Ameritas

ASI Dental Plan

The EdCare Group
Summary of Dental Benefits

	IN-NETWORK	OUT-OF-NETWORK
Diagnostic/Preventive Services • Oral examinations (two in 12 months) • Full mouth X-rays (once in a 5-year period) • Emergency palliative treatment • Prophylaxis (once every 6-months) • Fluoride treatment (once every 6-months, to age 18) • Space maintainers (to treat premature loss of primary teeth) • Application of sealants (on permanent first and second molars with no restorations and the occlusal surface intact up to age 16; does not include the repair or replacement of a sealant on any tooth within 3 years of application)	**Coverage** Incentive level 70%, 80%, 90%, 100%	**Coverage** Incentive level 70%, 80%, 90%, 100% (Fees based on MAC*)
Basic Services • Restorations for all teeth (composite/resin, amalgam, synthetic or plastic fillings) • Amalgam fillings allowed for molar restorations • Periodontics • Endodontics • Oral surgery (surgical procedures including extractions, incision and drainage of abscesses; and administration of anesthesia and post-operative care) • Crowns, jackets, inlays, onlays, and cast restorations are a benefit only if teeth cannot be restored with amalgam, plastic, or composite restorations (on the same tooth, benefit only once every 5 years)	**Coverage** Incentive level 70%, 80%, 90%, 100%	**Coverage** Incentive level 70%, 80%, 90%, 100% (Fees based on MAC*)
*With our dental plans, members can receive care from any dentist they choose. However, with one of our PPO dental network providers, their out-of-pocket costs almost always will be less. That's because these providers agree to charge a discounted network fee – known as the MAC or Maximum Allowable Charge – for each covered procedure.		

Major Services • Installation of fixed bridges to replace one or more missing natural teeth (prosthodontic appliances are benefits once every five years) • Installation of partial dentures and complete dentures if provided to replace missing natural teeth (includes all adjustments made during the 6-month period following installation; prosthodontic appliances are benefits once every five years) • Installation of precision attachments for removable dentures; repair of full or partial dentures including addition of clasps, rests, or teeth to existing partial removable dentures. • Rebasing or relining removable dentures (limit twice per year) • Mouth guards	**Coverage - 50%**	**Coverage - 50%** (Fees based on MAC*)
Orthodontia Services	**Coverage - 50%**	**Coverage - 50%** (Fees based on MAC*)
Maximum benefit/person/calendar year	$1,750	$1,500
Lifetime orthodontia benefit for children and adults	$1,250	$1,250
Deductibles	None	None
Accidental Injury Benefit/calendar year Provided for conditions caused directly by external, violent and accidental means.	$1,000	$1,000
Predetermination of benefits When a course of dental treatment is expected to exceed $300, predetermination of benefits is recommended.	$300	$300

HOW COVERED DENTAL EXPENSE IS DETERMINED

Covered Dental Expense is based on a maximum charge for each covered service or supply, which the Plan will accept. It is not necessarily the amount a dentist bills for the service. Covered Dental Expense will always be the lesser of the billed charge or the MAC based on the Ameritas Schedule for the procedure preformed. Ameritas' Participating Dentists have agreed not to charge more than Ameritas' PPO fees. The Covered Person will not be responsible for any amount in excess of Ameritas' PPO fees when treatment is rendered by an Ameritas Participating Provider. The Covered Person will be responsible for any billed charges which exceed the MAC when treatment is rendered by a Non-Participating Dentist.

This plan is underwritten by Ameritas Life Insurance Corp.

PLAN EXCLUSIONS

This plan does not cover the following:

1. Services for injuries covered by Workers' Compensation or Employer's Liability Laws or services which are paid by any federal, state or local government agency, except Medi-Cal benefits.
2. Services for cosmetic purposes except when necessitated by an Accidental injury. Mandibular molar crowns and maxillary second and third molar crowns are without a porcelain benefit. Crowns placed for periodontal splinting are not covered.
3. Conditions that are a result of hereditary or developmental defects including but not limited to cleft palate, jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
4. Treatment which restores tooth structure that was lost due to abrasion, erosion or abfracation; treatment which rebuilds or maintains chewing surfaces that are damaged because the teeth are out of alignment or occlusion; or treatment which stabilizes the teeth. Examples of such treatment are equilibration and periodontal splinting.
5. Any Single Procedure, bridge, denture or other prosthodontic service which was started before you were covered by this program.
6. Prescription medication-Includes prescription and non-prescription medications obtained in or outside the dental office. This includes, but is not limited to, injections, analgesia, and non-intravenous conscious sedation and includes the use of intraoral antibiotics placed around teeth.
7. Experimental procedures.
8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the0Dentist for treatment in any such facility.
9. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.
10. Grafting tissues from outside the mouth to tissue inside the mouth ("extra oral grafts").
11. Implants-Implant placement, the removal of implants, including any procedure to treatment related to the placement or removal of an implant.
12. TMJ/Jaw joint treatment-any diagnostic procedure, treatment, device, appliance, splint, occlusal guard, or occlusal adjustment relating to Temporomandibular Joint dysfunctional Syndrome.
13. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this program.
14. Oral Hygiene Counseling-Education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene instruction, plaque control, or tobacco cessation. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, floss, oral irrigation devices, and mouth rinses.
15. Customized Prosthetics-Precision, semi-precision attachments, stress breakers, personalization or customized prosthetics are not covered. Over dentures are considered customized, whose benefit is as a full or partial denture, subject to limitations and exclusions of removable denture.
16. Evaluations/Examinations-Limited to one comprehensive evaluation per dentist/dental office per lifetime, unless there are significant changes in the medical or dental status, or three or more years has elapsed since their last dental treatment. Periodic evaluations are limited to two every 12 months, which include all evaluations, specialist consultations and office visits for observations, in the frequency limits.
17. Medical/Dental Necessity-Treatment or procedures which are not recommended by a Dentist or Physician (practicing within the scope of their license) or which are deemed not be dentally or medically necessary.
18. Lost or Stolen Prosthetics or appliances-Replacement of prosthesis or any other type of appliance, which has been lost, misplaced, or stolen.
19. Myofunctional Therapy

20. Non-Professional Care-Services rendered by someone other than: a Dentist (D.D.S. or D.M.D.)
21. Excess & Unnecessary Care-Duplicate prosthetic devices or appliances.
22. Orthognathic surgery.
23. Splinting-Appliances and restorations for splinting teeth.
24. Analgesia and Non-conscious sedation.

This Summary of Benefits is a general description of coverage only.
Please refer to the Actual Summary Plan Description for detailed benefit information.

Administrated by Ameritas Group
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