PacificSource HEALTH PLANS

Dental Schedule of Benefits
Pediatric Dental 20-50-50 100D

Boise State University

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.

Advantage Network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the contracted allowable fee. Participating providers agree not to collect more than the contracted allowable fee. When you use an Advantage Network provider, you will pay only the participating provider amounts below. If you choose not to use a participating provider, or don't have access to them, reimbursement is based on the contracted allowable fee. If charges exceed the allowable fee, the excess charges are your responsibility.

This plan covers dental services for enrolled individuals age 18 and younger as required under the Affordable Care Act.

Please note: Even though you may have the same benefit for participating and non-participating providers, you may still be responsible for any amounts that a non-participating provider charges that are over the PacificSource allowable fee. Please see 'allowable fee' in the definitions section of your policy.

Annual Deductible	**Per Person, Per Contract Year**	**Per Family, Per Contract Year**
Participating Providers	$100	$300
Non-participating Providers	$350	$1,050
Out-of-Pocket Limit		
$350 per person / $700 for two or more people per contract year for enrolled individuals age 18 and younger. **Note: Your actual costs for services provided by a non-participating provider may exceed this policy's out-of-pocket limit for non-participating services. In addition, non-participating providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the non-participating out-of-pocket limit.**		
Exclusion Period	**Class II Services**	**Class III Services**
Number of Consecutive Months	None	None

The member is responsible for any amounts shown above, in addition to the following amounts.

Service	**Participating Providers:**	**Non-participating Providers:**
Class I Services (Covered for enrolled individuals age 18 and younger.)		
Examinations	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Dental cleaning (prophylaxis and periodontal maintenance)	Deductible then 20% co-insurance	Deductible then 20% co-insurance

Service	Participating Providers:	Non-participating Providers:
Topical fluoride	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Fluoride varnish	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Sealants	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Space maintainers	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Athletic mouth guards	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Brush biopsies	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Class II Services (Covered for enrolled individuals age 18 and younger.)		
Fillings	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Simple extractions	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Periodontal scaling and root planing	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Full mouth debridement	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Class III Services (Covered for enrolled individuals age 18 and younger.)		
Complicated oral surgery	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Pulp capping	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Pulpotomy	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Root canal therapy	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Periodontal surgery	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Crowns	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Replacement of existing prosthetic device	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Dentures	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Bridges	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Implants	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Orthodontia for medically necessary reasons for enrolled individual's age 18 and younger	Deductible then 50% co-insurance	Deductible then 50% co-insurance

This is a brief summary of benefits. Refer to your student guide for additional information or a further explanation of benefits, limitations, and exclusions.

Additional Information

What is the annual 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.

Note that there is a separate category for participating and non-participating providers when it comes to meeting your deductible. Only participating provider expense applies to the participating provider deductible and only non-participating provider expense applies to the non-participating provider deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for approved dental expenses during the contract year and applies to enrolled individuals age 18 and younger on your policy. Once the out-of-pocket limit has been met, the plan will pay 100 percent of covered charges for the rest of that year. Only participating provider expense applies to the out-of-pocket limit. Services provided by non-participating providers, non-essential health benefits, penalties and balance billed amounts over the allowable fee do not accumulate toward the out-of-pocket limit.

What is an exclusion period?

A member must be enrolled under the dental policy for the period of time stated above before this plan pays benefits. This exclusion period does not apply to persons insured under this policy on the policy's original effective date if the person was continuously covered under a predecessor policy of the policyholder, or for enrolled individuals age 18 and younger.

Preauthorization

Coverage of certain dental services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list on our website, PacificSource.com.