PacificSource HEALTH PLANS

Dental Benefit Summary
Dental Advantage 0-20-50 50-1000 S2

Bend Chamber of Commerce

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).

In-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 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 contracted allowable fee. If charges exceed the allowable fee, the excess charges are your responsibility.

Deductible Per Calendar Year	In-network	Out-of-network
Individual/Family	None/None	$50/$150
Benefit Maximum Per Calendar Year		
$1,000 per person. Applies to all Class II and Class III services.		
Exclusion Period	**Class II Services**	**Class III Services**
Number of Consecutive Months	None	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, 0%	After deductible, 0%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%	After deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%	After deductible, 0%
Fluoride (topical or varnish applications)	No deductible, 0%	After deductible, 0%
Sealants	No deductible, 0%	After deductible, 0%
Space maintainers	No deductible, 0%	After deductible, 0%
Athletic mouth guards	No deductible, 0%	After deductible, 0%
Brush biopsies	No deductible, 0%	After deductible, 0%
Class II Services		
Fillings	No deductible, 20%	After deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
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%
Complicated oral surgery	No deductible, 20%	After deductible, 20%
Pulp capping	No deductible, 20%	After deductible, 20%
Pulpotomy	No deductible, 20%	After deductible, 20%
Root canal therapy	No deductible, 20%	After deductible, 20%
Periodontal surgery	No deductible, 20%	After deductible, 20%
Tooth desensitization	No deductible, 20%	After deductible, 20%
Class III Services		
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%

This is a brief summary of benefits. Refer to your member 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 expense applies only to out-of-network providers.

What is the benefit maximum?

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

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.

Predetermination

Coverage of certain dental services and surgical procedures are by review. When a planned dental service 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.