Effective Date: August 01, 2025
Rate Guarantee: 24 Months
Situs State: MS

# Group Dental Insurance - Classic

## Employee Dental Insurance

| Monthly Premium | |
|---|---|
| **Employee Only** | $32.50 |
| **Employee + Spouse** | $64.40 |
| **Employee + Children** | $76.26 |
| **Employee + Family** | $116.28 |

| Passive PPO Plan | In-Network | Out-of-Network |
|---|---|---|
| **Benefit Year Maximum** | Applies to Class A, B & C Services<br>$1,000 per person | Applies to Class A, B & C Services<br>$1,000 per person |
| **CoInsurance** | | |
| Class A: Preventive | 100% | 100% |
| Class B: Basic | 80% | 80% |
| Class C: Major | 50% | 50% |
| Class D: Orthodontics | 50% | 50% |
| **Deductible** | Applies to Class B & C Services<br>$50 per person (Maximum 3 per family) | Applies to Class B & C Services<br>$50 per person (Maximum 3 per family) |

| Covered Services | Details |
|---|---|
| **Class A - Preventive**<br>No waiting period | • Oral evaluations (2 in 12 Months)<br>• Prophylaxis (4 in 12 Months )<br>• Bitewing x-rays (maximum of 4 films per 12 months)<br>• Full mouth x-rays (1 per 36 months)<br>• Fluoride (children up to age 16)<br>• Sealants (children up to age 16)<br>• Space maintainers<br>• Oral cancer screening for ages 40+ |
| **Class B - Basic**<br>No waiting period | • Fillings<br>• Posterior composite restorations<br>• Simple extractions<br>• Periodontal maintenance ( in combination with prophylaxis )<br>• Emergency pain |

| | |
|---|---|
| **Class C - Major**<br>No waiting period | • Inlays and onlays<br>• Surgical extractions<br>• General anesthesia (Unlimited)<br>• Non surgical periodontics<br>• Oral surgery<br>• Endodontics<br>• Surgical periodontics<br>• Crown, denture and bridge repairs<br>• Crowns, Bridges, Dentures and Implants |
| **Class D - Orthodontics**<br>No waiting period | • Separate lifetime maximum: $1,000<br>• This benefit is available only for those dependent children under the age of 19<br>• Orthodontic Refresh: Full lifetime maximum is available even if treatment is in progress at time of enrollment. Benefits will not be reduced if banded under prior insurance coverage. |

# Plan Benefits and Information

### Rollover Benefit

The rollover benefit is determined at the beginning a new benefit year and may be used to pay for Class A, B and C services only. To qualify for the Rollover benefit, in the previous benefit year: benefits were paid and the member has at least one cleaning and benefits paid for Class A, B and C services did not exceed the rollover threshold. If there is a break in coverage for any reason, the rollover benefit amount accumulated will be lost. The rollover benefit may vary or be unavailable in some states.

- Rollover Threshold: $500
- Rollover Amount: $250
- Rollover Maximum: $1,000

### Reimbursements

- In-Network: The network providers negotiated PPO fee schedule.
- Out-of-Network: 90th percentile.

# Large National PPO Network:

Going in-network is easy with our large national network that includes general dentists and specialists.

- **Network discounts:** Employees are free to choose any provider, but with our negotiated network discounts, they can save more.
- **Fewer disruptions:** Our expansive network allows more employees to keep their current dentist when switching to Pacific Life Dental.
- **Quality care:** Network dentists are credentialed and regularly reviewed to ensure quality care for your employees.

## EXCLUSIONS AND LIMITATIONS

We encourage members to request a pre-treatment estimate for major services or services that are expected to exceed $300.

The Policy contains exclusions and limitations, and unless identified in the Schedule of Covered Procedures, no benefits will be paid for the following:

- Any service that doesn't meet professionally recognized standards of dental practice or is considered to be experimental.
- Any service on a tooth with a guarded, questionable, or poor prognosis.
- Any service used solely to alter occlusal vertical dimensions, restore or maintain occlusion, treat a condition resulting from attrition, abrasion, erosion, or abfraction, or splint or stabilize teeth for periodontal reasons.
- Any service provided solely for cosmetic reasons, such as teeth whitening, characterization, or personalization of a dental prosthesis, or odontoplasty.
- Replacement of a lost, missing, or stolen appliance or dental prosthesis, or the fabrication of a spare appliance or dental prosthesis.
- Upgrading from one appliance or dental prosthesis to another appliance or dental prosthesis, such as replacing a bridge with a dental implant or replacing a denture with a bridge.
- A temporary or provisional appliance or dental prosthesis, unless it is an interim partial denture that replaces anterior teeth extracted while this coverage was in place. These are the incisor and cuspid teeth located in the front of the mouth.
- Overdentures and related services, including root canal therapy on teeth supporting the overdenture.
- Any educational or instructional service such as oral hygiene instruction, tobacco counseling or nutritional counseling.
- Bite registration, bite analysis or occlusion analysis - mounted case.
- Maxillofacial prosthetics to repair facial or skeletal anomalies, maxillofacial surgery, orthognathic surgery, or any oral surgery requiring the setting of a fracture or dislocation that results from or is incidental to a medical condition.
- Any service intended to treat or diagnose disorders of the temporomandibular joint (TMJ).
- Charges for implants unless specified in the Covered Procedures, 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.
- Treatment of malignancies, cysts, and neoplasms.
- Replacement of 3rd molars.
- Restorations used to restore teeth with micro fractures or fracture lines, undermined cusps, or large existing restorations without over pathology.

Other exclusions may apply, refer to the Schedule of Covered Procedures for a complete list.

Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. During a single visit, multiple periapical and bitewing x-rays may be paid as a full-mouth x-ray.

**Alternate Benefit:**

There are multiple options for dental treatment, all of which provide acceptable results. An alternate benefit may be applied if there is a less expensive Covered Procedure appropriate for the course of treatment, capable of producing acceptable results. When an Alternate Benefit is applied, the less expensive Alternate Benefit is used to determine the amount payable under the certificate.

**ADDITIONAL INFORMATION**

Dependent Children: Eligibility varies by state.

**Benefit Annual Maximum**

The maximum benefit amount available for services depends on the use of In-Network and Out-of-Network dentists. Benefits paid for services from an In-Network dentist will count toward the maximum amount available for services received from an Out-of-Network dentist. Benefits paid for services from an Out-of-Network dentist will also count toward the maximum amount available for services received from an In-Network dentist.

Effective Date: August 01, 2025
Rate Guarantee: 24 Months
Situs State: MS

# Vision Insurance Powered by EyeMed® - Classic-16

**Employee Vision Insurance**

POWERED BY eyeMed

| Monthly Premiums | |
|---|---|
| **Employee Only** | $7.92 |
| **Employee + Spouse** | $15.82 |
| **Employee + Children** | $16.62 |
| **Employee + Family** | $23.18 |

| Covered Services | Benefit Frequencies |
|---|---|
| **Exams** | Once Every Calendar Year |
| **Diabetic Exam Benefit** | Once Every 6 Months |
| **Frames** | Once Every Two Calendar Years |
| **Eyeglass Lenses** | Once Every Calendar Year |
| **Contact Lenses** | Once Every Calendar Year |

# EyeMed Insight Network

Members have the freedom to choose any provider with the EyeMed Insight® network. Our network offers the right mix of independent providers, regional retailers, and national retailers including:

- LensCrafters®
- Pearle Vision®
- Target Optical®

Visit pacificlife.com/vision to search for nearby providers.

**Shop online and stay in-network.**

- LensCrafters.com
- Glasses.com
- Ray-ban.com
- Targetoptical.com
- Contactsdirect.com

# Vision Insurance Powered by EyeMed®

**Employee Vision Insurance**

| EXAMS | In-Network | Out-of-Network |
|---|---|---|
| **Vision exam** (includes dilation if necessary) | $10 copay | $35 |
| **Retinal Imaging** | Up to $39 | Not covered |
| **Diabetic Exam** (if diagnosed with type 1 or type 2 diabetes) | | |
| Medical follow-up | Covered | $73 |
| Fundus photography | Covered | $61 |
| Extended opthalmoscopy | Covered | $23 |
| Gonioscopy | Covered | $23 |
| Scanning Laser | Covered | $40 |
| **EYEGLASSES** | | |
| Frames | $130 allowance (20% off balance less allowance) | $60 |
| **Eyeglass Lenses** | | |
| Single vision | $25 copay | $40 |
| Bifocal | $25 copay | $50 |
| Trifocal | $25 copay | $80 |
| Lenticular | $25 copay | $80 |
| Standard progressive | $90 copay | $50 |
| Premium progressive tier 1 | $110 copay | $50 |
| Premium progressive tier 2 | $120 copay | $50 |
| Premium progressive tier 3 | $135 copay | $50 |
| Premium progressive tier 4 | $90 copay, 20% off charge less $120 allowance | $50 |
| **Lens Options:** | | |
| Polycarbonate Lenses (under age 19) | Covered | $32 |
| Scratch resistant coating | Covered | $12 |
| **CONTACT LENSES** (in lieu of eyeglass lenses) | | |
| Elective contacts | $130 allowance | $104 |
| Non-elective contacts | Covered in Full | $300 |
| Standard contact lens fit + follow up | Up to $40 | Not Covered |
| Premium contact lens fit + follow up | 10% discount | Not Covered |

## ADDITIONAL DISCOUNTS

Employees and covered family members receive additional discounts when they visit an in-network provider including: 40% off additional complete pair of prescription eyeglasses; 15% off additional conventional contact lenses after benefit has been used; 20% off non-covered items including non-prescription sunglasses; 15% off retail or 5% off promotional price for LASIK or PRK from U.S. Laser Network.*

Also, members receive additional savings on non-covered lens options at in-network providers:

- UV Treatment - $15
- Tint (solid and gradient) - $15
- Adult polycarbonate - $40
- Anti-reflective coating
  - Standard - $45
  - Tier 1 - $57
  - Tier 2 - $68
- Photochromic / transition plastic lenses - $75
- Discounts on **hearing care** through Amplifon® hearing health care**:
  - 64% off hearing aids at thousands of locations nationwide
  - 60-day hearing aid trial period with no restocking fees
  - Free batteries for 2 years with initial purchase

*Lasik special pricing is not an insured benefit and may not be combined with any other discounts. Laser vision correction is an elective procedure, performed by specially trained providers. Discounts may not be available at all locations.

** Hearing discounts are not an insured benefit are subject to change.

## EXCLUSIONS AND LIMITATIONS

**Limitations**: Fees charged by provider for services other than a covered benefit and any local, state or federal taxes must be paid in full by the member to the provider. Such fees, taxes or materials are not covered under the Policy.

Allowances provide no remaining balance for future use within the same benefit frequency.

Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

**Exclusions**: No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; refraction, when not provided as part of a comprehensive eye examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; occupational safety eyewear; non-prescription sunglasses; plano (non-prescription) lenses; two pair of glasses in lieu of bifocals; services rendered after the date an member ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the member are within 31 days from the date of such order; lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next benefit frequency when vision materials would next become available.

Other exclusions may apply, see the Certificate of Coverage for a complete list.