PacificSource HEALTH PLANS

Dental Outline of Coverage
Dental Choice Plus 0-20-50 25-1250 S2

Belgrade School District

This outline of coverage provides a very brief description of the important features of the policy. Please note this outline is not intended to be part of the insurance contract. Only the actual policy provisions are final and binding. The policy details your rights and obligations, as well as those of PacificSource. **Please read your member handbook carefully.**

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).

Trend Data

PacificSource bases large group premiums on data accumulated from the entire Montana large group population. Certain factors such as demographics are incorporated into the rating process. The large group premium increases for the last five years were 2019 0%, 2018 0.0%, 2017 0.0%, 2016 0.0%, and 2015 3.0%.

Deductible Per Contract Year	All Providers
Individual/Family	$25 / $50
Benefit Maximum Per Contract Year	
$1,250 per person. Applies to all covered services.	

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	No deductible, 0%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%
Fluoride (topical or varnish applications)	No deductible, 0%
Sealants	No deductible, 0%
Space maintainers	No deductible, 0%
Athletic mouth guards	No deductible, 0%
Brush biopsies	No deductible, 0%
Class II Services	
Fillings	No deductible, 20%
Simple extractions	No deductible, 20%
Periodontal scaling and root planing	No deductible, 20%

Service/Supply	All Providers Member Pays
Full mouth debridement	No deductible, 20%
Complicated oral surgery	No deductible, 20%
Pulp capping	No deductible, 20%
Pulpotomy	No deductible, 20%
Root canal therapy	No deductible, 20%
Periodontal surgery	No deductible, 20%
Tooth desensitization	No deductible, 20%
Class III Services	
Crowns	After deductible, 50%
Dentures	After deductible, 50%
Bridges	After deductible, 50%
Replacement of existing prosthetic device	After deductible, 50%
Implants	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.

What is the benefit maximum?

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

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.

The Patient's right to know the costs of dental procedures.

The insured, or the insured's agent, may request an estimate of the member's portion of provider charges for any service or course of treatment that exceeds $500. PacificSource shall make a good faith effort to provide accurate information based on cost estimates and procedure codes obtained by the insured from the insured's health care provider. The estimate may be provided in writing or electronically. It is not a binding contract between PacificSource and the member, and is not a guarantee that the estimated amount will be the charged amount, or that it will include charges for unforeseen conditions.

Orthodontia 1000

Your group insurance 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
$1,000 per person	50%

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 to make 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.