

**POLICY INFORMATION**

Group Name: **City of Medford MPOA IAFF Local 1431**

Group Number: **G0033311**

**EMPLOYEE ELIGIBILITY REQUIREMENTS**

Minimum Hour Requirement: **MPOA Employees: 20 Hours**  
**IAFF 56-Hour Employees: 40 Hours**  
**IAFF 40-Hour Employees: 28 Hours**  
 Waiting Period Requirement: **First of the month following date of hire**

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 (chewing of food).

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

<b>Deductible Per Calendar Year</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Individual/Family</b>	None/None	\$25 / \$75
<b>Benefit Maximum Per Calendar Year</b>		
\$2,000 per person. Applies to all covered services.		

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

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Class I Services</b>		
<b>Examinations</b>	No deductible, 0%	After deductible, 0%
<b>Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex</b>	No deductible, 0%	After deductible, 0%
<b>Dental cleaning (prophylaxis and periodontal maintenance)</b>	No deductible, 0%	After deductible, 0%
<b>Fluoride (topical or varnish applications)</b>	No deductible, 0%	After deductible, 0%
<b>Sealants</b>	No deductible, 0%	After deductible, 0%
<b>Space maintainers</b>	No deductible, 0%	After deductible, 0%

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Athletic mouth guards</b>	No deductible, 0%	After deductible, 0%
<b>Brush biopsies</b>	No deductible, 0%	After deductible, 0%
<b>Class II Services</b>		
<b>Fillings</b>	No deductible, 20%	After deductible, 20%
<b>Simple extractions</b>	No deductible, 20%	After deductible, 20%
<b>Periodontal scaling and root planing</b>	No deductible, 20%	After deductible, 20%
<b>Full mouth debridement</b>	No deductible, 20%	After deductible, 20%
<b>Complicated oral surgery</b>	No deductible, 20%	After deductible, 20%
<b>Pulp capping</b>	No deductible, 20%	After deductible, 20%
<b>Pulpotomy</b>	No deductible, 20%	After deductible, 20%
<b>Root canal therapy</b>	No deductible, 20%	After deductible, 20%
<b>Periodontal surgery</b>	No deductible, 20%	After deductible, 20%
<b>Tooth desensitization</b>	No deductible, 20%	After deductible, 20%
<b>Class III Services</b>		
<b>Crowns</b>	No deductible, 50%	After deductible, 50%
<b>Dentures</b>	No deductible, 50%	After deductible, 50%
<b>Bridges</b>	No deductible, 50%	After deductible, 50%
<b>Replacement of existing prosthetic device</b>	No deductible, 50%	After deductible, 50%
<b>Implants</b>	No deductible, 50%	After deductible, 50%

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

# Additional information

## What is the 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.

Deductible expense applies only to out-of-network providers.

## What is the benefit maximum?

The benefit maximum is the maximum amount payable by this policy for covered services received each calendar year.

## Predetermination

Coverage of certain dental services and surgical procedures are by review. When a planned dental service exceeds \$300, PacificSource recommends a predetermination to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Predeterminations are not a guarantee of payment and do not change your out-of-pocket expense.

