



HealthPartners Exceed ChoiceSM Dental Plan

Tier I

When care is provided by or arranged and authorized by the selected Tier I dentist

Tier II

When care is provided by or arranged and authorized by a Tier II 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

\$750 per calendar year

Annual maximums are combined across all three tiers.

Deductible

■ Applies to Basic Care, Special Care & Prosthetics

None

\$50 per person; \$150 per family per calendar year

\$50 per person; \$150 per family per calendar year

Preventive and Diagnostic Care

■ Teeth cleaning, exams, dental x-rays & fluoride treatments

100% coverage

100% coverage

80% coverage

Sealants

■ Pit and fissure sealants

100% coverage

100% coverage

80% coverage

Basic Care

■ Fillings

100% coverage

80% coverage

60% coverage

■ Endodontics (root canal therapy)

80% coverage

50% coverage

50% coverage

■ Periodontics (gum treatment)

80% coverage

50% coverage

50% coverage

■ Oral surgery

80% coverage

50% coverage

50% coverage

Special Care

■ Restorative crowns & onlays

50% coverage

50% coverage

50% coverage

Prosthetics

■ Bridges, dentures & partial dentures

50% coverage

50% coverage

50% coverage

In this plan each member will select Tier I or Tier II benefits. Tier I members select the Tier I clinic where they will receive their care; members who select Tier II are not required to select a clinic and may receive care from any Tier II provider. Members who choose to see any licensed dentist outside of their clinic or tier selection receive Out-of-Network benefits.

Members may change clinics and/or tiers monthly and members within a family may choose different clinics or tiers.

When accessing specialty care, members of Tier I will receive a written and authorized referral from their selected clinic to receive the Tier I benefit.

No referrals are required of Tier II members when specialty care is received from a Tier II provider.

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 (bicuspid and molars) are restored with resin based composite materials (white filling), 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: *Applies to Tier II & Out-of-Network*

- 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.