



PCA Dental Plan

Employer Sponsored Dental, Voluntary Dental

Policy Number: 109944
Group Name: PCA Retirement & Benefits
Network: PDP Plus
Effective Date: January 1, 2020

PCA Dental Plan

National Rates Beginning January 1, 2020

Coverage	Rates
Basic Plan	
▪ Employee Only	\$33.42
▪ Employee + Spouse	\$76.37
▪ Employee + Child(ren)	\$99.24
▪ Employee + Family	\$141.97
Enhanced Plan	
▪ Employee Only	\$57.84
▪ Employee + Spouse	\$125.11
▪ Employee + Child(ren)	\$159.53
▪ Employee + Family	\$226.81
Voluntary Plan	
▪ Employee Only	\$46.46
▪ Employee + Spouse	\$100.54
▪ Employee + Child(ren)	\$124.61
▪ Employee + Family	\$178.56

Summary of Benefits Dental Insurance

Employer Sponsored Dental				
Class Description	Basic Plan		Enhanced Plan	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Reimbursement	Negotiated Fee Schedule	R&C 80th Percentile	Negotiated Fee Schedule	R&C 80th Percentile
Type A – Preventive	100%	100%	100%	100%
Type B – Basic	80%	80%	90%	90%
Type C – Major	0%	0%	50%	50%
Calendar Year Deductible applies to:	B & C	B & C	B & C	B & C
▪ Individual	\$50	\$50	\$50	\$50
▪ Family	\$150	\$150	\$150	\$150
	Aggregate	Aggregate	Aggregate	Aggregate
Calendar Year Maximum (applies to A,B,C services)	\$1,000	\$1,000	\$2,500	\$2,500
Orthodontia	Not Covered	Not Covered	50%	50%
Orthodontia Lifetime Maximum	Not Covered	Not Covered	\$1,000	\$1,000

* Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Lower Cost (Flex))

Class Description: Basic Plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
<ul style="list-style-type: none"> ▪ Examinations ▪ Prophylaxis: Cleanings ▪ Sealants ▪ Space Maintainers ▪ Fluoride ▪ Full Mouth X-Rays ▪ Bitewing X-Rays ▪ Periapical X-Rays ▪ Other X-Rays 	<ul style="list-style-type: none"> ▪ 1 time in 6 months ▪ 1 time in 6 months ▪ 1 per molar in 3 years ▪ 1 time in 12 months ▪ Once in 5 calendar years ▪ 1 time in 12 months
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
<ul style="list-style-type: none"> ▪ Emergency Palliative Treatment ▪ Examinations – Problem Focused ▪ Amalgam Fillings ▪ Periodontal Maintenance ▪ Non-Surgical Periodontics ▪ Prefabricated Crowns ▪ Repairs ▪ Recementations ▪ Dentures – Rebases / Relines ▪ Occlusal Adjustments ▪ Labs & Other Tests ▪ Non-Surgical Endodontics ▪ Oral Surgery: Simple Extractions 	<ul style="list-style-type: none"> ▪ 1 per tooth in 8 Years
TYPE C	
<i>Services are not provided with this plan</i>	

Exclusions

Basic Plan

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
- Services for which a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment.
- Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child.
- Services or appliances which restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
- Restorations or appliances used for the purpose of periodontal splinting.
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Missed appointments.
- Services covered under any workers' compensation or occupational disease law.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Implantology, including repairs.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- Orthodontia services or appliances.
- Repair or a replacement of an orthodontic appliance.
- Cast restorations – including inlays, onlays crowns.
- Implant Supported Prosthetics.
- Crown Build-Ups – Post and Cores.
- Root Canal.
- Pulpotomy.
- Apexification and Recalcification.
- Periodontal Surgery.
- Dentures, including complete, partial and Overdentures.
- Denture Adjustments.
- Fixed Bridges.
- Surgical extractions.
- All other oral surgery not described elsewhere.
- General Anesthesia / IV Sedation.
- General Services.

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Lower Cost (Flex))

Class Description: Enhanced Plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 1 time in 6 months
▪ Prophylaxis: Cleanings	▪ 1 time in 6 months
▪ Space Maintainers	
▪ Fluoride	▪ 1 time in 12 months
▪ Full Mouth X-Rays	▪ Once in 5 calendar years
▪ Bitewing X-Rays	▪ 1 time in 12 months
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations – Problem Focused	
▪ Sealants	▪ 1 per molar in 3 years
▪ Amalgam Fillings	
▪ Periodontal Maintenance	
▪ Non-Surgical Periodontics	
▪ Prefabricated Crowns	▪ 1 per tooth in 8 Years
▪ Repairs	
▪ Recementations	
▪ Dentures – Rebases / Relines	
▪ Occlusal Adjustments	
▪ Labs & Other Tests	
▪ Non-Surgical Endodontics	
▪ Oral Surgery: Simple Extractions	
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Surgical Endodontics	
▪ Periodontal Surgery	
▪ Crown Buildups / Post Core	▪ 1 per tooth in 8 Years
▪ Dentures	▪ 1 in 8 years
▪ Denture Adjustments	
▪ Fixed Bridges	▪ 1 in 8 years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 8 Years
▪ Implant Services	▪ 1 per tooth position in 8 years
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth position in 8 years
▪ General Anesthesia	
▪ Oral Surgery: Surgical Extractions	
Orthodontics	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

Exclusions

Enhanced Plan

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
- Services for which a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment.
- Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child.
- Services or appliances which restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
- Restorations or appliances used for the purpose of periodontal splinting.
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Missed appointments.
- Services covered under any workers' compensation or occupational disease law.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- General Services.
- Implants supported prosthetics to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.

Summary of Benefits Dental Insurance

Voluntary Dental		
Class Description	Voluntary Plan	
	In-Network	Out-of-Network*
Reimbursement	Negotiated Fee Schedule	R&C 80th Percentile
Type A – Preventive	100%	100%
Type B – Basic	80%	80%
Type C – Major	50%	50%
Calendar Year Deductible applies to:	B & C	B & C
▪ Individual	\$50	\$50
▪ Family	\$150	\$150
	Aggregate	Aggregate
Calendar Year Maximum (applies to A,B,C services)	\$2,500	\$2,500
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	\$1,000	\$1,000
<p>* Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.</p>		

Class Description: Voluntary Plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 1 time in 6 months
▪ Prophylaxis: Cleanings	▪ 1 time in 6 months
▪ Space Maintainers	
▪ Fluoride	▪ 1 time in 12 months
▪ Full Mouth X-Rays	▪ Once in 5 calendar years
▪ Bitewing X-Rays	▪ 1 time in 12 months
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations – Problem Focused	
▪ Sealants	▪ 1 per molar in 3 years
▪ Amalgam Fillings	
▪ Periodontal Maintenance	
▪ Non-Surgical Periodontics	
▪ Prefabricated Crowns	▪ 1 per tooth in 8 Years
▪ Repairs	
▪ Recementations	
▪ Dentures – Rebases / Relines	
▪ Occlusal Adjustments	
▪ Labs & Other Tests	
▪ Non-Surgical Endodontics	
▪ Oral Surgery: Simple Extractions	
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Surgical Endodontics	
▪ Periodontal Surgery	
▪ Crown Buildups / Post Core	▪ 1 per tooth in 8 Years
▪ Dentures	▪ 1 in 8 years
▪ Denture Adjustments	
▪ Fixed Bridges	▪ 1 in 8 years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 8 Years
▪ Implant Services	▪ 1 per tooth position in 8 years
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth position in 8 years
▪ General Anesthesia	
▪ Oral Surgery: Surgical Extractions	
Orthodontics	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

Exclusions
<p>Voluntary Plan</p> <ul style="list-style-type: none"> ▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child. ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first. ▪ The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide. ▪ Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food. ▪ Caries susceptibility tests. ▪ Precision attachments associated with fixed and removable prostheses. ▪ Adjustment of a denture made within 6 months after installation by the same dentist who installed it. ▪ Duplicate prosthetic devices or appliances. ▪ Replacement of a lost or stolen appliance, cast restoration or denture. ▪ Intra and extraoral photographic images. ▪ Fixed and removable appliances for correction of harmful habits. ▪ Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards. ▪ Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota. ▪ General Services. ▪ Implants supported prosthetics to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.