EmpowerHMS
Dental Schedule of Benefits
Effective October 1, 2017

Dental Coverage

Network Options	**In-Network: Aetna**			**Out-of-Network: Non-Network Reimbursement**
Reimbursement Levels	**Based on Contracted Fees**			**Maximum Reimbursable Charge**
Calendar Year Benefits Maximum Applies to: Class, I, II, III & IX expenses	**$1,000**			**$1,000**
Calendar Year Deductible Individual Family	**$50** **$150**			**$50** **$150**
Benefit Highlights	**Plan Pays**	**You Pay**	**Plan Pays**	**You Pay**
Class I: Diagnostic & Preventative Oral Evaluation Prophylaxis: Routine Cleanings X-rays: Non-Routine Emergency Care to Relieve Pain Brush Biopsies	**100%** **No Deductible**	**No Charge**	**100%** **No Deductible**	**No Charge**
Class II: Basic & Restorative Restorative: Fillings X-rays: Non-Routine Oral Surgery: Simple Extractions Anesthesia: general and IV sedation Endodontics: minor and major Periodontics: minor and major Repairs: Dentures Repairs: Bridges, Crowns and Inlays Denture Relines, Rebases and Adjustments	**80%** **After Deductible**	**20%** **After Deductible**	**80%** **After Deductible**	**20%** **After Deductible**
Class III: Major Restorative Inlays and Onlays Oral Surgery: All except Simple Extractions Extractions of Impacted Teeth Anesthesia: general and IV sedation Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain Bridges and Dentures	**50%** **After Deductible**	**50%** **After Deductible**	**50%** **After Deductible**	**50%** **After Deductible**
Class IV: Orthodontia Coverage for Dependent Children to age 19 **Lifetime Benefits Maximum: $1,000**	**50%** **No Deductible**	**50%** **No Deductible**	**50%** **No Deductible**	**50%** **No Deductible**
Class V: Implants	**50%** **After Deductible**	**50%** **After Deductible**	**50%** **After Deductible**	**50%** **After Deductible**

Benefit Plan Provisions:	
In-Network Reimbursement	For services provided by an In-Network Dentist, we will reimburse the dentist according to the Fee Schedule or Discount Schedule.
Non-Network Reimbursement	For services provided by a non-network dentist, we will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider charges in the geographic area. The dentist may balance bill up to their usual fees.
Cross Accumulations	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Late Entrant Limitation Provision	Payment will be reduced by 50% for Class III, IV, & V services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.

Alternate Benefit Provision	Provision when more than one covered Dental Service could provide suitable treatment based on common dental standards, Core will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Timely Filing	Out of network claims submitted to Core after 365 days from date of service will be denied
Benefit Plan Provisions:	
Missing Tooth Limitation	For teeth missing prior to coverage with Empower, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations	2 per calendar year
X-rays (routine) Bitewings:	2 per calendar year
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 19.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 14.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Inlays, Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Benefit Exclusions: ***Covered Expenses will not include, and no payment will be made for the following:***	
Procedures and services not listed under Benefit Highlights;	
Diagnostic: cone beam imaging; Preventive Services: instruction for plaque control, oral hygiene and diet;	
Restorative: Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and/or third molars;	
Periodontic: bite registrations; splinting; Prosthodontic: precision or semi-precision attachments;	
Procedures, appliances or restorations, except full dentures, whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); stabilize periodontally involved teeth; or restore occlusion;	
Athletic mouth guards; Replacement of a lost or stolen appliance; Services performed primarily for cosmetic reasons; Personalization;	
Services that are deemed to be medical in nature; Services and supplies received from a hospital; Drugs: prescription drugs	
Charges in excess of the Maximum Reimbursable Charge.	
Contracted providers are not obligated to provide discounts on non-covered services and may charge their usual fees.	

*This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.