Renaissance DENTAL | UTAH PREFERRED DENTAL PLANS

# PREFERRED | ADULT OR FAMILY
# DENTAL BENEFIT SELECTION GUIDE

**ADULT OR FAMILY DENTAL PLANS:** FOR ADULTS ***OR*** ADULTS + CHILDREN SEEKING EHB ***OR*** NON-EHB BENEFITS | PEDIATRIC "EHB" PLAN BENEFITS INCLUDED

**PEDIATRIC ESSENTIAL HEALTH BENEFITS ("EHB") PLAN:** FOR CHILDREN SEEKING EHB BENEFITS | **NO WAITING PERIODS** ON PEDIATRIC EHB BENEFITS

## YOUR RENAISSANCE DENTAL BENEFIT SELECTION GUIDE:

THE SIDE BY SIDE DENTAL BENEFIT COMPARISONS BELOW HELP GUIDE YOU IN SELECTING A PLAN THAT IS RIGHT FOR YOU AND YOUR FAMILY.

NOTES: ADULTS DEFINED AS AGE >19 AND CHILDREN DEFINED AS AGE <19.
* THE MOST RECENT RATE FOR THIS PLAN CAN BE CONFIRMED AT HEALTHCARE.GOV.

| ADD YOUR MARKET PLACE QUOTES IN THE ROWS TO THE RIGHT.* | CERTIFIED HIGH PLANS PAY | | SELECTED PLAN — CERTIFIED LOW PLANS PAY | |
|---|---|---|---|---|
| | ADULT OR FAMILY In-Network / Out-of-Network | PEDIATRIC "EHB" In-Network / Out-of-Network | **ADULT OR FAMILY** *In-Network / Out-of-Network* | **PEDIATRIC "EHB"** *In-Network / Out-of-Network* |
| | $ _____ | $ _____ | **$ _____** | $ _____ |
| **Diagnostic & Preventive Services-**exams, cleanings, bitewing x-rays & fluoride treatments | 100% / 80% | 100% / 100% | **100% / 70%** | 100% / 100% |
| **Basic Services**<br>**Emergency Palliative Treatment—**to temporarily relieve pain | 100% / 80% | 100% / 100% | **100% / 70%** | Not Covered |
| **Sealants—**to prevent decay of permanent teeth | Not Covered | 100% / 100% | **Not Covered** | 100% / 100% |
| **Radiographs—**all other X-rays | 100% / 80% | 100% / 100% | **100% / 70%** | 100% / 100% |
| **Minor Restorative Services—**fillings and crown repair<br>**Simple Extractions—**non-surgical extractions<br>**Periodontal Maintenance—**following active periodontal therapy<br>**Other Basic Services—**miscellaneous services | 75% / 60%<br>*Waiting Period: 6 Months* | Not Covered | **60% / 40%**<br>**Waiting Period: 6 Months** | Not Covered |
| **Major Services**<br>**Oral Surgery Services—**extractions and dental surgery<br>**Endodontic Services—**root canals<br>**Periodontic Services—**to treat gum disease<br>**Relines and Repairs—**to bridges and dentures | 75% / 60%<br>*Waiting Period: 12 Months* | Not Covered | **60% / 40%**<br>**Waiting Period: 12 Months** | Not Covered |
| **Prosthodontic Services—**bridges, implants and dentures<br>**Major Restorative Services—**crowns<br>**Other Major Services—**miscellaneous services | 50% / 40%<br>*Waiting Period: 12 Months* | Not Covered | **50% / 30%**<br>**Waiting Period: 12 Months** | Not Covered |
| **Orthodontics—**medically necessary services/treatment (for example braces) until age 19 | Not Covered | Not Covered | **Not Covered** | Not Covered |
| **Benefit Year Deductible—**per person / per family. (deductible does not apply to all services, for list of services please refer to the additional plan information) | $50 / $150 | $50 / $150 | **$50 / $150** | $50 / $150 |

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# CERTIFIED DENTAL COVERAGE
# TO HELP KEEP YOUR SMILE HEALTHY!

RENAISSANCE COMBINES QUALITY PLANS, A NATIONWIDE NETWORK, AND EXCEPTIONAL CUSTOMER SERVICE FOR **A BENEFITS EXPERIENCE THAT *Stands Out*.**

ENROLL YOU AND YOUR FAMILY IN A MARKETPLACE "EHB" CERTIFIED LOW DENTAL PLAN FROM RENAISSANCE, AND **START SMILING BRIGHTER TODAY!**

## BETTER MANAGE YOUR HEALTH WITH REGULAR VISITS TO THE DENTIST:

Oral health and overall health are connected, and dentists are in a unique position to detect more than 120 signs and symptoms of non-dental diseases, including diabetes and heart disease, through patient examination.[1] This can help you manage your overall health as well as health care costs.

## SAVE WITH RENAISSANCE DENTAL COVERAGE:

The example below outlines how much you can save when you combine dental benefits with our nationwide network:

| SUBMITTED FEE | IN-NETWORK DENTIST MAXIMUM APPROVED FEE | COVERAGE LEVEL | WE PAY | YOU PAY |
|---|---|---|---|---|
| $950.00 | $744.00 | 50% | $372.00 | **$372.00** |

SET BY OUR PROVIDER CONTRACT

61% DECREASE FROM THE DENTIST'S SUBMITTED FEE

NOTE: The payment example above is based on you visiting an in-network dnetist and is for illustration purposes only. Fees and reimbursements can vary by location and dentist. It does however represent how the payment is determined.

## EASY-TO-ACCESS, EASY-TO-USE BENEFITS:

Renaissance provides access to more than 300,000 dental office locations throughout the country.[2] When visiting an in-network dentist you won't have to wait to get reimbursed. Participating dental offices will complete and file claims for you, making your dental benefits easy to use.

Find an in-network provider near you at
**MyRenProviders.com**

ADDITIONAL PLAN INFORMATION ON FOLLOWING PAGE ► ► ► ►

1) J Am Dent Assoc, Vol 134, No suppl_1, 41S-48S. 2003 American Dental Association and Dental Management of The Medically Compromised Patient, 7th Edition, 2008, Mosby Elsevier,St Louis, MO.

2) Renaissance Internal Data, 2020.

# ADDITIONAL PLAN INFORMATION FOR UTAH PREFERRED PLUS PLANS:

**EHB COVERED SERVICES INCLUDE: COVERED SERVICES TO INDIVIDUALS UNDER THE AGE OF 19 THAT ARE CONSIDERED ESSENTIAL HEALTH BENEFITS AS DEFINED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

**ANNUAL IN-NETWORK OUT-OF-POCKET MAXIMUM FOR EHB COVERED SERVICES—**An out-of-pocket maximum is the maximum amount that you or an eligible dependent will pay for covered services throughout a benefit year. For all in-network EHB covered services provided to individuals under the age of 19, your maximum out-of-pocket payments under this policy shall be $375 per benefit year if this policy covers one individual under the age of 19, or $750 per benefit year if this policy covers two or more individuals under the age of 19. Any coinsurance, copayments or deductibles paid by you for in-network EHB covered services provided to individuals under the age of 19 shall count toward that in-network annual out-of-pocket maximum. The in-network annual out-of-pocket maximum will not include any amounts paid for the following: (i) premiums; (ii) annual payments made by you for non-covered services; (iii) payments made by you to out-of-network dentists; (iv) coinsurance, copayments or deductibles paid by you for services other than EHB covered services; or (v) coinsurance, copayments or deductibles paid by you for EHB covered services provided to individuals 19 years of age and older. Once your applicable in-network annual out-of-pocket maximum is reached for the benefit year, all in-network EHB covered services provided to individuals under the age of 19 will be covered at 100 percent of the Maximum Approved Fee.

**OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM FOR EHB COVERED SERVICES—**There is no annual out-of-pocket maximum for out-of-network EHB covered services. You will be responsible for all coinsurance, copayments, deductibles and balance billing amounts associated with all out-of-network EHB covered services provided to you or your eligible dependent throughout the benefit year.

**DEDUCTIBLES FOR EHB COVERED SERVICES—**For individuals under the age of 19 seeking EHB covered services, the deductible is $50 per individual per benefit year limited to a maximum of $150 per family per benefit year for basic and major services. The deductible does not apply to diagnostic and preventive services, radiographs/diagnostic imaging/diagnostic casts, emergency palliative treatment, sealants and orthodontic services.

**ANNUAL AND LIFETIME MAXIMUM PAYMENTS FOR EHB COVERED SERVICES—**For all EHB covered services provided to individuals under the age of 19, there are no annual or lifetime maximum payments.

**Waiting Period for EHB Covered Services—**There are no waiting periods for individuals under the age of 19 seeking EHB covered services.

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**NON-EHB COVERED SERVICES INCLUDE: ALL COVERED SERVICES THAT ARE NOT ESSENTIAL HEALTH BENEFITS AS DEFINED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.**

**ANNUAL AND LIFETIME MAXIMUM PAYMENT FOR NON-EHB COVERED SERVICES—**For all covered services provided to individuals 19 years of age or older, and for non-EHB covered services provided to individuals under the age of 19, the annual maximum payment shall be $1,000 per individual per benefit year on diagnostic and preventive, basic and major services.

**ANNUAL OUT-OF POCKET MAXIMUM PAYMENT FOR NON-EHB COVERED SERVICES—**An out-of-pocket maximum is the maximum amount that you or your eligible dependent will pay for covered services throughout a benefit year. There is no annual out-of-pocket maximum payment for non-EHB covered services. You will be responsible for all coinsurance, copayments, deductibles and balance billing amounts associated with all non-EHB covered services provided to you or your eligible dependent throughout the benefit year.

**DEDUCTIBLES FOR NON-EHB COVERED SERVICES—**For individuals 19 years of age or older, or individuals under the age of 19 seeking non-EHB covered services, the deductible per individual per benefit year is $50 limited to a maximum of $150 per family per benefit year for basic and major services. The deductible does not apply to diagnostic and preventive services, radiographs/diagnostic imaging/diagnostic casts, emergency palliative treatment and sealants.

**WAITING PERIOD FOR NON-EHB COVERED SERVICES—**Individuals seeking non-EHB covered services, will be eligible for coverage for diagnostic and preventive, basic and major services in accordance with the applicable waiting periods set forth in the Dental Benefit Selection Guide above, measured from your or their date of coverage under the policy.

Eligible dependents enrolled after your date of enrollment will have their own waiting periods in accordance with the above.

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**EXCLUSIONS AND LIMITATIONS FOR ALABAMA PREFERRED AND PREFERRED PLUS PLANS: INDIVIDUALS SEEKING NON-EHB COVERED SERVICES, WILL BE ELIGIBLE FOR COVERAGE FOR DIAGNOSTIC AND PREVENTIVE, BASIC AND MAJOR SERVICES IN ACCORDANCE WITH THE APPLICABLE WAITING PERIODS SET FORTH IN THE DENTAL BENEFIT SELECTION GUIDE ABOVE, MEASURED FROM YOUR OR THEIR DATE OF COVERAGE UNDER THE POLICY.**

**EXCLUSIONS:** Charges or treatment for correction of congenital or developmental malformations or dentistry for aesthetic reasons; cosmetic surgery (including repairs to facings posterior to second bicuspid); treatment by anyone other than a licensed dentist or dental hygienist; veneers; prefabricated crowns as final restoration on permanent teeth and paste-type root canal fillings on permanent teeth; appliances, procedures and restorations for increasing vertical dimension, occlusion, tooth structure loss due to attrition, abrasion or erosion, or for periodontal splinting; lost, missing or stolen appliances; services not in the policy.

**LIMITATIONS:** Coverage for services may be limited based on the age of the person receiving services; coverage for certain services may be limited to maximum number of occurrences during a specified time period (such as two times per year or one time every three years); coverage for general anesthesia and/or intravenous sedation, sealants, prosthodontics (implants), orthodontic services and space maintainers is limited. Coverage ceases upon termination of the policy. Products and services referred to herein may not be available in all states or jurisdictions.

# ADDITIONAL PLAN INFORMATION FOR UTAH PREFERRED PLANS:

**EHB COVERED SERVICES INCLUDE: COVERED SERVICES TO INDIVIDUALS UNDER THE AGE OF 19 THAT ARE CONSIDERED ESSENTIAL HEALTH BENEFITS AS DEFINED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

**ANNUAL IN-NETWORK OUT-OF-POCKET MAXIMUM FOR EHB COVERED SERVICES—**An out-of-pocket maximum is the maximum amount that you or an eligible dependent will pay for covered services throughout a benefit year. For all in-network EHB covered services provided to individuals under the age of 19, your maximum out-of-pocket payments under this policy shall be $375 per benefit year if this policy covers one individual under the age of 19, or $750 per benefit year if this policy covers two or more individuals under the age of 19. Any coinsurance, copayments or deductibles paid by you for in-network EHB covered services provided to individuals under the age of 19 shall count toward that in-network annual out-of-pocket maximum. The in-network annual out-of-pocket maximum will not include any amounts paid for the following: (i) premiums; (ii) annual payments made by you for non-covered services; (iii) payments made by you to out-of-network dentists; (iv) coinsurance, copayments or deductibles paid by you for services other than EHB covered services; or (v) coinsurance, copayments or deductibles paid by you for EHB covered services provided to individuals 19 years of age and older. Once your applicable in-network annual out-of-pocket maximum is reached for the benefit year, all in-network EHB covered services provided to individuals under the age of 19 will be covered at 100 percent of the Maximum Approved Fee.

**OUT-OF-NETWORK OUT-OF-POCKET MAXIMUM FOR EHB COVERED SERVICES—**There is no annual out-of-pocket maximum for out-of-network EHB covered services. You will be responsible for all coinsurance, copayments, deductibles and balance billing amounts associated with all out-of-network EHB covered services provided to you or your eligible dependent throughout the benefit year.

**DEDUCTIBLES FOR EHB COVERED SERVICES—**For individuals under the age of 19 seeking EHB covered services, the deductible is $50 per individual per benefit year limited to a maximum of $150 per family per benefit year for basic and major services. The deductible does not apply to diagnostic and preventive services and orthodontic services.

**ANNUAL AND LIFETIME MAXIMUM PAYMENTS FOR EHB COVERED SERVICES—**For all EHB covered services provided to individuals under the age of 19, there are no annual or lifetime maximum payments.

**WAITING PERIOD FOR EHB COVERED SERVICES—**There are no waiting periods for individuals under the age of 19 seeking EHB covered services.

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**NON-EHB COVERED SERVICES: NON-EHB COVERED SERVICES INCLUDE ALL COVERED SERVICES THAT ARE NOT ESSENTIAL HEALTH BENEFITS AS DEFINED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.**

**ANNUAL AND LIFETIME MAXIMUM PAYMENT FOR NON-EHB COVERED SERVICES—**For all covered services provided to individuals 19 years of age or older, and for non-EHB covered services provided to individuals under the age of 19 seeking non-EHB covered services, the annual maximum payment shall be $1,000 per individual per benefit year on diagnostic and preventive, basic and major services.

**ANNUAL OUT-OF POCKET MAXIMUM PAYMENT FOR NON-EHB COVERED SERVICES—**An out-of-pocket maximum is the maximum amount that you or your eligible dependent will pay for covered services throughout a benefit year. There is no annual out-of-pocket maximum payment for non-EHB covered services. You will be responsible for all coinsurance, copayments, deductibles and balance billing amounts associated with all non-EHB covered services provided to you or your eligible dependent throughout the benefit year.

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**WAITING PERIOD FOR NON-EHB COVERED SERVICES—**Individuals seeking non-EHB covered services, will be eligible for coverage for diagnostic and preventive, basic and major services in accordance with the applicable waiting periods set forth in the Dental Benefit Selection Guide above, measured from your or their date of coverage under this policy.

Eligible dependents enrolled after your date of enrollment will have their own waiting periods in accordance with the above.

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**EXCLUSIONS AND LIMITATIONS FOR ALABAMA PREFERRED AND PREFERRED PLUS PLANS: THE ABOVE SUMMARIES INCLUDED ARE INTENDED TO HIGHLIGHT THE DENTAL BENEFITS PROVIDED BY THE POLICY. POLICIES HAVE EXCLUSIONS AND LIMITATIONS THAT MAY LIMIT COVERAGE. FOR COMPLETE COVERAGE DETAILS PLEASE REFER YOUR POLICY.**

**EXCLUSIONS:** Charges or treatment for correction of congenital or developmental malformations or dentistry for aesthetic reasons; cosmetic surgery (including repairs to facings posterior to second bicuspid); treatment by anyone other than a licensed dentist or dental hygienist; veneers; prefabricated crowns as final restoration on permanent teeth and paste-type root canal fillings on permanent teeth; appliances, procedures and restorations for increasing vertical dimension, occlusion, tooth structure loss due to attrition, abrasion or erosion, or for periodontal splinting; lost, missing or stolen appliances; services not in the policy.

**LIMITATIONS:** Coverage for services may be limited based on the age of the person receiving services; coverage for certain services may be limited to maximum number of occurrences during a specified time period (such as two times per year or one time every three years); coverage for general anesthesia and/or intravenous sedation, sealants, prosthodontics (implants), orthodontic services and space maintainers is limited. Coverage ceases upon termination of the policy. Products and services referred to herein may not be available in all states or jurisdictions.

Underwritten by Renaissance Life & Health Insurance Company of America, P.O. Box 1596, Indianapolis, IN 46206.