This dental care policy covers the following services when performed by a licensed dentist 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. Such standards are determined by the PacificSource Dental Director and/or Board of Directors. The following services may also be provided by a dental hygienist or denturist to the extent that he/she is operating within the scope of his/her license as required under law in the State of Oregon. Eligible charges are limited to the usual, customary, and reasonable charges of dental providers in the same service area for similar treatment of similar dental conditions.

Advantage Network dentists agree to write off any charges over and above negotiated, contracted fees for most services. When you use an Advantage Network dentist, you will not be responsible for any excess charges and will pay only your plan’s coinsurance amount. If you choose not to use an Advantage Network dentist, or don’t have access to them, reimbursement is based on the 85th percentile of the Advantage Network fee schedule. If those charges exceed the fee schedule, the excess charges are your responsibility.

Maximum Annual Benefit $1,000 per person per contract year

Annual Deductible None

PLAN PAYMENT SCHEDULE

| Class I Services: | Plan pays 100% toward covered Class I Services-Diagnostic and Preventive Treatment. |
| Class II Restorative Services: | Plan pays 80% toward covered Class II Restorative Services-Basic Restorative Treatment. |
| Class II Complicated Services: | Plan pays 80% toward covered Class II Complicated Services-Complicated Treatment. |
| Class III Services: | Plan pays 50% toward covered Class III Services-Major Treatment. |

COVERED EXPENSES

CLASS I SERVICES – DIAGNOSTIC AND PREVENTIVE TREATMENT – 100%

Diagnostic  Exams (routine or other diagnostic exams) are covered twice per person per contract year. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered. Problem focused exams are limited to two per contract year.

  Full mouth x-rays and/or panorex are covered up to one complete mouth series and/or panorex in any three-year period and limited to four bite-wing films in a six-month period. When an accumulative charge for additional periapical x-rays in a one-year matches that of a complete mouth series, no further periapical x-rays or panorex are available for the remainder of year.

  ViziLite Plus TBlue is limited to two per contract year.

Preventive  Dental cleaning (prophylaxis and periodontal maintenance) are covered to a combined total of three procedures per person per contract year. The limitation for dental cleaning applies to any combination of prophylaxis and/or periodontal maintenance in the contract year. A separate charge for periodontal charting is not a covered benefit. Periodontal maintenance is not covered when performed within three months of periodontal scaling and root planing and/or curettage.

  Topical applications of fluoride are covered to two applications per contract year.

  Fluoride varnish applications are covered to 12 applications per contract year for children age twelve and under if the child is deemed at risk for dental infection.

  The application of sealants is covered to one application in a five-year period to permanent molars and bicuspids.

  Space maintainers are covered.

  Nightguards (occlusal guard) and athletic mouth guards are not covered.

CLASS II RESTORATIVE SERVICES – BASIC RESTORATIVE TREATMENT – 80%

Restorative  A composite, resin or similar restoration in a posterior (back) tooth is covered to the amount that
would be paid for a corresponding amalgam restoration. A separate charge for anesthesia when used during restorative procedures is not a covered benefit. Only one filling is allowed per tooth surface. PacificSource will pay for a filling on a tooth surface only once every contract year.

**Oral Surgery**

*Simple and surgical extractions of teeth* and other minor oral surgery procedures are covered. General anesthesia used in conjunction with these extractions administered by a dentist in a dental office is also covered. A separate charge for alveolectomy performed in conjunction with removal of teeth is not a covered benefit.

Benefits for *brush biopsies* used to aid in the diagnosis of oral cancer are covered.

**Periodontic**

*Periodontal scaling and root planing and/or curettage* is covered but limited to only one procedure per quadrant in any 24-month period. For the purpose of this limitation, eight or fewer teeth existing in one arch will be considered one quadrant.

Benefits for *full mouth debridement* are limited to once every 36 months. This procedure is only covered if the teeth have not received a prophylaxis in the prior 24 months and if an evaluation cannot be performed due to the obstruction by plaque and calculus on the teeth. This procedure is not covered if performed on the same date as the prophylaxis.

**CLASS II COMPLICATED SERVICES – COMPLICATED TREATMENT – 80%**

**Oral Surgery**

Complicated oral surgical procedures such as impacted teeth when preauthorized by PacificSource. Benefits include general anesthesia when administered by a dentist in a dental office.

**Endodontic**

*Pulp capping* is covered only when there is an exposure to the pulp. These are direct pulp caps. Indirect pulp caps are not covered.

*A pulpotomy* is payable only for deciduous teeth.

*Root canal therapy* is covered on the same tooth only for one charge in a two-year period.

**Periodontic**

*Periodontal surgery* is covered when the procedure is preauthorized by PacificSource and accompanied by a periodontal diagnosis and history of conservative (non-surgical) periodontal treatment.

**Adjunctive**

*Tooth desensitization* is covered as a separate procedure from other dental treatment, when preauthorized by PacificSource.

**Restorative**

*Crowns* and other cast or laboratory processed restorations when teeth cannot be restored with other materials. Benefits include the restoration of any one tooth in a five-year period.

Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.

If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the member or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

**CLASS III SERVICES – MAJOR TREATMENT – 50%**

**Prosthodontic**

*Cast partial denture, full, immediate, or overdenture* are covered only to the cost of a standard full or cast partial denture. A separate charge for denture adjustments and relines performed within six months of the initial placement is not a covered benefit. Benefits for subsequent relines are provided only once in a 12-month period. Cast restorations for partial denture abutment teeth or for splinting purposes are not covered unless the tooth in and of itself requires a cast restoration.

Replacement of an existing prosthetic device when the device being replaced is unserviceable, cannot be made serviceable, and has been in place for at least five years.

*Fixed bridges or removable cast partials* are covered for member age 17 and older. Benefits for temporary full or partial dentures must be preauthorized. Benefits for the initial placement of full or partial dentures or fixed bridges (including acid-etch metal bridges) are provided only if the denture or bridgework includes replacement of a natural tooth which is extracted or lost while the member's coverage is in effect. However, this limitation does not apply after the member has been covered under the policyholder's group dental plan for a period of at least 36 consecutive months.

*Implant*

Benefits for the surgical placement and removal of *implants* are limited to once per lifetime per tooth space for each service. Services must be preauthorized by PacificSource to be covered. Benefits
include final crown and implant abutment over a single implant and final implant-supported bridge abutment and implant abutment or pontic. An alternative benefit per arch of a conventional full or partial denture for the final implant-supported full or partial denture prosthetic device is available.

**Late Enrollment**

If dental coverage is waived, the employee can enroll themselves or dependents on the policy’s anniversary date and a 12-month waiting period for Class III services will apply. Employees and/or dependents who enroll with dental benefits under this policy, but later terminated coverage may enroll on an anniversary date of the policy, but will be subject to a 12-month waiting period from the date coverage was last terminated for Class III major dental services.

**EXCLUSIONS – See handbook for more details**

This policy does not provide benefits in any of the following circumstances or for any of the following conditions:

- Aesthetic dental procedures
- Antimicrobial agents
- Benefits not stated
- Biopsies or histopathologic exams (separate charge)
- Bone replacement grafts
- Charges for broken appointments
- Collection of cultures and specimens
- Connector bar or stress breaker
- Core build-ups are not covered unless used to restore a tooth that has been treated endodontically (root canal)
- Cosmetic/reconstructive services or supplies
- Denture replacement made necessary by loss, theft, or breakage
- Diagnostic cast (study model), gnathological recording, occlusal appliance, occlusal equilibration procedure, or similar procedure
- Drugs and medications that are prescribed drugs, premedication, desensitizing medicaments, analgesics (e.g., nitrous oxide or IV sedation), any other euphoric drugs, or any take-home medicine or supplies distributed by a provider
- Educational programs -Instructions and/or training in plaque control and oral hygiene
- Experimental or investigational procedures
- Service or supply provided in connection with the treatment of simple or compound fractures of the mandible
- General anesthesia except when administered by a dentist in connection with oral surgery in his/her office
- Gingivectomy, gingivoplasty or crown lengthening in conjunction with crown preparation or fixed bridge services done on the same date of service
- Hospital charges or additional fees charged by the dentist for hospital treatment
- Hypnosis
- A separate charge for infection control or sterilization
- Intra and extra coronal splinting – Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth
- Oral surgery treating any fractured jaw
- Orthognathic surgery
- Periodontal probing, charting, splinting, and re-evaluations
- Photographic images
- Pin retention in addition to restoration
- Precision attachments
- Pulpotomies on permanent teeth
- Removal of clinically serviceable amalgam restoration to be replaced by material free of mercury, except if proof of allergy to silver amalgam
- Services otherwise available (i.e., Veterans’ Administration, Medicare, covered on a medical plan, etc)
- Service or supply for which no charge is made and you are not legally required to pay, or which a provider or facility is not licensed to provide even though service or supply may otherwise be eligible. Includes services provided by you or an immediate family member
- Temporomandibular joint (TMJ) -Any Service or supply for treatment of any disturbance of the TMJ
- Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers’ compensation
- Tooth transplantation
- Treatment not necessary according to acceptable dental practice or treatment not likely to have a reasonably favorable prognosis
- Treatment prior to enrollment or treatment after insurance ends
- Treatment while incarcerated
- Unwilling to release information
- War-related conditions
- Work-related conditions – Services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers’ compensation
There is a six-month waiting period for orthodontia services once the benefit is in place. Enrollment in the orthodontia coverage must be the same as enrollment in the dental plan, and orthodontic benefits are provided to all covered dependent children providing treatment is started prior to their 23rd birthday.

**COVERED CHARGES**

PacificSource will pay 50% of the dentist's or orthodontist’s charge for orthodontics.

**LIFETIME MAXIMUM**

The maximum amount payable by PacificSource for orthodontic benefits to an eligible patient is $1,000.

**LATE ENROLLMENT**

If dental coverage is waived, the employee can enroll themselves or dependents on the policy’s anniversary date and a 12-month waiting period for Orthodontia services will apply. Employees and/or dependents who enroll with dental benefits under this policy, but later terminated coverage may enroll on an anniversary date of the policy, but will be subject to a 12-month waiting period from the date coverage was last terminated for Orthodontia.

**EXCLUSIONS**

- The obligation of PacificSource to make payments for orthodontic treatment will cease upon termination of treatment for any reason prior to completion of the case.
- PacificSource will not make any payment for repair or replacement of an orthodontic appliance furnished under this program.
- PacificSource's obligation to make monthly or other periodic payments for orthodontics shall cease on termination of eligibility.
- The obligation of PacificSource to make payments for orthodontic treatment begun prior to the eligibility date of the patient will be calculated on the balance of a dentist's or orthodontist's normal payment pattern remaining at the patient's initial eligibility date. The above-mentioned maximum will apply fully to this amount.