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Dental

Benefit Summary

San Jose State University Research Foundation **Effective Date:** January 01, 2019

Policy Number: [redacted]

Class Definition: Class 1: All Active Full Time Employees working at least 20 hours per week **Plan:**

Easily access the care you need with our comprehensive dental coverage

Regular dental care is one of the best ways to maintain a winning smile. It's also an important way to protect your overall health, though the cost of care can add up with preventive cleanings, exams, and more serious procedures. Dental insurance can help. AXA* has partnered with Maximum Care, a leading national PPO network, to provide flexible, comprehensive dental coverage and access to an extensive network of 210,000 access points and over 78,000 unique dental providers.

What your benefits cover:

Plan Benefits and Features	In-Network	Out-of-Network
Coinsurance	100/90/60	100/90/60
Annual Individual Deductible	$50	$50
Annual Family Deductible	$150	$150
Annual Individual Maximum Benefit	$2,500	$2,500
Orthodontia		
Orthodontia Individual Deductible	$0	$0
Orthodontia Lifetime Maximum Benefit	$1,500	$1,500

Preventive Services

Services	In-Network	Out-of-Network	Limitations
Evaluations			
• Periodic Oral Evaluation	100%	100%	2 times per 12 months
• Limited Oral Evaluation - Problem Focused	100%	100%	2 times per 12 months
• Comprehensive Oral Evaluation	100%	100%	2 times per 12 months

Treatments			
• Routine Dental Prophylaxis	100%	100%	2 times per 12 months
• Fluoride Treatment	100%	100%	2 times per 12 months
• Sealants - child	100%	100%	Covered for a child up to age 13

Preventive Services

Services	In-Network	Out-of-Network	Limitations
X-Rays			
• Complete Series of X-Rays	100%	100%	Once every 36 consecutive months
• Periapical X-Rays	100%	100%	Allowed on an emergency or episodic basis
• Bitewing X-Rays	100%	100%	2 sets every 12 months
• Panoramic X-Ray	100%	100%	
Testing			
• Adjunctive Pre-Diagnostic Testing	100%	100%	
• Pulp Vitality Tests	100%	100%	

Basic Services **Waiting Period:** None

Services	In-Network	Out-of-Network	Limitations
• Emergency Palliative Treatment	90%	90%	
• Removal of Impacted Tooth	90%	90%	
• Basic Restorative Services (amalgam, composite resin acrylic, synthetic or plastic fillings) [1]	90%	90%	1 per tooth surface per 12 consecutive months
• Non-Surgical Extractions	90%	90%	
• Surgical Extractions [2]	90%	90%	
• Endodontics-Root Canal	90%	90%	1 per tooth per lifetime
• Non-Surgical Periodontics (scaling and root planning)	90%	90%	1 per quadrant per 24 consecutive months
• Pulp Cap	90%	90%	
• Oral Surgery	90%	90%	Limited to 1 per unique site per 36 months
• Peridontal maintenance [3]	90%	90%	
• Space maintainers and recementation of space maintainers [4]	90%	90%	
• Osseous Surgery	90%	90%	
• Full Mouth debridement	90%	90%	When dentally necessary to enable comprehensive evaluation and diagnosis
• Administration of antibiotic to clear infectious bacteria from areas below the gumline	90%	90%	
• Theraputic pulpotomy	90%	90%	
• Anesthesia	90%	90%	Covered when medically or dentally necessary in conjunction with covered dental services.

Limitations:

[1] Basic restorative services are limited as follows

a. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a covered service.

b. Micro filled resin restorations which are non-cosmetic.

c. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.

d. Preventive resin restorations are only a covered service for a child under age 18 and are limited to one per tooth per 36 months for non-restored first and second permanent molars.

[2] Surgical Extractions - Extractions of primary teeth or adult teeth solely for orthodontic purposes will be classified as orthodontic services.

[3] Only where periodontal treatment has been performed, limited to 4 times in every 12 months less the number of teeth cleanings and debridement received during such benefit year.

[4] Once per every 60 consecutive months for children under age 18. Benefit includes all adjustment within 6 months of installation.

Major Services Waiting Period: None

Services	In-Network	Out-of-Network	Limitations
• Inlays/Onlays/Crowns	60%	60%	1 replacement per tooth per 60 consecutive months
• Dentures complete, partial, overdenture (upper and lower)	60%	60%	1 replacement per 60 consecutive months [1]
• Implants	60%	60%	1 per tooth per lifetime
• Bridges	60%	60%	1 replacement per 60 consecutive months [1]
• Other Dental Prosthetics	60%	60%	1 replacement per 60 consecutive months [1]
• Repair of Dentures	60%	60%	
• Adding Teeth to Dentures	60%	60%	

Limitations:

[1] Covered when Medically Necessary or Dentally Necessary

Orthodontic Services Waiting Period: None

Services	In-Network	Out-of-Network	Limitations
• Orthodontic Services	50%	50%	Dependent Children only

Whitening Services

Services	In-Network	Out-of-Network	Limitations
• Teeth Whitening by Dentist	50%	50%	Not to exceed $400 every 2 years

Manage Your Benefits

Go to www.axa.us.com/employeebenefits and log on to **EB360®** to view your account details.

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Choose from 210,000 dental access points and over 78,000 unique dental providers.

If you have any questions, please don't hesitate to contact us at 1-866-274-9887.

We look forward to helping you managing your benefits with confidence and ease.

What is not covered?

Limitations: In addition to the limitations listed in the schedule of benefits, payment of benefits is limited under this certificate as follows:

1. Orthodontic services must begin while this insurance is in force. If the insurance ends during the course of the treatment plan, the monthly benefits will end.
2. Services must begin after the end of any applicable waiting period. Waiting periods for each category of service show on the schedule of benefits.
3. When multiple dental services of similar types are provided, the frequency limit under the plan will combine all the similar types of services under the stated frequency limit in combination. Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this plan, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, we will only pay benefits for the root canal therapy.

Exclusions: We will not pay benefits under this certificate for any of the following:

1. Any procedures not specifically listed as a covered service in the schedule of benefits.
2. Services which are not dentally necessary and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
3. Services for which the insured person would not be required to pay in the absence of dental insurance.
4. Services or supplies received by an insured person before the dental insurance starts for that person.
5. Treatment or services received outside of the United States.
6. Services which are primarily cosmetic, except for non-medically necessary orthodontia and services covered under the Teeth Whitening Benefit.
7. 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 and polishing of teeth; or
    - fluoride treatments.
8. Services or appliances which restore or alter occlusion or vertical dimension.
9. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
10. Restorations or appliances used for the purpose of periodontal splinting.
11. The prophylactic removal of third molars is not a covered service. Asymptomatic third molar removal or removal due to malocclusion or for orthodontic reasons is not covered. Third molar removal when there is no pathology present is not covered.
12. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
13. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.

14. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
15. Charges for missed appointments.
16. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by your employer, labor union, mutual benefit association, or VA hospital.
17. Services covered under other coverage provided by your employer.
18. Temporary or provisional restorations.
19. Temporary or provisional appliances.
20. Prescription drugs.
21. Services for which the submitted documentation indicates a poor prognosis.
22. Fixed and removable appliances for correction of harmful habits.
23. Application of desensitizing agents.
24. Repair or replacement of an orthodontic device.
25. 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.
26. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
27. Caries susceptibility tests.
28. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
29. Precision attachments associated with fixed and removable prostheses.
30. Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
31. Duplicate prosthetic devices or appliances.
32. Replacement of a lost or stolen appliance, cast restoration or denture.
33. Intra and extra-oral photographic images.
34. Cone beam imaging.
35. Diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders.
36. Diagnostic casts, unless part of overall treatment plan for medically necessary orthodontia.
37. Labial veneers.
38. Modification of removable prosthodontic and other removable prosthetic services.
39. Occlusal adjustments
40. The following services are not Covered Services:
    - a connector bar,
    - a stress breaker,
    - coping,
    - pediatric partial dentures

The policy has limitations and exclusions. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. AXA Equitable Life Insurance Company and MONY Life Insurance Company of America are not affiliated with Careington Benefit Solutions or the Maximum Care PPO Network. Policy Form MOEBP15DEN; AXEBP15DEN and State Variations.