PacificSource HEALTH PLANS

Dental Benefit Summary
**Dental Advantage 0-20-50 1500**

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.

Advantage Network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the contracted allowable fee. Participating providers agree not to collect more than the contracted allowable fee. When you use an Advantage Network provider, you will pay only the participating provider amounts below. If you choose not to use a participating provider, or don't have access to them, reimbursement is based on the contracted allowable fee. If charges exceed the allowable fee, the excess charges are your responsibility.

**This plan covers dental services for enrolled individuals age 18 and younger as required under the Affordable Care Act.**

| Annual Deductible | Per Person, Per Calendar Year | Per Family, Per Calendar Year |
|---|---|---|
| Participating Providers | None | None |
| Non-participating Providers | $50 | $150 |
| **Annual Benefit Maximum – for enrolled individuals age 19 and older** | | |
| $1,500 per person per calendar year. Applies to all covered services. | | |
| **Out-of-Pocket Limit** | | |
| $350 per person / $700 for two or more people per calendar year for enrolled individuals age 18 and younger.<br>**Please Note: Non-participating providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and that amount does not count toward your out-of-pocket limit. Participating provider expense and non-participating provider expense apply together toward your out-of-pocket limits.** | | |

| Exclusion Period | Class II Services | Class III Services |
|---|---|---|
| Age 18 and younger – Number of Consecutive Months | None | None |
| Age 19 and older – Number of Consecutive Months | None | 12 |

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

| Service | Participating Providers | Non-participating Providers |
|---|---|---|
| **Class I Services** | | |
| Examinations | No charge* | 20% co-insurance* |
| Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex | No charge* | 20% co-insurance* |
| Dental cleaning (prophylaxis and periodontal maintenance) | No charge* | 20% co-insurance* |
| Topical fluoride | No charge* | 20% co-insurance* |
| Fluoride varnish | No charge* | 20% co-insurance* |
| Sealants | No charge* | 20% co-insurance* |

| Service | Participating Providers | Non-participating Providers |
|---|---|---|
| Space maintainers | No charge* | 20% co-insurance* |
| Athletic mouth guards | No charge* | 20% co-insurance* |
| Brush biopsies | No charge* | 20% co-insurance* |
| **Class II Services** | | |
| Fillings | 20% co-insurance* | Deductible then 20% co-insurance |
| Simple extractions | 20% co-insurance* | Deductible then 20% co-insurance |
| Periodontal scaling and root planing | 20% co-insurance* | Deductible then 20% co-insurance |
| Full mouth debridement | 20% co-insurance* | Deductible then 20% co-insurance |
| **Class III Services** | | |
| Complicated oral surgery | 50% co-insurance* | Deductible then 50% co-insurance |
| Pulp capping | 50% co-insurance* | Deductible then 50% co-insurance |
| Pulpotomy | 50% co-insurance* | Deductible then 50% co-insurance |
| Root canal therapy | 50% co-insurance* | Deductible then 50% co-insurance |
| Periodontal surgery | 50% co-insurance* | Deductible then 50% co-insurance |
| Tooth desensitization | 50% co-insurance* | Deductible then 50% co-insurance |
| Crowns | 50% co-insurance* | Deductible then 50% co-insurance |
| Replacement of existing prosthetic device | 50% co-insurance* | Deductible then 50% co-insurance |
| Dentures | 50% co-insurance* | Deductible then 50% co-insurance |
| Bridges | 50% co-insurance* | Deductible then 50% co-insurance |
| Implants | 50% co-insurance* | Deductible then 50% co-insurance |
| Orthodontia for medically necessary reasons for enrolled individuals age 18 and younger | 50% co-insurance* | 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 expense applies only to non-participating providers. 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 for enrolled individuals age 19 and older.

## What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for approved dental expenses during the plan year and applies to enrolled individuals age 18 and younger on your policy. Once the out-of-pocket limit has been met, the plan will pay 100 percent of covered charges for the rest of that year. Non-essential health benefits, penalties, and balance billed amounts over the allowable fee do not accumulate toward the out-of-pocket limit.

Participating provider expense and non-participating provider expense apply together toward your out-of-pocket limits.

## 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, or for enrolled individuals age 18 and younger.

## Preauthorization

Coverage of certain dental 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, Pacificsource.com/member/preauthorization.aspx.