

**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
<b>Benefit Maximum Per Benefit Year</b>		
\$1,000 per individual. Applies to all covered services.		
Exclusion Period	Number of Consecutive Months	
Class II Services	None	
Class III Services	None	

**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
<b>Class I Services</b>		
Examinations	No deductible, 0%	No deductible, 0%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%	No deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%	No deductible, 0%
Fluoride (topical or varnish applications)	No deductible, 0%	No deductible, 0%
Sealants	No deductible, 0%	No deductible, 0%

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Space maintainers</b>	No deductible, 0%	No deductible, 0%
<b>Athletic mouth guards</b>	No deductible, 0%	No deductible, 0%
<b>Brush biopsies</b>	No deductible, 0%	No deductible, 0%
<b>Class II Services</b>		
<b>Fillings</b>	No deductible, 20%	After deductible, 20%
<b>Simple extractions</b>	No deductible, 20%	After deductible, 20%
<b>Periodontal scaling and root planing</b>	No deductible, 20%	After deductible, 20%
<b>Full mouth debridement</b>	No deductible, 20%	After deductible, 20%
<b>Complicated oral surgery</b>	No deductible, 20%	After deductible, 20%
<b>Pulp capping</b>	No deductible, 20%	After deductible, 20%
<b>Pulpotomy</b>	No deductible, 20%	After deductible, 20%
<b>Root canal therapy</b>	No deductible, 20%	After deductible, 20%
<b>Periodontal surgery</b>	No deductible, 20%	After deductible, 20%
<b>Tooth desensitization</b>	No deductible, 20%	After deductible, 20%
<b>Class III Services</b>		
<b>Crowns</b>	No deductible, 50%	After deductible, 50%
<b>Dentures</b>	No deductible, 50%	After deductible, 50%
<b>Bridges</b>	No deductible, 50%	After deductible, 50%
<b>Replacement of existing prosthetic device</b>	No deductible, 50%	After deductible, 50%
<b>Implants</b>	No deductible, 50%	After deductible, 50%

**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.

## What is the benefit maximum?

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

## 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](https://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.