HealthPartners®

Small Employer

HealthPartners Dental Advantage Choice Plan

	In Network When care is provided by or arranged and authorized by the selected HealthPartners network dentist	**Out-of-Network** When care is provided by an out-of-network dentist
Annual Maximum		
	$1,500 per calendar year	$1,000 per calendar year
	Annual maximums are combined across both tiers.	
Deductible		
■ **Applies to Basic Care, Special Care & Prosthetics**	None	$50 per person; $150 per family per calendar year
Preventive and Diagnostic Care		
■ **Teeth cleaning, exams, dental x-rays & fluoride treatments**	100% coverage	80% coverage
Sealants		
■ **Pit and fissure sealants**	100% coverage	80% coverage
Basic Care		
■ **Fillings**	100% coverage	80% coverage
■ **Endodonitics (root canal therapy)**	80% coverage	60% coverage
■ **Periodontics (gum treatment)**	80% coverage	60% coverage
■ **Oral surgery**	80% coverage	50% coverage
Special Care		
■ **Restorative crowns & onlays**	50% coverage	50% coverage
Prosthetics		
■ **Bridges, dentures & partial dentures**	50% coverage	50% coverage

In this plan, members choose a dental clinic from the network where they will receive their care. Members may change clinics monthly, and family members may choose *different* dental clinics. Members receive higher benefits for care received from their selected network provider, but may also choose to receive care from any licensed dentist. When specialty care is needed, members will receive a written & authorized referral from their dentist, who will guide their care or they may self refer and receive out-of-network benefits.

Emergency Care

Refer to the Group Dental Member Contract for coverage of emergency dental services.

Orthodontic Care

Some employers may choose to offer our optional orthodontic benefits. Check with your employer.

This is a benefit summary sheet only. This dental plan may not cover all your dental care expenses. For exact terms and conditions, consult a Group Membership Contract or call Member Services at (952) 883-5000 or call toll free at 1-800-883-2177.

Benefit Limitations:

- Oral hygiene instruction limited to once per enrollee per lifetime.
- Coverage for space maintainers limited to replacement of prematurely lost primary teeth for dependent members under age 19.
- When posterior teeth (bicuspids and molars) are restored with resin based (white filling) composite materials, benefits will be calculated using the charge which is appropriate for an equivalent amalgam restoration (silver filling).
- Replacement of fixed or removable prosthetic appliances limited to once every five years.
- Certain limitations apply to repair, rebase and relining of dentures.
- Out-of-Network dental services related to the replacement of any teeth missing prior to the member's effective date are not covered.

Other Limitations:

- Coverage for dental exams limited to twice each calendar year.
- Coverage for dental cleanings (prophylaxis or periodontal maintenance) limited to twice each calendar year.
- Sealants limited to one application per tooth, per lifetime for permanent molars.
- Coverage for professionally applied topical fluoride limited to once each calendar year, for members under age 19.
- Coverage for bitewing x-rays limited to once each calendar year.
- Full mouth or panoramic x-rays limited to once every three years.
- Non-surgical and surgical periodontics limited to once in two years.

Read your contract and appendix carefully to determine which expenses are covered.

Our mission is to improve the health of our members, our patients and the community.