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 (chewing of food).

Advantage Network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the contracted allowable fee. In-network providers agree not to collect more than the contracted allowable fee. When you use an Advantage Network provider, you will pay only the in-network provider amounts below. If you choose not to use an in-network provider, or don't have access to one, 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. Coverage for pediatric services will end on the last day of the month in which the enrolled individual turns 19.

Deductible Per Calendar Year	In-network	Out-of-network
Individual/Family	None/None	$50 / $150
Benefit Maximum Per Calendar Year		
$1,500 per person for enrolled individuals age 19 and older. Applies to all covered services.		
Out-of-Pocket Limit Per Calendar Year		
$350 per person / $700 for two or more people for enrolled individuals age 18 and younger. Note: In-network provider expense and out-of-network provider expense apply together toward your out-of-pocket limits. Even though you may have the same benefit for in-network and out-of-network providers, your actual costs for services provided by an out-of-network provider may exceed this policy's out-of-pocket limit for out-of-network services. In addition, out-of-network 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 is not counted towards the out-of-pocket limit. Please see allowable fee in the definitions section of your policy.		
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	6	12

The member is responsible for the above deductible and the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Class I Services		
Examinations	No deductible, 0%	No deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%	No deductible, 20%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%	No deductible, 20%
Fluoride (topical or varnish applications)	No deductible, 0%	No deductible, 20%
Sealants	No deductible, 0%	No deductible, 20%
Space maintainers	No deductible, 0%	No deductible, 20%
Athletic mouth guards	No deductible, 0%	No deductible, 20%
Brush biopsies	No deductible, 0%	No deductible, 20%
Class II Services		
Fillings	No deductible, 20%	After deductible, 20%
Simple extractions	No deductible, 20%	After deductible, 20%
Periodontal scaling and root planing	No deductible, 20%	After deductible, 20%
Full mouth debridement	No deductible, 20%	After deductible, 20%
Class III Services		
Complicated oral surgery	No deductible, 50%	After deductible, 50%
Pulp capping	No deductible, 50%	After deductible, 50%
Pulpotomy	No deductible, 50%	After deductible, 50%
Root canal therapy	No deductible, 50%	After deductible, 50%
Periodontal surgery	No deductible, 50%	After deductible, 50%
Tooth desensitization	No deductible, 50%	After deductible, 50%
Crowns	No deductible, 50%	After deductible, 50%
Dentures	No deductible, 50%	After deductible, 50%
Bridges	No deductible, 50%	After deductible, 50%
Replacement of existing prosthetic device	No deductible, 50%	After deductible, 50%
Implants	No deductible, 50%	After deductible, 50%
Orthodontia for medically necessary reasons for enrolled individual's age 18 and younger	No deductible, 50%	After deductible, 50%

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

Additional information

What is the 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 out-of-network providers. Deductible does not apply to Class I Services.

What is the benefit maximum?

The benefit maximum is the maximum amount payable by this policy for covered services received each calendar year for enrolled individuals age 19 years 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 calendar 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.

In-network provider expense and out-of-network provider expense apply together toward your out-of-pocket limits.

What is an exclusion period?

A member must be enrolled under the dental policy for the period of time stated above before this plan pays benefits. This exclusion period does not apply to 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.

Predetermination

Coverage of certain dental services and surgical procedures are by review. When a planned dental services exceeds $300, PacificSource recommends a predetermination to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Predeterminations are not a guarantee of payment and do not change your out-of-pocket expense.

Discrimination is against the law

PacificSource Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.