

Summary of benefits.

GOOD FOR EFFECTIVE DATES OF JANUARY 1 - DECEMBER 31, 2019.

P E N N S Y L V A N I A

	Pediatric Only Coverage Plans		Family Coverage Plans	
	Pediatric High Option	Pediatric Low Option	Family High Option	Family Low Option
One Child	\$25.03	\$18.04		
Two or More Children	\$41.31	\$29.77		
Individual			\$20.73	\$14.96
Individual + Spouse			\$41.47	\$29.91
Individual + Child(ren)			\$55.78	\$40.21
Family			\$82.77	\$59.68
	Pediatric High Option	Pediatric Low Option	Family High Option	Family Low Option
Copay*	N/A	\$10	N/A	\$10
Deductible*	\$50 per covered individual \$150 maximum per policy	\$50 per covered individual \$150 maximum per policy	\$50 per covered individual \$150 maximum per policy	\$50 per covered individual \$150 maximum per policy
Preventive Services*	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services*	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Major Services*	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Medically Necessary Orthodontia*	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Maximum Out-of-Pocket	\$350 one child \$700 two or more children	\$350 one child \$700 two or more children	\$350 one child \$700 two or more children	\$350 one child \$700 two or more children
Annual Benefit Max (19 and over)	N/A	N/A	\$1,000	\$1,000

Contact Information

- Questions related to enrollment, billing or payment should be directed to DentaTrust Billing and Enrollment at **(855) 890-3243**.
- Questions related to member services (claims) should be directed to DentaQuest at **(844) 254-9466**.
- Search for participating providers by using our Find a Dentist tool at: **hixfadpa.dentalcareplus.com**.

Underwritten by Dental Care Plus, Inc., 100 Crowne Point Place, Cincinnati, Ohio 45241. NAIC number 96265.

*Note: Out-of-network providers are permitted to charge for the difference between the allowed amount and out-of-network provider's billed charges. You may be required to pay more for services obtained from an out-of-network provider than for the same services provided by an in-network provider.

This is a dental PPO policy, form number DQ PA 300 HIX IND FAMILY and DQ PA 300 HIX IND CHILD. Coverage is subject to policy terms, limitations and exclusions. Plan benefits provided and premium amounts will vary depending on the level of coverage selected. For costs and complete details of coverage, call (855) 890-3243. For age 19 and under there are no waiting periods for Restorative/Other Basic Services or Complex Dental Services.

Please see the Summary of Benefits for more information on plan coverage.

Diagnostic and Preventive Services

Benefits are available for the following dental services to diagnose or to prevent tooth decay and other forms of oral disease. These dental services are what most covered individuals receive during a routine preventive dental visit. Examples of these services include:

- Comprehensive Oral Evaluation
- Periodic exam – once every six months.
- X-rays of the entire mouth – once every 36 months.
- Bitewing x-rays (x-rays of the crowns of the teeth) – once every six months.
- Single tooth x-rays as needed.
- Oral and facial photographic images.
- Study models and casts used in planning treatment.
- Oral Pathology Laboratory
- Routine cleaning, scaling and polishing of teeth – once every six months.
- Fluoride treatment, topical fluoride:
 - Varnish: under age 19 – one every six months.
 - Topical application of fluoride (excluding prophylaxis): under age 19 – one every six months.
- Space maintainers required due to the premature loss of teeth – only for children under age 19 and not for the replacement of primary or permanent anterior teeth.
- Sealants on unrestored permanent molars, under age 19 – one sealant per tooth per three years on permanent first and second molars

Restorative and Other Basic Services

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth; (b) repair dentures or bridges; (c) rebase or reline dentures; (d) repair or recement bridges, crowns and onlays; and (e) remove diseased or damaged natural teeth. Examples of these services include:

- Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist's charge.
- Crowns, onlays and inlays as follows, but only when the teeth cannot be restored with the fillings due to severe decay or fractures:
 - Initial placement of crowns, onlays and inlays.
 - Replacement of crowns, onlays and inlays – once each 60 months per tooth.
- Repair or recement crowns and onlays.
- Adding teeth to existing partial or full dentures.

Major (Complex) Dental Services

Benefits are available for the following dental services and supplies to treat oral disease including: replace missing natural teeth with artificial ones; remove diseased or damaged natural teeth and restore severely decayed or fractured teeth. Examples of these services include:

- Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth.
- General anesthesia only when necessary and appropriate for covered surgical services and only when provided by a licensed, practicing dentist.
- Tissue conditioning,
- Periodontal services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery).
 - Periodontal maintenance – four in 12 months following active periodontal therapy.
- Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy.
- Dentures and bridges:
 - Complete or partial dentures and fixed bridges including services to measure, fit and adjust them – once each 60 months.
 - Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least 60 months before replacement.
 - Repair of dentures or fixed bridges. Recementing of fixed bridges.
 - Rebase or reline dentures – once every 36 months, six months after initial installation.
 - Adding teeth to existing partial or full dentures.
- Implants – only for dependents under age 19 only if determined to be a dental necessity.
- Occlusal guards – one in 12 months for patients between the ages of 13 and 18.
- Palliative (emergency) treatment of dental pain – minor procedures.

Medically Necessary Orthodontics

12 month waiting period

Covered orthodontic services are limited to medically necessary orthodontic treatment for individuals under age 19. Medical necessity will be determined by the Plan after review of the orthodontic case records, which must be submitted for approval prior to the commencement of treatment.

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Limitations and Exclusions

- Bitewing x-rays – one set per six consecutive months.
- Panoramic or full mouth x-rays – one per three-year period.
- Prophylaxis – one per six consecutive month period.
- Routine prophylaxis is limited to no more than one per six consecutive month period and periodontal maintenance procedures are limited to four per 12 consecutive month period.
- Sealants – one per tooth per three years on permanent first and second molars.
- Fluoride treatment – one per six consecutive months through age 18.
- Space maintainers only eligible for Members through age 18 when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.
- Restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or fractured teeth.
- Crowns, bridges, inlays, onlays, buildups, post and cores – one per tooth in a five- year period.
- Crown lengthening – one per tooth per lifetime.
- Referral for specialty care is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.
- Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's seventh birthday.
- Pupal therapy – through age five on primary anterior teeth and through age 11 on primary posterior teeth.
- Root canal treatment – one per tooth per lifetime.
- Periodontal scaling and root planing – one per 24 consecutive month period per area of the mouth.
- Surgical periodontal procedures – one per 24 consecutive month period per area of the mouth.
- Full and partial dentures – one per arch in a five- year period.
- Denture relining, rebasing or adjustments – are included in the denture charges if provided within six (6) months of insertion by the same dentist.
- Subsequent denture relining or rebasing – limited to one every 36 consecutive months thereafter.
- Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25 cm, frenectomy and crown lengthening.
- Wisdom teeth (third molars) extracted for Members under age 15 are not eligible for payment in the absence of specific pathology.
- If for any reason orthodontic services are terminated or coverage under the Program is terminated before completion of the approved orthodontic treatment, the responsibility of the Health Benefit Plan will cease with payment through the month of termination.
- Orthodontic treatment – not eligible for Members over age 18.
- Comprehensive orthodontic treatment plan – one per lifetime.
- In the case of a Dental Emergency involving pain or a condition requiring immediate treatment, the Program covers necessary diagnostic and therapeutic dental procedures administered by and Out-of-Network Dentist up to the difference between the Out-of-Network Dentist's charge and the Member Copayment up to a maximum of \$50 for each emergency visit.
- Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).
- An Alternate Benefit Provision (ABP) may be applied by the Primary Dental Office if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.

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