The Dental Care PLUS GROUP

Benefit Summary

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Product: DPPO

Network: DentaSelect Plus

Benefit Year: The 12 month period beginning January 1st and ending December 31st (calendar year)

Annual Maximum Benefit: $1000 per Member

Orthodontic Lifetime Maximum Benefit: $1000 per Eligible Member
Limited to eligible dependent children under age 19

Deductible: Deductible for services provided by an In-Network Provider

$50 per Member, per Benefit Year
$150 per Family, per Benefit Year

Deductible for services provided by an Out-of-Network Provider

$50 per Member, per Benefit Year
$150 per Family, per Benefit Year

The deductible applies to Basic and Major Benefits only
Any deductible amount that is satisfied will be applied toward both the In-Network and Out-of-Network deductibles

Covered Dental Services	Deductible Applied	In Network		Out-of Network	
		Percentage of Allowable Expense Paid by the Plan	*Member Copayment*	*Percentage of Allowable Expense Paid by the Plan*	*Member Copayment*
Preventive Benefits	No	100%	None	100%	None
Basic Benefits	Yes	50%	50%	50%	50%
Major Benefits	Yes	50%	50%	50%	50%
Orthodontic Benefits	No	50% Limited to eligible dependent children under age 19	50%	50% Limited to eligible dependent children under age 19	50%

Out of network claims are reimbursed at the Advantage 900 level.
Endodontic Services are covered as Basic Benefits.
Periodontic Services are covered as Basic Benefits.
Sealants are covered as Basic Benefits.
Implants are covered as Major Benefits.

Dependent children are eligible for coverage until age 26.

A complete description of covered services, limitations and exclusions is available in the Certificate of Insurance.
Members who receive services from a non-participating provider are subject to balance billing.

Covered Services

STANDARD GROUP CONTRACT

The Dental Care PLUS GROUP
The plus is service.

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Preventive Benefits

PREVENTIVE AND DIAGNOSTIC SERVICES

Routine oral examinations: limited to two visits each year
Prophylaxis (cleaning): limited to two each year
Topical application of fluoride: limited to two treatments each year to children under age 18
Bitewing X-Rays: limited to one set each year
Vertical bitewing X-Rays: limited to once every three years (7-8 films)
Periapical X-Rays: limited to five films each year
Full-mouth X-Rays (complete series or panoramic): limited to once every three years

Basic Benefits

DIAGNOSTIC SERVICES

Emergency/limited oral examinations
Office visit after hours: for emergencies only
Referral consultations and examinations performed by a specialist
Extraoral X-Rays
Emergency palliative treatment

SEALANTS & PREVENTIVE RESIN RESTORATIONS

Permanent molar teeth: limited to children under 15 years of age and once every five years per tooth

SPACE MAINTAINERS

Space maintainer – fixed, unilateral: limited to children under 19 years of age
Distal shoe space maintainer – fixed, unilateral: limited to children under 8 years of age

ORAL SURGERY

Includes local anesthesia and routine postoperative care.
Extractions
- Simple single-tooth extractions
- Root removal – exposed roots

Surgical extractions
- Removal of an erupted tooth (uncomplicated)

Incision and drainage of abscess
Biopsy and examination
General anesthesia or intravenous sedation: only when necessary and provided in connection with oral surgery

PERIODONTIC SERVICES

Includes local anesthesia and routine postoperative care.
Emergency treatment (periodontal abscess, acute periodontitis, etc.)
Periodontal scaling and root planing: limited to four quadrants once per 12 months as definitive treatment when pocket depths of at least 4mm are demonstrated
Scaling in presence of generalized moderate or severe gingival inflammation: limited to once in a 24 month period when clinical documentation demonstrates that 30% or more of teeth are involved.
Surgical periodontics (including post-surgical visits): limited to two additional recalls in the first year following complex surgery
Gingivectomy, osseous and muco-gingival surgery, gingival grafting
Guided tissue regeneration
Periodontal maintenance procedure: limited to two each year following a history of periodontal disease

ENDODONTIC SERVICES

Includes local anesthesia and routine postoperative care.
Root canal therapy, traditional
Retreatment of previous root canal: must be at least three years following previous root canal on same tooth
Recalcification and apexification

RESTORATIVE SERVICES

Includes local anesthesia. Multiple restorations on single surface considered as a single restoration.
Restorations (amalgam, composite and sedative fillings): limited to once every two years per tooth (same surfaces only)
Pins: pin retention as part of restoration when used instead of gold or crown restoration
Stainless-steel crowns when tooth cannot be adequately restored with filling material
Recementation of inlays, onlays, crowns, bridges, and space maintainers
Repairs to crowns and bridges

FULL AND PARTIAL DENTURE REPAIRS

Repair broken complete or partial dentures
Replacement of broken teeth on complete or partial denture
Additions to partial dentures to replace extracted natural teeth

Major Benefits

RESTORATIVE SERVICES

Inlays, Onlays, Crowns, Post and Core
Limited to once in five years on the same tooth.
Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.

ORAL SURGERY

Includes local anesthesia and routine postoperative care.
Surgical extractions
- Removal of impacted tooth – soft tissue
- Removal of impacted tooth – partially bony
- Removal of impacted tooth – completely bony
- Removal of impacted tooth – completely bony, with complications
- Surgical removal of residual roots

Pre-prosthetic oral surgery
- Alveoloplasty and vestibuloplasty

PROSTHODONTIC SERVICES

Fixed bridge: limited to one original or replacement prosthesis every five years
Complete upper or lower denture: limited to one original or replacement prosthesis every five years
Partial upper or lower denture: limited to one original or replacement prosthesis every five years
Relining and rebasing: limited to once every three years

Orthodontic Services*

Orthodontic benefits refer to plan design for individual lifetime maximum.
Comprehensive orthodontic treatment
Other orthodontic treatment: limited to one appliance per individual
Appliance for tooth guidance
Orthodontic retention appliance
All benefits paid toward orthodontia services by your current employer's previous dental carrier(s) will be applied to the Dental Care Plus lifetime orthodontia maximum.

Call us at (800) 367-9466 or visit our website at DentalCarePlus.com with any questions you have about service or coverage.

*May or may not apply to your specific plan. Please refer to your benefit summary in your packet or your benefits administrator for details.

Dental insurance plans are issued by Dental Care Plus, Inc., located at 100 Crowne Point Place, Cincinnati, OH 45241. Domicile: Ohio. NAIC No. 96265.

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Implant Services*

IMPLANT SERVICES ARE COVERED AS MAJOR BENEFITS AS FOLLOWS:

Implants: limited to one original or replacement implant every five years (per tooth)

Implant abutments: limited to one original or replacement implant abutment every five years (per tooth)

Implant and abutment supported crowns, bridges and dentures: limited to one original or replacement prosthesis every five years (per tooth)

Scaling and debridement in the presence of inflammation of an implant: limited to once in a 24 month period.

Implants in replacement of natural teeth which were extracted while the individual was not covered under the Plan are excluded from coverage

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