**St. Paul Public Schools 2020**  
**Dental Tiered Open Access Plan**

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 800-883-2177.

<table>
<thead>
<tr>
<th>Plan Highlights</th>
<th>Benefit Level 1 HealthPartners Dental Group</th>
<th>Benefit Level 2 HealthPartners Open Access</th>
<th>Out-of-Network Care from an out-of-network provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>Annual maximum pays $2,000 per calendar year</td>
<td>Annual maximum pays $1,500 per calendar year</td>
<td>Annual maximum pays $1,500 per calendar year</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>Deductibles are combined across all tiers</td>
<td>Deductibles are combined across all tiers</td>
<td>Deductibles are combined across all tiers</td>
</tr>
<tr>
<td>- Applies to Basic Care, Special Care &amp; Prosthetics</td>
<td>None per calendar year</td>
<td>$10 per person per calendar year</td>
<td>$10 per person per calendar year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$30 per family per calendar year</td>
<td>$30 per family per calendar year</td>
</tr>
</tbody>
</table>

**Preventive and Diagnostic Care**

- Teeth cleaning, exams, dental x-rays and fluoride treatments  
  - You pay nothing  
- Sealants  
  - You pay nothing

**Basic Care**

<table>
<thead>
<tr>
<th>Basic Care I</th>
<th>Benefit Level 1 HealthPartners Dental Group</th>
<th>Benefit Level 2 HealthPartners Open Access</th>
<th>Out-of-Network Care from an out-of-network provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Fillings (amalgam and anterior composite)</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
</tr>
<tr>
<td>- Posterior composite (white) fillings</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
</tr>
<tr>
<td></td>
<td>You also pay the difference between the amalgam and composite fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Simple extractions</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
</tr>
<tr>
<td>- Non-surgical periodontics</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
</tr>
<tr>
<td>- Endodontics (root canal therapy)</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
<td>You pay 15%</td>
</tr>
</tbody>
</table>

**Basic Care II**

- Surgical periodontics  
  - You pay 15%  
- Complex oral surgery  
  - You pay 15%

**Special Care**

- Restorative crowns & onlays  
  - You pay 15%  
- Bridges, dentures & partial dentures  
  - You pay 50%  
- Dental implants  
  - You pay 50%

**Prosthetics**

<table>
<thead>
<tr>
<th>Orthodontic Services</th>
<th>Orthodontic lifetime maximums are combined in and out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Orthodontic care for all ages</td>
<td>You pay 50% with a Lifetime maximum benefit of $1,000 paid by the plan</td>
</tr>
</tbody>
</table>

*If your out-of-network dentist charges more than the maximum allowable amount, you may be responsible for the difference.*

**Emergency Care**

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

**Little PartnersSM Benefit:** Services for children 12 years old and under will be covered at 100% without deductible, annual maximum, or frequency limitations, when provided by a HealthPartners network dentist. Excluded services: Orthodontics, dental implants, and services that are not covered for all members.

**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.
- Replacement of crowns and 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 missing teeth prior to the member’s effective date are not covered.

### Other Limitations: Applies to Benefit Level 2 and 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 every three years.
- 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.
- Out-of-Network dental services related to the replacement of teeth missing prior to the member’s effective date are not covered.

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**Our mission:**

*We seek to improve health and well-being in partnership with our members, patients and community.*