PEHP Dental Care

Introduction

PEHP wants to keep you healthy and smiling brightly. We offer dental plans that provide coverage for a full range of dental care.

When you use in-network providers, you pay a specified co-pay and PEHP pays the balance. When you use out-of-network providers, PEHP pays a specified portion of the In-Network Rate (In-Network Rate), and you are responsible for the balance.

There is no deductible for Diagnostic or Preventive services.

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. The Master Policy is available at www.pehp.org. Call PEHP Customer Service to request a copy.

Waiting Period for Orthodontic, Implant, and Prosthodontic Benefits

There is a Waiting Period of six months from the effective date of coverage for Orthodontic, Implant, and Prosthodontic benefits.

Members returning from military service will have the six-month waiting period for orthodontics waived if they reinstate their dental coverage within 90 days of their military discharge date.

Missing Tooth Exclusion

Services to replace teeth that are missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with PEHP.

However, the plan may review the abutment teeth for eligibility of Prosthodontic benefits. The Missing Tooth Exclusion does not apply if a bridge or denture was in place at the time the coverage became effective.

Limitations and Exclusions

Written preauthorization may be required for prosthodontic services. Preauthorization is not required for orthodontics.

Refer to the Dental Care Master Policy for complete benefit limitations, exclusions, and specific plan guidelines.

Master Policy

Refer to the PEHP Dental Master Policy for complete benefit limitations and exclusions and specific plan guidelines. The Master Policy is available at www.pehp.org. Call PEHP Customer Service to request a copy.

If you use an Out of Network provider, your benefits will be reduced by 20%. Out of Network providers may collect charges that exceed PEHP's In Network Rate.

	Preferred Dental Care		Traditional Dental Care	
	IN NETWORK	**OUT OF NETWORK**	**IN NETWORK**	**OUT OF NETWORK**
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS				
Deductible (Does not apply to diagnostic or preventive services)	**$25** per member, **$75** maximum per family	**$25** per member, **$75** maximum per family	None	None
Annual Benefit Max	**$1,500**	**$1,500**	**$1,500**	**$1,500**
DIAGNOSTIC	**YOU PAY**	**YOU PAY**	**YOU PAY**	**YOU PAY**
Periodic Oral Examinations	No Charge	**20%** of In-Network Rate	No Charge	**20%** of In-Network Rate
X-rays	**20%** of In-Network Rate	**40%** of In-Network Rate	No Charge	**20%** of In-Network Rate
PREVENTIVE				
Cleanings and Fluoride Solutions	**20%** of In-Network Rate	**40%** of In-Network Rate	No Charge	**20%** of In-Network Rate
Sealants | Permanent molars only through age 17	**20%** of In-Network Rate	**40%** of In-Network Rate	No Charge	**20%** of In-Network Rate
RESTORATIVE				
Amalgam Restoration	**20%** of In-Network Rate AD*	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
Composite Restoration	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
ENDODONTICS				
Pulpotomy	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
Root Canal	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
PERIODONTICS				
	20% of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	4**0%** of In-Network Rate
ORAL SURGERY				
Extractions	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate
ANESTHESIA | General Anesthesia in conjunction with oral surgery or impacted teeth only				
General Anesthesia	**20%** of In-Network Rate AD	**40%** of In-Network Rate AD	**20%** of In-Network Rate	**40%** of In-Network Rate

Prosthodontic, implant, and orthodontic services below are not eligible for six months from the date coverage begins unless prior, continuous dental coverage can be shown

PROSTHODONTIC BENEFITS | Preauthorization may be required				
Crowns	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
Bridges	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (partial)	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
Dentures (full)	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
IMPLANTS				
All related services	**50%** of In-Network Rate AD	**70%** of In-Network Rate AD	**50%** of In-Network Rate	**70%** of In-Network Rate
ORTHODONTIC BENEFITS | 6-month Waiting Period				
Maximum Lifetime Benefit per Member	**$1,500**		**$1,500**	
Eligible Appliances and Procedures	**50%** of eligible fees to plan maximum AD		**50%** of eligible fees to plan maximum	

Missing Tooth Exclusion » Services to replace teeth missing prior to effective date of coverage are not eligible for a period of five years from the date of continuous coverage with a PEHP-sponsored dental plan. Learn more in the Dental Master Policy.

*** AD** = After Deductible

Regence Expressions℠ Dental Plan

$0 Deductible
$1,500 Ma *July 1, 2015*

STATE OF UTAH
Effective Date: July 1, 2015

Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Benefit Summary	
Deductible per contract year	$0 Per Member Deductible $0 Family Deductible
Maximum benefit per contract year	$1,500 Per Member

Understanding Your Benefits

- Once you have satisfied any applicable deductible, we pay a percentage of the allowed amount for covered servies up to any maximum benefit. When our payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Member Responsibility).
- We do not reimburse Dentists for charges above the allowed amount. A **Participating Dentist** will not charge you for any balances for covered services beyond your coinsurance amount. **Nonparticipating Dentists**, however, may bill you for any balances over our payment level in addition to any coinsurance amount. You can find a list of providers at our Website or by calling Customer Service.

Covered Dental Services (Per Member)	***Member Responsibility***
Preventive Dental Services ▪ Bitewing x-rays: 2 per contract year ▪ Complete intra-oral mouth x-rays: Once in a 3-year period ▪ Cleanings: 2 per contract year (in lieu of periodontal maintenance) ▪ Oral examinations: 2 per contract year ▪ Panoramic mouth x-rays: Once in a 3-year period ▪ Sealants (bicuspids and molars only): Under 15 years of age ▪ Space Maintainers: Under 13 years of age ▪ Topical fluoride application: Under 26 years of age, 2 treatments per contract year	0%
Basic Dental Services ▪ Repair of Bridges, Crowns, Dentures: Coverage for adjustments and repair allowed one year of after placement ▪ Endodontic services including root canal treatment, pulpotomy and apicoectomy ▪ Emergency treatment for pain relief ▪ Fillings consisting of composite and amalgam restorations ▪ General dental anesthesia or intravenous sedation (subject to necessity) ▪ Uncomplicated and complex oral surgery procedures ▪ Periodontal maintenance: 2 per plan year (in lieu of preventive cleanings) ▪ Periodontal debridement: Once in a 3-year period ▪ Periodontal scaling and root planing: 2 per contract year ▪ Vestibuloplasty	20%
Major Dental Services ▪ Bridges: Except no benefits are provided for replacement made fewer than 5-years after placement ▪ Crowns: Except no benefits are provided for replacement made fewer than 5-years after placement ▪ Dentures (full and partial): Except no benefits are provided for replacement made fewer than 5-years after placement ▪ Implants (endosteal)	50%
Orthodontia Services ▪ Orthodontic treatment: No age limit ▪ $1,500 per member lifetime maximum benefit	50%

Dental Exclusions
We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise covered service for an injury, if the injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the injury, as required by federal law.
Aesthetic Dental Procedures: Services and supplies provided in connection with dental procedures that are primarily aesthetic, including bleaching of teeth and labial veneers.
Antimicrobial Agents: Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
Collection of Cultures and Specimens
Condition Caused By Active Participation in a War or Insurrection: The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.
Condition Incurred In or Aggravated During Performances In the Uniformed Services: The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.
Connector Bar or Stress Breaker
Cosmetic/Reconstructive Services and Supplies except for dentally appropriate services and supplies to treat a congenital anomaly and to restore a physical bodily function lost as result of injury or illness.
Desensitizing: Application of desensitizing medicaments or desensitizing resin for cervical and/or root surface.
Diagnostic Casts or Study Models
Duplicate X-Rays
Expenses Before Coverage Begins or After Coverage Ends: Services and supplies incurred before your effective date under the contract or after your termination under the contract except as may be provided under the other continuation options of the contract.
Facility Charges: Services and supplies provided in connection with facility services, including hospitalization for dentistry and extended-care facility visits.
Fees, Taxes, Interest: Charges for shipping and handling, postage, interest or finance charges that a dentist might bill.
Fractures of the Mandible: Services and supplies provided in connection with the treatment of simple or compound fractures of the mandible.
Gold-Foil Restorations
Government Programs: Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program.
Home Visits
Implants: Services and supplies provided in connection with implants, whether or not the implant itself is covered.
Investigational Services: Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures (health interventions).
Medications and Supplies including take home drugs, pre-medications, therapeutic drug injections and supplies.
Motor Vehicle Coverage and Other Insurance Liability
Nitrous Oxide
Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges.
Occlusal Treatment: Services and supplies provided in connection with dental occlusion, including occlusal analysis, adjustments and occlusal guards.
Oral Hygiene Instructions
Oral Surgery treating any fractured jaw and orthognathic surgery. By orthognathic surgery, we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship of the facial bones.
Personal Comfort Items: Items that are primarily used for personal comfort or convenience, contentment, personal hygiene, aesthetics or other nontherapeutic purposes.
Photographic Images
Pin Retention in Addition to Restoration
Precision Attachments
Prosthesis including maxillofacial prosthetic procedures and modification of removable prosthesis following implant surgery.
Provisional Splinting
Replacements: Services and supplies provided in connection with the replacement of any dental appliance (including, but not limited to, dentures and retainers), whether lost, stolen or broken.

Dental Exclusions
Riot, Rebellion and Illegal Acts: Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.
Self-Help, Self-Care, Training or Instructional Programs
Separate Charges: Services and supplies that may be billed as separate charges (these are considered inclusive of the billed procedure) including any supplies, local anesthesia and sterilization.
Services and Supplies Provided by a Member of Your Family
Services Performed in a Laboratory
Surgical Procedures: Services and supplies provided in connection with the following surgical procedures: exfoliative cytology sample collection or brush biopsy; incision and drainage of abscess extraoral soft tissue, complicated or non-complicated; radical resection of maxilla or mandible; removal of nonodontogenic cyst, tumor or lesion; surgical stent and surgical procedures for isolation of a tooth with rubber dam.
Temporomandibular Joint (TMJ) Dysfunction Treatment
Third-Party Liability: Services and supplies for treatment of illness or injury for which a third party is or may be responsible.
Tooth Transplantation: Services and supplies provided in connection with tooth transplantation, including reimplantation from one site to another and splinting and/or stabilization.
Travel and Transportation Expenses
Work-Related Conditions: Expenses for services and supplies incurred as a result of any work related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

Please note: This benefit summary provides a brief description of your dental plan benefits, limitations and exclusions under your dental plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our Website, **www.Regence.com**. Please refer to your benefits booklet for a complete list of benefits, the limitations and exclusions that apply and a definition of dentally appropriate.

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Contact Customer Service at 1 (888) 367-2119

www.regence.com