

**COUNTY OF IMPERIAL**  
**BENEFITS AT A GLANCE**  
EFFECTIVE JANUARY 1, 2015

**This summary does not contain all of the provisions or limitations which apply to your Dental coverage. For coverage details, see your benefit booklet. Upon receipt of your benefit booklet, please discard this summary, as benefits are subject to change.**

**Point of Service (POS) Plan**

Your employer has agreed to participate in a Point of Service (POS) Plan identified by the Claims Administrator for this plan.

As you may know, Point of Service (POS) Plans are the most versatile type of plan and provide two to three tiers (points) of coverage. A person covered under a Point of Service (POS) plan can move between these different tiers of coverage each time dental care is received.

Please note that your employer's participation in the EPO or PPO does not mean that your choice of provider will be restricted. You may still seek needed dental care from any Dentist you wish. However, in order to avoid higher charges and reduced benefit payments, you are urged to obtain such care from Exclusive Providers or Preferred Providers whenever possible.

<b>DENTAL EXPENSE COVERAGE</b>			
<b>SERVICE</b>	<b>EPO PROVIDER</b>	<b>PPO PROVIDER</b>	<b>NON-PPO/NON-EPO PROVIDERS</b>
<b>Calendar Year Deductible*</b> <ul style="list-style-type: none"> <li>• Preventive Procedures</li> <li>• Basic &amp; Major Procedures (combined) <ul style="list-style-type: none"> <li>Per Person</li> <li>Per Family</li> </ul> </li> <li>• Orthodontia</li> </ul>	None	None	None
<b>Maximum Payment Limits*</b> <ul style="list-style-type: none"> <li>• Preventive, Basic, &amp; Major Procedures (combined)</li> <li>• Orthodontia</li> </ul>	\$2,000 per calendar year \$1,000 per lifetime	\$1,500 per calendar year \$1,000 per lifetime	\$1,000 per calendar year \$1,000 per lifetime
<b>Procedure Categories</b> <ul style="list-style-type: none"> <li>• Preventive</li> <li>• Basic</li> <li>• Major</li> <li>• Orthodontia</li> </ul>	100%	100%	100%
<b>Dental Treatment Plan</b> When charges for a Period of Dental Treatment (other than Emergency Treatment) are expected to exceed \$300, it is strongly recommended that you file a Dental Treatment Plan with the Claims Administrator before treatment begins.			
*PPO, EPO, Non-PPO, and Non-EPO Calendar Year Deductibles and Maximum Payment Limits reduce each other.			

**COVERED CHARGES:**

**Dental Care Unit 1 - Preventive Procedures**

**Examinations**

Only two of the below listed examinations will be covered in any 12 consecutive months.

- Oral examination (evaluation)
- Periodic examination (evaluation)
- Office visit

Limit combined with emergency examinations as described under Part 2 – Basic Procedures.

## Second Opinion

Benefits will be payable for a Second Opinion obtained with respect to a recommended Treatment or Service at 100% of Second Opinion Consultation Charges (Deductible waived), subject to Prevailing Charges.

Note: Obtaining a confirming Second Opinion does not guarantee payment of the Treatment or Service. All other terms, provisions, conditions, limitations, and exclusions of the Group plan remain in full force and effect with respect to benefits.

## Radiographs

### Full Mouth Survey

Complete series (including bitewings)  
Panoramic

Only one of the listed full mouth surveys will be covered in any 36 consecutive months.

### Bitewing

Limited to a maximum of 4 bitewing films in one visit, once in any six consecutive month period.

### Occlusal/Periapical

### Extraoral x-rays

Sialography  
Cephalometric film  
Posterior-anterior or lateral skull and facial bone survey  
Other extraoral

Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges.

## Preventive Services

### Prophylaxis (cleaning of teeth)

Covered twice in any 12 consecutive months. Limit combined with Periodontal Prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures) as described under Part 2 – Basic Procedures. (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a 12-month period. Benefits will be paid at 100% of Covered Charges and the Deductible will be waived for this additional cleaning).

### Topical application of fluoride

Applicable only to Dependent children under age 18. Only one application will be covered in any 12 consecutive months.

### Space maintainers

Applicable only to Dependent children under age 16. Repairs to space maintainers are not covered.

### Topical application of sealants

Applicable only to first and second permanent molars for Dependent children under age 18. Covered once each tooth in any 24 consecutive months.

## Other Services

### Harmful Habit Appliance

Limited to one time per person under the age of 16.

### Consultation with specialist

Covered once in any 6 consecutive months. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

### Palliative treatment

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.

### Biopsy of oral tissue

Diagnostic Casts

Covered once in any 24 consecutive months.

## **Dental Care Unit 2 - Basic Procedures**

### **Restorations**

Fillings (amalgam, silicate, plastic, or composite)

Multiple restorations on one surface will be paid as a single filling. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations.

Stainless steel crown

### **Bone Replacement Graft**

Covered once per site in any 36 consecutive months.

### **Oral Surgery**

Extraction of teeth

Alveoloplasty

Removal of dental cysts and tumors

Surgical incision and drainage of dental abscess

### **Other surgical procedures**

Surgical exposure to aid eruption

Excision of hyperplastic tissue

### **Anesthesia**

General anesthesia

IV Sedation

General anesthesia or IV Sedation is covered as a separate procedure only when required for complex oral surgical procedures covered under this plan (and only when performed in a dental office)

### **Periodontic Services**

Scaling and root planing (each quadrant)

Covered once each quadrant in any 24 consecutive months. (Expectant mothers, diabetics and those with heart disease, benefits will be payable at 100% of Covered Charges and the Deductible will be waived).

Periodontal appliance

One appliance is covered in any 36 consecutive months.

Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures).

Covered only if at least three months have elapsed after completion of active therapeutic scaling and root planing or active surgical periodontal treatment. Covered twice in any 12 consecutive months. Limit combined with Prophylaxis (cleaning of teeth) limit under Part 1 – Preventive Procedures. (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a 12-month period. Benefits will be paid at 100% of Covered Charges and the Deductible will be waived for this additional cleaning).

## **Periodontal Surgical Procedures**

- Gingival flap procedure
- Gingivectomy
- Gingival curettage
- Osseous surgery
- Pedicle soft tissue graft
- Free soft tissue graft
- Subepithelial connective tissue graft
- Distal or proximal wedge procedure
- Crown lengthening

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 36 consecutive months.

## **Endodontic Services**

Vital pulpotomy

Covered for deciduous teeth only

Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care

- Apexification
- Apicoectomy
- Retrograde filling
- Root resection
- Hemisection

## **Other Services**

Emergency Exam

Covered as a separate procedure only if no other service (except x-rays) is provided during the visit. Only two exams are covered in any 12 consecutive months. Limit combined with routine examinations limit under Part 1 – Preventive Procedures.

Antibiotic drug injection

## **Dental Care Unit 3 - Major Procedures**

### **Restorations**

Inlays and onlays

Inlay or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement.

Labial Veneer

Veneer restorations are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement.

Crowns (single restorations only)

- Resin (laboratory)
- Resin, prefabricated
- Resin with nonprecious metal
- Resin with semiprecious metal
- Resin with gold
- Porcelain
- Porcelain with nonprecious metal
- Porcelain with semiprecious metal
- Porcelain with gold
- Gold (3/4 cast)
- Gold (full cast)
- Nonprecious metal (full cast)
- Semiprecious metal (full cast)

Crowns are covered only if the tooth cannot be restored by a filling and (for replacements) at least five years (60 consecutive months) have elapsed since the last placement. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. Crowns for the replacement of veneer, inlay, or onlay are covered only if at least five years (60 consecutive months) have elapsed since the last placement of the restoration. Crowning of implant replacing a tooth missing prior to the effective date is not covered. For persons under 16 years of age, the benefit for crowns on vital teeth are limited to resin or stainless steel crowns. Crowning of implant replacing a pontic will not be covered unless at least 60 consecutive months has elapsed since placement of the pontic. The date the crown is cemented in the mouth will be used in determining benefits payable.

#### Cast post and core

Covered only for teeth that have had root canal therapy. Covered once per tooth per 60 consecutive months. There will be no separate benefit payable for cast post and core if restorative procedure is not covered under this plan.

#### Crown Buildup

Covered only when required for retention and preservation of the tooth. There will be no separate benefit payable for crown build up if restorative procedure is not covered under this plan. Covered once per tooth per 60 consecutive month period.

### **Prosthodontics, Fixed**

#### Fixed bridges - initial placement or replacement

Initial placement of fixed bridges to replace teeth which were missing prior to the effective date of the individual's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while the person is covered under this plan (provided that tooth was not an abutment to an existing partial denture that is less than five years old). In that event, benefits are payable only for the replacement of those teeth which were extracted while covered under the plan.

Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge is more than five years old, (60 consecutive months).

### **Prosthodontics, Removable**

#### Complete or partial dentures - initial placement or replacement

Initial placement of complete or partial dentures to replace teeth which were missing prior to the effective date of the individual's coverage will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while covered under this plan. In that event, benefits are payable only for the replacement of those teeth which were extracted while covered under the plan.

Benefits for the replacement of an existing complete or partial denture are payable only if the existing denture is more than five years old (60 consecutive months).

Covered Charges for complete or partial dentures do not include any additional charges for over-dentures or for precision or semi-precision attachments.

### **Other Services**

#### Recementing

- Inlay
- Onlay
- Crown
- Bridgework

#### Repairs to complete or partial denture, bridge, or crown

Covered once in any six consecutive months.

#### Relining or rebasing complete or partial dentures

Covered once in any six consecutive months.

#### Tissue Conditioning

Covered once in any six consecutive months.

Denture Adjustment

Covered once in any six consecutive months.

#### **Dental Care Unit 4 - Orthodontia**

##### **Orthodontic Services**

Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures.

Removable or fixed appliances for tooth or bony structure guidance or retention.

##### **Limitations**

Dental Covered Charges will not include and no benefits will be paid for:

- Treatment or Service that is not for Necessary Dental Care; or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- the services of any person who is not a Dentist or Dental Hygienist; or
- the services of any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- personalization of dentures or crowns (or any other treatment that is primarily cosmetic); or
- Treatment or Service that does not meet professionally recognized standards of quality; or
- drugs and medicines (other than antibiotic injections); or
- instructions for plaque control, oral hygiene or diet; or
- bite registration or occlusal analysis; or
- Treatment or Service to alter or maintain vertical dimension or restore or maintain occlusion; or
- Treatment or Service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance. However, replacement of a lost or stolen crown, fixed bridge, or complete or partial denture will be considered a Covered Charge if such replacement meets the requirements as described above; or
- Treatment or Service for provisional or permanent splinting; or
- Treatment or Service for which you or your Dependent has no financial liability or that would be provided at no charge in the absence of coverage; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- implants; or
- anterior  $\frac{3}{4}$  cast crowns; or
- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from participation in criminal activities; or
- Treatment or Service that is covered by a Workers' Compensation Act or other similar law; or
- Treatment or Service paid for by a Medicare Supplement Insurance Plan; or
- Treatment or Service that is temporary; or
- Treatment or Service replacing tooth structure lost from abrasion, attrition, erosion or abfraction; or
- Treatment or Service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years; or
- Treatment or Service for temporomandibular joint disorders; or
- Treatment or Service that is an Experimental or Investigational Measure; or
- Treatment or Service provided outside the United States except as follows:
  - for Treatment or Service provided in Mexico by providers participating in the FDH Mexico network. Benefits for such treatment will be paid at the same level as a PPO Provider; or
  - for Treatment or Service due to Emergency Treatment.
- Treatment or Service for which benefits are payable under the medical coverage of your plan.

##### **Terms you should know:**

**Coinsurance:** The percentage of covered charges you pay and the percentage of covered charges the plan pays after you and your dependents satisfy your calendar year deductible.

**Calendar Year:** Means January 1 through December 31 of each year.

**Calendar Year Deductible:** The total amount you and/or your dependents pay in a calendar year before the plan begins paying. If charges for covered services received during the last three months of the calendar year are applied to the deductible, the deductible for the next calendar year will be reduced by that amount.

**Calendar Year Maximum:** The amount of payments for covered dental services that the plan will make in a calendar year. Any amounts incurred during the year that are above the maximum are your responsibility.

**Prevailing Charge:** The price most providers in your area charge for a specific service. When using non-network providers, you pay any amount over the prevailing charge.

**Point of Service Design (POS):** A point-of-service design is one that involves three levels of benefits. The benefit level is determined by the network membership of the provider used for care. This design utilizes both the Exclusive Provider Organization (EPO) and Preferred Provider Organization (PPO) networks.

The group coverage described above is self-funded by your employer with administrative services provided by Principal Life Insurance Company. This means Principal Life does not assume any of the risk for any dental claims. Because this material is a summary, it does not state all coverage provisions, restrictions of coverage, benefits, conditions, limitations, or provisions required by federal law. If any provision presented here is found to be in conflict with federal law, that provision will be applied to comply with federal law. The group plan determines all rights, benefits, exclusions and limitations of the coverage described above.