# Pioneer Educators Health Trust Dental Plan

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 04/01/2013 - 03/31/2014**

**Coverage for:** Individual & Eligible Family

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myRegence.com or by calling 1 (866) 240-9580. (Note: the Uniform Glossary can be accessed at: www.cciio.cms.gov.)

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$50** claimant / **$150** family per calendar year. Doesn't apply to the following services: preventive dental services. **Co-insurance** or amounts in excess of the **allowed amount** do not count toward the **deductible**. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | No. | There's no limit on how much you could pay during a coverage period for your share of the cost of covered services. |
| **What is not included in the out-of-pocket limit?** | This plan has no **out-of-pocket limit**. | Not applicable because there's no **out-of-pocket limit** on your expenses. |
| **Is there an overall annual limit on what the plan pays?** | Yes. **$1,500** | This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits. |
| **Does this plan use a network of providers?** | No. | This plan treats **providers** the same in determining payment for the same services. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**. |

- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a crown is $500, your **co-insurance** payment of 50% would be $250. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. The plan does not reimburse dentists for charges above the **allowed amount**. If a **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a dentist charges $200 for an examination and the **allowed amount** is $150, you may have to pay the $50 difference. (This is called **balance billing**.)

| Common Dental Event | Services You May Need | Your cost | Limitations & Exceptions |
|---|---|---|---|
| **If you have preventive dental services** | Cleanings and examinations | No charge | Coverage is limited to 2 cleanings and 2 preventive oral examinations / year.<br>**Deductible** waived. |
| | X-rays | No charge | Coverage is limited to 2 bitewing x–ray series/ year.<br>Coverage is limited to 1 complete intra-oral mouth and 1 panoramic mouth x-rays once in a 3 year period.<br>**Deductible** waived. |
| | Other preventive dental services | No charge | Coverage is limited to claimants under age 18 for sealants (permanent bicuspids and molars only), claimants under age 12 for space maintainers, and claimants under age 18 and limited to 2 treatments / year for topical fluoride application.<br>**Deductible** waived. |
| **If you need basic dental services** | Periodontal services | 20% co-insurance | Coverage is limited to 2 periodontal maintenance / year (in lieu of preventive cleanings).<br>Coverage is limited to 1 periodontal debridement in a 3 year period.<br>Coverage is limited to 1 per quadrant in a 2 year period for periodontal scaling and root planing. |
| | Endodontic services | 20% co-insurance | ——none—— |
| | Emergency and other basic dental services | 20% co-insurance | ——none—— |
| **If you need major dental services** | Bridges | 50% co-insurance | Coverage is limited to replacement bridges once per 7 years after placement. |
| | Crowns, inlays and onlays | 50% co-insurance | Coverage is limited to replacement crowns, inlays or onlays once per tooth, 7 years after placement. |

| Common Dental Event | Services You May Need | Your cost | Limitations & Exceptions |
|---|---|---|---|
| | Dentures (full and partial) | 50% co-insurance | Coverage is limited to replacement dentures 7 years after placement. |
| | Implants (endosteal) | Not covered | ——none—— |
| **If you need orthodontic services** | Orthodontia services | 50% co-insurance | Coverage is limited to $1,500 per claimant / lifetime maximum benefit.<br>**Deductible** waived. |

## Excluded Services:

| **Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|---|---|---|
| • Aesthetic dental procedures<br>• Cosmetic/reconstructive services and supplies, except congenital anomalies<br>• Duplicate x–rays<br>• Facility charges<br>• Gold–foil restorations | • Implants<br>• Nitrous Oxide<br>• Occlusal treatment<br>• Orthognathic surgery | • Temporomandibular joint (TMJ) Dysfunction Treatment<br>• Tooth transplantation<br>• Veneers |