

This outline of coverage provides a very brief description of the important features of the policy. Please note this outline is not intended to be part of the insurance contract. Only the actual policy provisions are final and binding. The policy details your rights and obligations, as well as those of PacificSource.

PLEASE READ YOUR POLICY CAREFULLY!

This dental care policy covers the following services when performed by a licensed dentist, dental hygienist or denturist to the extent that they are operating within the scope of their license as required under law in the state of issuance, 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.

Estimated Premium

Plan Name	Employee Only	Employee + Spouse	Employee + Child	Employee + Children	Family
Dental Choice 0-20-50 50-1500	Populated when purchased.				

Trend Data

PacificSource bases large group premiums on data accumulated from the entire Montana large group population. Certain factors such as demographics are incorporated into the rating process. The large group premium increases for the last five years were 2016 0.0%, 2015 3.0%, 2014 2.0%, 2013 -1.4%, and 2012 4.4%.

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
All Providers	\$50	\$150
Annual Benefit Maximum		
\$1,500 per person per calendar year. Applies to all covered services.		
Exclusion Period	Class III Services	
Age 18 and younger - Number of Consecutive Months	12	
Age 19 and older - Number of Consecutive Months	12	

The member is responsible for any amounts shown above, in addition to the following amounts.

Service	All Providers
Class I Services	
Examinations	No charge*
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No charge*
Dental cleaning (prophylaxis and periodontal maintenance)	No charge*

Service	All Providers
Topical fluoride	No charge*
Fluoride varnish	No charge*
Sealants	No charge*
Space maintainers	No charge*
Athletic mouth guards	No charge*
Brush biopsies	No charge*
Class II Services	
Fillings	Deductible then 20% co-insurance
Simple extractions	Deductible then 20% co-insurance
Periodontal scaling and root planing	Deductible then 20% co-insurance
Full mouth debridement	Deductible then 20% co-insurance
Class III Services	
Complicated oral surgery	Deductible then 50% co-insurance
Pulp capping	Deductible then 50% co-insurance
Pulpotomy	Deductible then 50% co-insurance
Root canal therapy	Deductible then 50% co-insurance
Periodontal surgery	Deductible then 50% co-insurance
Tooth desensitization	Deductible then 50% co-insurance
Crowns	Deductible then 50% co-insurance
Replacement of existing prosthetic device	Deductible then 50% co-insurance
Dentures	Deductible then 50% co-insurance
Bridges	Deductible then 50% co-insurance
Implants	Deductible then 50% co-insurance

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

* Not subject to annual deductible

Additional Information

What is the annual deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that some services are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met.

Deductible does not apply to Class I Services.

What is the annual benefit maximum?

The annual benefit maximum is the maximum amount payable by this policy for covered services received each calendar year.

What is an exclusion period?

A member must be enrolled under the group dental policy for the period of time stated above before this plan pays benefits. This exclusion period may be reduced or removed for persons insured under this policy on the policy's original effective date if the person was continuously covered under a predecessor policy of the policyholder.

Preauthorization.

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list on our website at PacificSource.com.

The Patient's right to know the costs of dental procedures.

The insured, or the insured's agent, may request an estimate of the member's portion of provider charges for any service or course of treatment that exceeds \$500. PacificSource shall make a good faith effort to provide accurate information based on cost estimates and procedure codes obtained by the insured from the insured's health care provider. The estimate may be provided in writing or electronically. It is not a binding contract between PacificSource and the member, and is not a guarantee that the estimated amount will be the charged amount, or that it will include charges for unforeseen conditions. Contact our Customer Service Department to request an estimate.

Populated when purchased.