2026 Hennepin County Employee Dental Plan Design

Dental Plan Highlights Partial listing of covered services	**Dental Distinctions Network**		
	Benefit Level 1	Benefit Level 2	Out-of-Network
Annual Maximum and Deductible			
Annual Maximum	$1,500 per calendar year	$1,200 per calendar year	$1,000 per calendar year
Annual Deductible	None	$25 per person; $75 per family per calendar year	$50 per person; $150 per family per calendar year
Preventive and Diagnostic Care			
Little Partners for children 12 and younger	100% coverage	100% coverage	100% coverage
Teeth cleaning, exams, dental x-rays & fluoride treatments	100% coverage	100% coverage	100% coverage
Sealants			
Basic Care			
Fillings (Amalgam and anterior composite)	80% coverage	70% coverage after deductible	70% coverage after deductible
Posterior composite (white) fillings	60% coverage	50% coverage after deductible	50% coverage after deductible
Simple extractions	60% coverage	60% coverage after deductible	60% coverage after deductible
Non-surgical periodontics		50% coverage after deductible	50% coverage after deductible
Endodontics (root canal therapy)			
Surgical periodontics			
Complex oral surgery			
Special Care			
Restorative crowns & onlays	50% coverage	50% coverage after deductible	50% coverage after deductible
Prosthetics			
Bridges, dentures & partial dentures	50% coverage	50% coverage after deductible	50% coverage after deductible
Dental implants	50% coverage	50% coverage after deductible	50% coverage after deductible
Orthodontia			
Orthodontics dependents up to age 19	50% coverage up to $2,000 lifetime max	50% coverage up to $2,000 lifetime max	50% coverage up to $2,000 lifetime max