



Cypress Dental Group Plan Information Sheet



Highlights of the Cypress Dental MAC (LOW) Plan

The following chart provides a brief summary of the key benefits provided by Cypress Dental & Vision. On the following pages, you will find additional information to answer questions you may have. For a complete list of all covered procedures, limitations and exclusions, please refer to your booklet or contact Cypress Dental & Vision at the numbers below.

Dental Plan Summary for The Judson Studios

| \$2,500 Annual Maximum Per Person | Deductible | If In Network* You Pay: | If Out of Network** You Pay: |
|---|-------------------|--|---|
| Preventive Services | \$0 | 0% | 0% |
| Basic Services | \$50 | 20% | 20% |
| Combined Deductible: PPO Deductibles for Basic and Major services are combined. Out of Network deductible for Basic and Major services combined. | | | |
| Major Services | \$50 | 50% | 50% |

Family Deductible: \$150 per plan year

*When using a network provider there is no balance billing. Dentist agrees to charge based on negotiated scheduled fee allowance. Patient is responsible for coinsurance and deductible.

**When using non-network providers, you pay any amount billed by dentist over the scheduled fee allowance.

Contact [Cypress Dental & Vision](#) for all benefits, claims and eligibility questions:

Cypress Dental & Vision

7510 Shoreline Drive, Suite A-1, Stockton, CA 95219

Toll Free (800)350-3989

Fax (209)478-5614

Email claims@cypressadmin.com

Website www.cypressadmin.com

What Dental Procedures are Covered?

This list of common procedures shows which service category the procedure is included in and how often they are covered.

Procedure Frequencies and Limitations^{*}

Preventive Services

Frequency or Limitation

| | |
|-------------------------------------|--|
| Routine or comprehensive oral exams | Maximum 2 per calendar year |
| Check up cleanings | Maximum 2 per calendar year |
| Bitewing x-rays | Maximum 4 films per calendar year |
| Sealants | Maximum 1 procedure per 36 months, first and second molars only, limited to children under age 16; |
| Fluoride | One treatment per calendar year, limited to children under age 16 |

Basic Services

| | |
|--------------------------------|--|
| Full-mouth x-rays | Maximum 1 procedure per 36 months |
| Restorative Fillings | Replacement of existing limited to once per tooth per 12 months if under age 19, or once per tooth per 36 months if over age 19. |
| Simple extractions | |
| Emergency exams | |
| Periodontics: | |
| Root planning | Maximum 1 per 24 months per quadrant |
| Perio cleaning (deep cleaning) | Maximum 2 per calendar year |
| Endodontics (Root canal) | |
| Oral Surgery | |
| Surgical Extractions | |
| General Anesthesia/IV Sedation | Allowed for surgical procedure only |

Major Services

| | |
|-------------------|---|
| Crowns | Maximum 1 per 5 years per tooth |
| Bridges | Maximum 1 per 5 years per tooth |
| Dentures | Maximum 1 procedure per 5 |
| Space maintainers | Maximum 1 procedure per 36 months; Limited to children under age 16; Permanent molars only. |

^{*} *This is a summary of frequencies & limitations only. Refer to the certificate of coverage for a full description of benefits.*

How To Find A Participating Provider

Use the provider directory on www.cypressadmin.com to locate a PPO provider near you or to see if your dentist participates.

| | |
|---|--|
| 1 | Visit our website at www.cypressadmin.com |
| 2 | Click the Provider Directory tab at the top of the page |
| 3 | Click on the DenteMax Provider Directory |
| 4 | Enter the name of the provider you are looking for (if known). If you are looking for a nearby dentist, enter the city and state and/or zip code. Be sure to indicate how far you are willing to travel. |
| 5 | Select the desired specialty or use the Any default |
| 6 | The Network type is Commercial, click search to continue |

You may also refer your dentist to be included in the network from this site or you may call **(800) 752-1547**.

Pretreatment/Prior Authorizations

Cypress Dental & Vision does not require prior authorization for any procedure, we recommend it if you would like to know your share of cost up front. Simply ask your dentist to request a pretreatment estimate from our claims and benefits department. We will inform the dentist of the exact amount your insurance will cover and what amount you are responsible for.

Limitations & Exclusions^{*}

| | |
|---|---|
| Late Entrant Provision | If you choose not to sign up during the initial enrollment period, you will be considered a late entrant. Late entrants are eligible only for preventive services for the first 12 months they are covered under the policy. |
| Missing Tooth | Benefits for the initial placement of bridge, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Cypress Dental & Vision policy. |
| Orthodontia <i>Ortho may not be available with all plans</i> | <p>If there is an orthodontia (ortho) treatment in progress on the coverage effective date and you are covered under any prior group insurance for ortho, there will be immediate coverage for treatment if proof is submitted that shows:</p> <ol style="list-style-type: none"> 1. The lifetime maximum under any prior group insurance has not been exceeded, 2. Ortho treatment was started and bands or appliances were inserted while insured under any prior group insurance, and 3. Ortho treatment has been continued while insured is under this policy. 4. Lesser of lifetime max between prior plan and Cypress plan will prevail to determine continuation ortho benefit. <p>Cypress will credit payment made by the prior carrier toward the Cypress lifetime ortho payment limit.</p> <p>You will not be covered if ortho treatment is in progress prior to the effective date with Cypress Dental & Vision and you are not covered under any prior group coverage for ortho.</p> <p><i>Ortho may not be available with all plans</i></p> |
| Other Limitations | There are additional limitations to your coverage. A complete list is included in your certificate of insurance. |

^{*}This is a summary of limitations and exclusions please refer to your certificate of insurance for more information.