PARAMOUNT DENTAL

Affiliate of ProMedica

Summary of Dental Plan Benefits

This Summary of Dental Plan Benefits for the Comprehensive Family Plan is provided for some of the more frequently performed dental procedures. This Summary of Dental Plan Benefits should be read along with your Policy. Your Policy provides additional information about your Paramount Dental plan, including plan exclusions and limitations. If a statement in this Summary of Dental Plan Benefits conflicts with a statement in the Policy, the statement in the Policy governs. To receive coverage for services, you must use an In-Network Dentist.**

Plan Name: **Comprehensive Family Plan**

Policyholder Name: **(xxxxxxxxxx)** **Benefit Plan Year:** **(Month Year – Month Year)**

Covered Services	Adult Coverage In Network*	Pediatric Coverage (Under age of 19) In Network*
Diagnostic & Preventive Services	**Plan Pays**	**Plan Pays**
Exams – periodic, limited, comprehensive	100%	100%
Radiographs – full mouth series, panoramic, bitewings	100%	100%
Routine teeth cleanings	100%	100%
Fluoride	100%	100%
Sealants	0%	100%
Basic Services	**Plan Pays**	**Plan Pays**
Fillings – silver or white (anterior and posterior teeth)	70%	50%
Root canal therapy – anterior, posterior, retreatment	0%	50%
Non-surgical Periodontics – maintenance, debridement, scaling and root planing	70%	50%
Relines and repairs – existing bridges, existing partial and complete dentures	0%	0%
Simple extractions	70%	50%
Major Services	**Plan Pays**	**Plan Pays**
Crowns – porcelain, ceramic, stainless steel	50%	50%
Surgical Periodontics	0%	50%
Prosthodontic services – bridges, partial and complete dentures	0%	50%
Implants – placement of implant and abutment	0%	50% (Medically Necessary Only)
Surgical extractions	70%	50%
Adjunctive/Other Services	**Plan Pays**	**Plan Pays**
Emergency palliative treatment	70%	50%
Anesthesia – general and IV sedation	0%	50%
Adjunctive/Other Services	0%	50%
Orthodontic Services (Medically Necessary Only)	**Plan Pays**	**Plan Pays**
Orthodontic Services – braces	0%	50% (Medically Necessary Only)

***In Network** dentists have agreed to accept contracted maximum allowable fees on covered dental services. Your co-insurance percentage is based on that contracted fee. Therefore, your benefit dollars will go further and your out of pocket costs will likely be less when you visit a network dentist. To receive coverage for services, you must use an In-Network Dentist.

****** With the exception of emergency care, you must use an In-Network Dentist to receive coverage for services. In the event of a dental emergency, you may seek services from any Dentist (In-Network or Out-of-Network) in order to relieve pain, swelling, and bleeding. Such services received from an Out-of-Network Dentist will be treated as In-Network care.

- Oral evaluations (all procedure codes, including evaluations performed by a general dentist or specialist) are payable 2 per Benefit Plan Year beginning at eruption of the first tooth, but no later than 12 months of age.
- A routine teeth cleaning (prophylaxis) is payable 2 per Benefit Plan Year regardless of the dentist's specialty, unless performed within 6 months of periodontal scalings and root planing, periodontal full mouth debridement, or periodontal maintenance.
- Fluoride treatment - Non-varnish fluoride - once every 6 months; Varnish fluoride - 4 times per year for dependents age 0 – 2 and twice per year for dependents age 3 and above.
- Bitewing x-rays are payable to a maximum of 4 films in a 12 month period. Full mouth x-ray or Panoramic film are payable once per 4 years. The maximum amount considered for all radiographic images taken on one day will be equivalent to an allowance of a full mouth x-ray. The difference may not be billed to the Member.
- Sealants for fully erupted permanent molars for dependents under 19 years of age – once per tooth every 3 years.
- A restoration (amalgam or resin-based composite) is payable once in any 2 year period per tooth for anterior and posterior teeth.
- A core buildup will not be payable if performed within 3 years of restoration and/or replacement within 7 years on the same tooth. Coverage for a core buildup requires the submission of a duplicate, diagnostically acceptable, pre-operative radiographic image or intraoral photo. Coverage is limited to dependents under 19 years of age.
- Replacement of crowns are payable per tooth every 5 years.
- Root canal treatment includes periapical x-rays, cultures, follow up care, treatments, pulpotomy.
- A periodontal scaling and root planing is payable once in any 3 year period for adults 19 years and above and 2 year period per quadrant for dependents under 19 years of age and subject to the submission of full mouth probe chart with six points per tooth probings and diagnostic full mouth radiographs and/or vertical bitewings to determine if procedure meets plan criteria. A pretreatment estimate is recommended to determine coverage.
- Implants/Implant related services are payable once per tooth in any 5 year period. Coverage is limited to dependents under 19 years of age when Medically Necessary Only.
- Replacement of dentures, partial dentures, and fixed bridges are payable once per 7 years.

Orthodontic Services (Medically Necessary Only) – Orthodontic services are covered for children under 19 years of age and is only covered for children with significant impairment as a result of craniofacial abnormalities, malocclusions, caused by trauma, or congenital disharmonies that affect daily ability to function, like speaking and eating. Must be preauthorized.

Deductible – $50 for adults and **$25** for dependents under 19 years of age, per Benefit Plan Year. For dependents under 19 years of age the deductible is waived for preventive and diagnostic services. Limited to a maximum deductible of **$375** per child or **$750** per family, per Benefit Plan Year. Please reference your Policy for your Benefit Deductible/Out of Pocket Deductible methodology definition.

Plan Annual Maximum – $1,500 per adult per Benefit Plan Year on all services. There is no Plan Annual Maximum for dependents under 19 years of age.

Benefit Plan Year – The coverage period beginning on your effective date until the end of the calendar year.

Out-of-Pocket Maximum for Pediatric Dental Care – $375 per Benefit Plan Year for one child, $750 per Benefit Plan Year for two or more children.

Eligibility – You and, if applicable, your legal spouse (or domestic partner) and your children who meet the dependent age requirements are eligible on the policy effective date.

Dependent Age Limit – Dependent coverage includes children up to age 26, regardless of any, or a combination of any, of the following factors: financial dependency, residency, student status, employment status, or marital status.

Waiting Period for Covered Services – Basic restorative, endodontics, periodontal services, oral surgery, and adjunctive services will not be covered until after a member is enrolled in the dental plan for 6 consecutive months. Major restorative services, prosthodontic services, implant services, other major services, and orthodontic services will not be covered until after a member is enrolled in the dental plan for 9 consecutive months. The Waiting Period for Covered Services does not apply to pediatric dental care.

Insurance products are marketed by Paramount Dental and underwritten and administered by (company name). Paramount Dental plans are insured by (regulated company name) with network management services provided by (company name). Please visit www.InsuringSmiles.com where you can find your Policy, Summary of Dental Plan Benefits, as well as finding a dentist and any other plan information.