

DENTAL BENEFIT SUMMARY

PLAN INFORMATION

Group Name: **City of Oregon City**
Group Number: **G0020199**
Plan Name: **Dental Indemnity Incentive Plan 1500 S3**
Plan Year: **August 1, 2020-July 31, 2021**

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement: **Twenty (20) hours per week**
Waiting Period Requirement: **First of the month following three (3) full calendar months of employment.**

This dental Plan 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).

The dental benefit is a percentage of the billed charges for covered dental expenses incurred, subject to the annual benefit maximum.

Annual Benefit Maximum Per Calendar Year

\$1,500 per person. Applies to Class II and Class III Services Only.

Payment

Class I and II Services: The Plan pays 70% toward covered Class I and Class II services during the first year of eligibility. Payment increases by 10% each successive eligibility year, up to the maximum of 100%. In order to qualify for each 10% increase, members must visit the dentist at least once during each eligibility year. Failure to do so will cause a 10% reduction in payment for the next eligibility year, although payment will never drop below 70%.

Class III Services: The Plan pays 50% of covered Class III services. There is no yearly increase in payment.

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

Service/Supply	All Providers Member Pays
Class I Services	
Examinations	30% co-insurance
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	30% co-insurance

Service/Supply	All Providers Member Pays
Dental cleaning (prophylaxis and periodontal maintenance)	30% co-insurance
Fluoride (topical or varnish applications)	30% co-insurance
Sealants	30% co-insurance
Space maintainers	30% co-insurance
Athletic mouth guards	30% co-insurance
Class II Services	
Fillings	30% co-insurance
Simple extractions	30% co-insurance
Periodontal scaling and root planing	30% co-insurance
Full mouth debridement	30% co-insurance
Complicated oral surgery	30% co-insurance
Pulp capping	30% co-insurance
Pulpotomy	30% co-insurance
Root canal therapy	30% co-insurance
Periodontal surgery	30% co-insurance
Tooth desensitization	30% co-insurance
Class III Services	
Crowns	50% co-insurance
Replacement of existing prosthetic device	50% co-insurance
Dentures	50% co-insurance
Bridges	50% co-insurance
Implants	50% co-insurance

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

Additional information

What is the benefit maximum?

The annual benefit maximum is the maximum amount payable by this Plan for covered services received each calendar year. Class I Services do not accumulate towards the annual benefit maximum.

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.

COSMETIC ORTHODONTIC BENEFIT SUMMARY

Plan Year: August 1, 2020-July 31, 2021

This Plan covers orthodontia for all eligible members. Enrollment in orthodontia coverage must be the same as enrollment in the dental Plan.

The dollar amount listed below is the maximum benefit allowed for all orthodontic services covered under this benefit, when prescribed by a licensed dentist or licensed orthodontist.

Lifetime Benefit Maximum	All Providers Member Pays
\$1,500 per person	50% co-insurance

Benefit Limitations

Benefits for orthodontic covered services will be paid monthly on a pro-rated basis over the length of the treatment. If the orthodontic treatment began before the patient was eligible for this Plan, this Plan will continue to make payments toward the remaining balance due, as of the patient's initial eligibility date. The benefit maximum listed above will apply fully to this amount. PacificSource's obligation, on behalf of the Plan Sponsor, to administer payment for orthodontic treatment ends when the patient's eligibility ends, or when treatment is terminated before the case is completed.

Exclusions

- This Plan does not cover repair or replacement of orthodontic appliances furnished under this program.
- Mail order or Internet/web based providers are not eligible providers.