

SUMMARY OF BENEFITS



DENTAL INDEMNITY Comprehensive 50/1500 0711

This dental care policy covers the following services when performed by a licensed dentist and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function. Such standards are determined by the PacificSource Dental Director and/or Board of Directors. The following services may also be provided by a dental hygienist or denturist to the extent that he/she is operating within the scope of his/her license as required under law in the State of Oregon. Eligible charges are limited to the usual, customary, and reasonable charges of dental providers in the same service area for similar treatment of similar dental conditions.

Advantage Network dentists agree to write off any charges over and above negotiated, contracted fees for most services. When you use an Advantage Network dentist, you will not be responsible for any excess charges and will pay only your plan's coinsurance amount. If you choose not to use an Advantage Network dentist, or don't have access to them, reimbursement is based on the 85th percentile of usual, customary, and reasonable (UCR) charges. If those charges exceed the UCR charges, the excess charges are your responsibility.

Maximum Annual Benefit..... \$1,500 per person per calendar year

Annual Deductible \$50 per person per calendar year / \$150 per family per calendar year

The deductible is an amount of covered dental expenses the member pays each calendar year before the plan's benefits begin. All Class I, II, and III services are subject to the deductible.

PLAN PAYMENT SCHEDULE

Class I Services: Plan pays 80% toward covered Class I Services-Diagnostic and Preventive Treatment after the deductible is satisfied.

Class II Services: Plan pays 80% toward covered Class II Services-Basic Restorative Treatment after the deductible is satisfied.

Class III Services: Plan pays 50% toward covered Class III Services-Major Treatment after the calendar year deductible is satisfied.

COVERED EXPENSES

CLASS I SERVICES - DIAGNOSTIC AND PREVENTIVE TREATMENT

Diagnostic *Exams* (routine or diagnostic exams) are covered twice per calendar year. Separate charges for review of a proposed treatment plan or for diagnostic aids are not covered. Problem focused exams covered twice per calendar year.

Full mouth x-rays and/or panorex are covered to one complete mouth series and/or panorex in any three-year period and further covered to four bite-wing films in a six-month period. When an accumulative charge for periapical x-rays in one-year matches that of a complete mouth series, no further periapical x-rays are available for the remainder of year.

Preventive *Dental cleaning (prophylaxis and periodontal maintenance)* are covered to three procedures of any combination of prophylaxis and/or periodontal maintenance per calendar year. Separate charge for periodontal charting is not covered. Periodontal maintenance is not covered if within three months of periodontal scaling and root planing and/or curettage.

Topical application of fluoride is covered to two applications per calendar year. *Fluoride varnish* covered to 12 applications per calendar year if age three or under and at risk for dental infection.

Sealants are covered to one application in five-years to permanent molars and bicuspids for individuals through age 18.

Space maintainers are covered for individuals through age 13.

Athletic mouth guards are covered to one per lifetime through age 17 if the member is still enrolled in secondary school.

Brush biopsies used to aid in the diagnosis of oral cancer are covered.

CLASS II SERVICES – BASIC TREATMENT

Restorative *A composite resin or similar restoration* in a posterior (back) tooth is covered to the amount that would be paid for a corresponding amalgam restoration. A separate charge for anesthesia when used during restorative procedures is not covered. Only one filling is allowed per tooth surface per calendar year.

Oral Surgery *Simple and surgical extractions of teeth* and other minor oral surgery procedures are covered. *Complicated oral surgery procedures* are covered if preauthorized. Includes general anesthesia administered by the dentist in a dental office. A separate charge for alveolectomy is not a covered benefit.

Periodontic *Periodontal scaling and root planing and/or curettage* covered to one procedure per quadrant in any 24-month period.

Periodontal surgery is covered to procedures that have been preauthorized and accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.

Preventive *Full mouth debridement* covered every 36 months if teeth have not had a prophylaxis in prior 36 months and evaluation cannot be performed due to obstruction by plaque and calculus. Not covered if performed same date as prophylaxis.

Adjunctive *Tooth desensitization* is covered as a separate procedure from other dental treatment.

Endodontic Pulp capping covered if there is an exposure to the pulp. These are direct pulp caps. Indirect pulp caps are not covered.

A pulpotomy is payable only for deciduous teeth.

Root canal therapy on the same tooth are payable only for one charge in a three-year period.

CLASS III SERVICES - MAJOR TREATMENT

Restorative Crowns and other cast or laboratory-processed restorations are covered to the restoration of any tooth in a five-year period. If tooth can be restored with a material such as amalgam or composite resin, covered to the cost of amalgam or non-laboratory composite resin restoration even if another type of restoration is selected by the patient and/or dentist.

Prosthetic The replacement of an existing prosthetic device are provided only when the device being replaced is unserviceable, cannot be made serviceable, and has been in place for at least five years.

Any cast partial denture, full denture, immediate denture, or overdenture is covered to the cost of a standard full or cast partial denture. A separate charge for denture adjustments and relines performed within six months of initial placement is not covered. Subsequent relines are provided only once in a 12-month period. Cast restorations for partial denture abutment teeth or for splinting purposes are not covered unless the tooth in and of itself requires a cast restoration.

Fixed bridges or removable cast partials are covered. Temporary full or partial dentures must be preauthorized. The initial placement of full or partial dentures or fixed bridges (including acid-etch metal bridges) are provided only if the denture or bridgework includes replacement of a natural tooth which has been extracted or lost while coverage is in effect (unless member has been covered under this group dental plan for at least 36 consecutive months).

Implant Surgical placement and removal of implants are covered once per lifetime per tooth space for each service if preauthorized. Includes final crown and implant abutment over a single implant and final implant-supported bridge abutment and implant abutment or pontic. An alternative benefit per arch of a conventional full or partial denture for the final implant-supported full or partial denture prosthetic device is available.

EXCLUSIONS – See handbook for more details

- Aesthetic dental procedures
- Antimicrobial agents
- Benefits not stated
- Biopsies or histopathologic exams (separate charge)
- Charges for broken appointments
- Collection of cultures and specimens
- Connector bar or stress breaker
- Cosmetic/reconstructive Service or supply
- Drugs and medications that are prescribed drugs, premedication, desensitizing medicaments, analgesics (e.g., nitrous oxide or IV sedation), any other euphoric drugs, or any take-home medicine or supplies distributed by a provider
- Diagnostic cast (study model), gnathological recording, occlusal appliance, occlusal equilibration procedure, or similar procedure
- Educational programs -Instructions and/or training in plaque control and oral hygiene
- Experimental or investigational procedures
- Service or supply provided in connection with the treatment of simple or compound fractures of the mandible
- General anesthesia except when administered by a dentist in connection with oral surgery in his/her office
- Hospital charges or additional fees charged by the dentist for hospital treatment
- Hypnosis
- A separate charge for infection control or sterilization
- Oral surgery treating any fractured jaw
- Orthodontic services
- Orthognathic surgery
- Periodontal probing, charting, splinting, and re-evaluations
- Photographic images
- Pin retention in addition to restoration
- Precision attachments
- Pulpotomies on permanent teeth
- Removal of clinically serviceable amalgam restoration to be replaced by material free of mercury, except if proof of allergy to silver amalgam
- Services otherwise available (i.e., Veterans' Administration, Medicare, etc)
- Service or supply for which no charge is made and you are not legally required to pay, or which a provider or facility is not licensed to provide even though service or supply may otherwise be eligible. Includes services provided by you or an immediate family member.
- Temporomandibular joint (TMJ) -Any Service or supply for treatment of any disturbance of the TMJ
- Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation
- Tooth transplantation
- Treatment not necessary according to acceptable dental practice or treatment not likely to have a reasonably favorable prognosis
- Treatment prior to enrollment or treatment after insurance ends
- Treatment while incarcerated
- Unwilling to release information
- War-related conditions or work-related condition