

# Multiflex Dental Plan Summary of Benefits

**Plan: Classic Select 1500 - Calendar Year Maximum: \$1,500.00**

*This plan uses the Maximum Care™ network. Members may enjoy discounts by using one of the many dentists within the Maximum Care™ network.*

Out-of-Network benefits will be paid based on MAC fees which is the Maximum Allowable Charge of a pre-determined fee schedule used to pay out-of-network claims. You may be responsible for the difference between the MAC and the actual dental charge from a Non-Participating Provider.

**NOTE: Calendar Year Deductible per member applies across all Classes of Services.**

Classes of Services	Description of Services	Multiflex Pays	You Pay
Diagnostic & Preventative Services <b>Benefits begin immediately</b>	<ul style="list-style-type: none"> <li>• Two routine exams of mouth and teeth per rolling 12 month period</li> <li>• Two cleanings and polishings per rolling 12 month period</li> <li>• Space Maintainers</li> </ul>	100% in-network/70% out-of-network of all covered preventative services	0% in-network/30% out-of-network Coinsurance after \$50 per member/\$150 family calendar year deductible
Minor Restorative Services <b>Benefits begin after 6 months of enrollment</b>	<ul style="list-style-type: none"> <li>• Extraction of teeth</li> <li>• X-Rays</li> <li>• Re-cementing</li> <li>• Fillings</li> </ul>	80% in-network/70% out-of-network of all covered minor restorative services	20% in-network/30% out-of-network Coinsurance after \$50 per member/\$150 family calendar year deductible
Major Dental Services (Oral Surgery, Endodontic/ Periodontal, Prosthodontic) <b>Benefits begin after 18 months of enrollment</b>	<ul style="list-style-type: none"> <li>• Oral Surgery</li> <li>• Scaling</li> <li>• Endodontic Treatment of Disease</li> <li>• Periodontal services</li> <li>• Crown build up</li> <li>• Denture or bridge</li> <li>• General Anesthesia and analgesic</li> <li>• Restoration services</li> </ul>	60% in-network/50% out-of-network of all covered major dental services	40% in-network/50% out-of-network Coinsurance after \$50 per member/\$150 family calendar year deductible

***The benefits matrix above is a summary for informational purposes only. Refer to your official Certificate of Coverage and Schedule of Benefits upon purchase for a detailed description of coverage benefits, limitations, and exclusions. Only the terms and conditions of coverage benefits listed in the policy are binding.***

### Eligible Expenses

We will pay for eligible expenses you incur for yourself or on behalf of your insured dependent. Expenses must be incurred while the policy is in force and the person is covered by the policy. To be an eligible expense, the dental service or procedure must be performed by a dentist, physician or a dental hygienist.

### Deductible Amount

The deductible is an amount of charges you must incur for yourself or on behalf of your insured before we start paying benefits. The Deductible will be waived on in-network preventative services.

### Maximum Calendar Year Limit

The maximum limit payable for all eligible expenses in any calendar year is shown in the Brochure. The maximum calendar year limit, if any, will apply to each person covered under the policy.

### Maximum Care™ PPO Network

This plan is designed to use the Maximum Care™ dental network. You are free to see any dentist you choose, however, choosing a MaxCare network dentist qualifies you to receive in-network savings on your dental services. To find a Maximum Care™ provider, please visit our website at [mbaadmin.com](http://mbaadmin.com).

### Out-of-Network MAC Fees

While you are free to see any dentist you choose, out-of-network benefits will be paid based on MAC fees which is the Maximum Allowable Charge of a pre-determined fee schedule used to pay out-of-network claims. You may be responsible for the difference between the MAC and the actual dental charge from a out-of-network provider. Using an out-of-network provider will result in decreased savings on your dental services.

### Eligibility

Coverage is offered to individuals plus their eligible dependents (spouse and unmarried children from birth to age 19; extended to age 25 if child is a full-time student). This may vary based on state requirements.

### Termination of Coverage

Coverage terminates on the earliest of the following dates:

- (A) the last day of the month in which you cease to be eligible for coverage;
- (B) the last day of the month in which your dependent is no longer a dependent as defined;
- (C) subject to the grace period, the last day of the month for which a premium has been paid by you or on your behalf;
- (D) or the date the master policy ends.

### Effective Date

You and your dependents are covered on the later of: the date we accept your enrollment and determine an effective date; or the date you first acquire a dependent, if the date is after your coverage begins. Effective dates will be the first of the month only.

### Reasonable and Customary

Reasonable and customary means the usual, customary and regular charges for the area where such expenses are incurred.

## Exclusions

No benefits are payable under the policy for the services listed below. In addition, the services listed below will not be recognized toward the satisfaction of any deductible.

- 1 Any services which are not included in the schedule of covered procedures;
- 2 Any service started or appliance installed before the effective date or after the termination date, except in those instances noted in this certificate;
- 3 Any service, which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least 3 years, as determined by us;
- 4 Any procedure we determine is not necessary, does not offer a favorable prognosis, does not have uniform professional endorsements or is experimental in nature;
- 5 Crowns, inlays, onlays, cast restorations, or other laboratory prepared restorations on teeth, which may be satisfactorily restored with an amalgam or composite resin filling;
- 6 Any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
- 7 Appliances, services or procedures relating to:
  - a. the change or maintenance of vertical dimension;
  - b. restoration of occlusion (unless otherwise noted in the schedule of covered procedures - only for occlusal guards);
  - c. splinting;
  - d. correction of attrition, abrasion, erosion or abfraction;
  - e. bite registration; or
  - f. bite analysis;
- 8 Replacement of bridges;
- 9 Replacement of full or partial;
- 10 Replacement of crowns, inlays, or onlays;
- 11 For orthodontia services;
- 12 Services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
- 13 Charges for implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized Services or attachments.
- 14 Athletic mouth guards; myofunctional therapy; treatment for malignancies, cysts and neoplasms; failure to keep scheduled appointment; charges for completion of claim forms, infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; charges for travel time; transportation costs; professional advice; treatment of jaw fractures; orthognathic surgery; exams required by a third party other than us, personal supplies (e.g., water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
- 15 Prescription drugs, premedication, pharmaceuticals, or analgesia;
- 16 Dental disease, defect or injury caused by a declared or undeclared war or any act of war or terrorism or taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane;
- 17 Dental treatment not approved by the American Dental Association or which is clearly experimental in nature;
- 18 Any charge for a service for which benefits are available under Worker's Compensation or an occupational disease act or law, even if you did not purchase the coverage that is available to you (unless you are not required to be covered under Worker's Compensation);

- 19 Any charge for a service performed outside of the United States other than for emergency treatment. Benefits for emergency treatment performed outside of the United States are limited to a maximum of \$100 per plan
- 20 The initial placement of a removable full denture or a removable partial denture unless it includes the replacement of a natural tooth extracted while the person is insured under the policy;
- 21 The initial placement of a fixed partial denture including a Maryland bridge, unless it includes the replacement of a natural tooth extracted while the person is insured under the policy, provided that tooth was not an abutment to an existing partial denture.
- 22 The replacement of teeth beyond the normal complement of 32;
- 23 The replacement of an existing removable partial denture with a fixed partial denture unless upgrading to a fixed partial denture is essential to the correction of the covered person's dental condition;
- 24 Local anesthetic, including light anesthetic, as a separate fee;
- 25 Any treatment plan which involves full-mouth reconstruction by the removal and reestablishment of occlusal contacts of 10 or more teeth with restorations, crowns, onlays, inlays, fixed partial dentures, dentures, or any combination of these services;
- 26 Services with respect to congenital (hereditary) or developmental (before birth) malformations, except during the 31 day period immediately following the birth of your child, including but not limited to; cleft palate, maxillary and mandibular (upper and lower) malformations, enamel hypoplasia (lack of development), fluorosis, and anodontia;
- 27 Dental care paid for, required, or provided by or under the laws of a national, state, local or provincial government, or treatment furnished within a hospital or other facility owned or operated by a national or state government unless the insured person has a legal obligation to pay;
- 28 Dental services performed in a hospital and related hospital fees;
- 29 Services covered under an existing medical plan;
- 30 The portion of an expense which is in excess of the reasonable charge;
- 31 Fees associated with a cancelled or missed appointment;
- 32 General anesthesia and I.V. sedation, unless deemed medically necessary as determined by a professional consultant.

Missing teeth limitation: We will not pay benefits for replacement of teeth missing on a covered person's effective date of insurance under this certificate for the purpose of the initial placement of a full denture, partial denture or fixed bridge.

Please note: Exclusion language may not be applicable in all states. Please refer to the Certificate of Coverage for a complete list of exclusions in your state.