependent rates (under 20) are added to the total monthly premium**
- **Rates are applicable to the entire state of Minnesota**

Benefits | Pediatric Dental Plan B

**Pediatric benefits are applicable for dependents under age 19*

In-Network and Out of Network Deductible - $50

Services	In- Network Percentage Paid	Out-of-Network Percentage Paid
Preventative Services (no deductible)		
Routine examination-once every 6 months	100%	100%
Cleanings-once every 6 months	100%	100%
X-rays	100%	100%
Fluoride Treatment-two times per 12 months	100%	100%
Sealants	100%	100%
Space Maintainers	100%	100%
Basic Services		
Fillings	80%	80%
Major Services		
Crowns	50%	50%
Denture	50%	50%
Bridges	50%	50%
Orthodontic Services-24 month wait period		
Medically necessary orthodontic	50%	50%
Annual Maximum Per Person/Per Calendar Year	$0	$1000
Annual Out of Pocket Maximum	$350 for 1 child/$700 for 2 or more children	$0

Listed below is a general overview of exclusions and limitations and is not intended to be a complete description. Only those services and supplies specifically listed in the Dental Benefit Plan Summary are covered under the plan, regardless of dental necessity.

In addition to specific exclusions set forth in other sections of this Dental Benefit Plan Summary, coverage is NOT provided for:

- Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a Subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.
- Dental services or health care services not specifically covered under the Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.
- Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post-payment review of dental records. If services are found to be cosmetic, we reserve the right to collect any payment and the member is responsible for the full charge.
- Dental services completed prior to the date the Covered Person became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
- Case presentations, office visits and consultations.
- Incomplete, interim or temporary services.
- Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan.
- Athletic mouth guards, enamel microabraision and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
- Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- Bacteriologic tests.
- Cytology sample collection.
- Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

- Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Oral hygiene instruction.
- Restorative cast post/core or core build-up, including pins and posts.
- Occlusal procedures.
- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Diagnostic casts.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Brush biopsy and the accession of a brush biopsy.
- Restorations placed for preventive or cosmetic purposes.
- Inlays, onlays and crowns placed for preventive or cosmetic purposes.
- Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

Limitations

a) Optional Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

b) Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, to the extent as required by MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.

c) Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statues Section 62A.042. For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft

lip or cleft palate is available under any other policy or contract of insurance, this plan shall be primary and the other policy or contract shall be secondary.