



UPlan HealthPartners Dental Network Plan

The University of Minnesota

The following is an overview of your HealthPartners coverage. For exact coverage terms and conditions, consult your plan materials, or call Member Services at (952) 883-5000 or 1-800-883-2177.

Plan highlights Partial listing of covered services	HealthPartners Dental Network Care from a network provider
Annual Maximum	
Annual maximum	\$1,500 per calendar year

Deductible	
▪ Applies to Basic Care, Special Care & Prosthetics	None
Preventive and Diagnostic Care	
▪ Teeth cleaning, exams, dental x-rays and fluoride treatments	100% coverage
▪ Sealants	80% coverage
Basic Care	
Basic Care I	
▪ Fillings (amalgam and anterior composite)	80% coverage
▪ Posterior composite (white fillings)	80% coverage
▪ Simple extractions	80% coverage
▪ Non-surgical periodontics	80% coverage
▪ Endodontics (root canal therapy)	80% coverage
Basic Care II	
▪ Surgical periodontics	80% coverage
▪ Complex oral surgery	80% coverage
Special Care	
▪ Restorative crowns & onlays	80% coverage
Prosthetics	
▪ Bridges, dentures & partial dentures	50% coverage
▪ Dental implants	50% coverage
Orthodontic Services	
▪ Orthodontic care for dependents under age 19	80% coverage up to \$2,800 Lifetime maximum

Emergency Care

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

Diabetes and Pregnancy: Additional periodontal services (exams, cleanings, scaling and root planing, and debridement) for our members who are diabetic and/or pregnant are covered at 100% in-network. Deductibles, annual maximums, and frequency limitations will be waived on these specific services for members referred into the program by a HealthPartners network dentist.

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.

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.

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. When specialty care is needed, members receive a referral from their dentist who will guide their care. There is no coverage for non-emergency services provided by out-of-network providers.

THIS IS A BENEFIT SUMMARY SHEET ONLY. THIS DENTAL PLAN MAY NOT COVER ALL YOUR DENTAL CARE EXPENSES. FOR COMPLETE INFORMATION ABOUT BENEFITS AND SERVICES, ASK YOUR EMPLOYER OR CALL THE MEMBER SERVICES INFORMATION LINE AT (952) 883-5000 OR CALL TOLL FREE AT 1-800-883-2177.

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