PacificSource HEALTH PLANS

Bend Chamber of Commerce

Dental Benefit Summary
Dental Advantage 20-50-75 50-1000 S2

Benefit Year: Calendar Year

This plan covers the following services when performed by a provider 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).

In-network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the allowable fee. In-network providers agree not to collect more than the allowable fee. When you use an in-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 allowable fee. If charges exceed the allowable fee, the excess charges are your responsibility.

Deductible Per Benefit Year	In-network	Out-of-network
Individual/Family	None/None	$50 / $150
Benefit Maximum Per Benefit Year		
$1,000 per person. Applies to Class II and Class III services.		
Exclusion Period	**Number of Consecutive Months**	
Class II Services	None	
Class III Services (Initial placement of dentures, fixed bridges, and implants)	36	
Class III Services (All other benefits)	6	

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

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Class I Services		
Examinations	No deductible, 20%	After deductible, 20%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 20%	After deductible, 20%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 20%	After deductible, 20%
Fluoride (topical or varnish applications)	No deductible, 20%	After deductible, 20%
Sealants	No deductible, 20%	After deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Space maintainers	No deductible, 20%	After deductible, 20%
Athletic mouth guards	No deductible, 20%	After deductible, 20%
Brush biopsies	No deductible, 20%	After deductible, 20%
Class II Services		
Fillings	No deductible, 50%	After deductible, 50%
Simple extractions	No deductible, 50%	After deductible, 50%
Periodontal scaling and root planing	No deductible, 50%	After deductible, 50%
Full mouth debridement	No deductible, 50%	After deductible, 50%
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%
Class III Services		
Crowns	No deductible, 75%	After deductible, 75%
Dentures	No deductible, 75%	After deductible, 75%
Bridges	No deductible, 75%	After deductible, 75%
Replacement of existing prosthetic device	No deductible, 75%	After deductible, 75%
Implants	No deductible, 75%	After deductible, 75%

This is a brief summary of benefits. Refer to your handbook 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 applies only to out-of-network expenses.

What is the benefit maximum?

The benefit maximum is the maximum amount payable by this plan for covered services received each benefit year. Expenses for Class I Services do not apply toward the maximum.

What is an exclusion period?

A member must be enrolled under the plan for the period of time stated above before this plan pays benefits. The exclusion period is waived for members who are covered under this plan on the plan's original effective date if the member was continuously covered under a predecessor plan of the employer.

Prior authorization

Coverage of certain services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.