

Dental Coverage

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Good dental habits are an important part of safeguarding your general health. They also help you reduce dental bills. The dental coverage available from MPTN is designed to encourage good preventive care to help you maintain healthy teeth and gums. The program also helps you pay for a broad range of other dental services when treatment is needed. Each time you need dental care, you choose whether to see an in-network provider or an out-of-network provider. Your choice determines the benefits you receive. Generally, your benefits are higher when you go “in-network.” When you enroll, you must select a coverage level:

- Single (team member only),
- Single +1 (team member + one family member), or
- Family (team member + two or more family members).

Please note that you may elect a different level for dental coverage than you do for medical coverage. See the Health Care Coverage section for more information.

This Plan Document and SPD supersedes all earlier descriptions of the plans, as of January 1, 2024.

Because the benefits and other programs described in this Plan Document and SPD may change, MPTN will provide updated information as necessary and as required by tribal, federal or other applicable law.

How the Plan Works

With the MPTN Dental Plan, you have coverage regardless of which licensed dental care provider you use. However, you generally pay less when you receive care from an in-network provider. If you receive care from an out-of-network provider, you will pay your deductible, your coinsurance and any portion of the fee in excess of the plan allowance, which is the preset fee on which plan benefits are based.

In addition, if you receive any dental service or care — either in- or out-of-network — that is not listed on the schedule below, you will pay the provider in full. The fees are not eligible for reimbursement and do not count against your deductible. For more information about specific dental benefits, contact Pequot Plus Customer Service before you receive treatment.

The benefits you receive depend on the type of care you receive, as shown in the following table.

	In-Network	Out-of-Network
Annual Deductible	None	\$100 per individual \$300 per family Separate \$50 annual deductible per individual for orthodontic services.
Annual Maximum	\$1,500 per individual (not including benefits for orthodontic services)	\$1,500 per individual (not including benefits for orthodontic services)
Preventive Services		
Preventive and Diagnostic Care	Plan pays 100% of the plan allowance, with no deductible	Plan pays 100% of the plan allowance, with no deductible. You pay any portion of the provider fee in excess of the plan allowance.
Basic Services		
Restorative Services	Plan pays 80% of the plan allowance, with no deductible	Plan pays 80% of the plan allowance, after deductible. You pay any portion of the provider fee in excess of the plan allowance.
Endodontic Services	Plan pays 80% of the plan allowance, with no deductible	Plan pays 80% of the plan allowance after deductible. You pay any portion of the provider fee in excess of the plan allowance.
Periodontic Services	Plan pays 80% of the plan allowance, with no deductible	Plan pays 80% of the plan allowance, after deductible.

To Find a Dental Provider...

Contact Pequot Plus Customer Service at 1-888-779-6872 for the most current list of which dental providers participate in the MPTN dental network.

		You pay any portion of the provider fee in excess of the plan allowance.
Oral Surgery	Plan pays 80% of the plan allowance, with no deductible	Plan pays 80% of the plan allowance, after deductible. You pay any portion of the provider fee in excess of the plan allowance.
Major Services Major Services Orthodontic Services Orthodontic Services (for covered children through the end of their 18th year)	Plan pays 50% of the plan allowance, with no deductible Plan pays 50% of the plan allowance, with no deductible, up to a maximum lifetime benefit of \$1,500	Plan pays 50% of the plan allowance, after deductible. You pay any portion of the provider fee in excess of the plan allowance. Plan pays 50% of the plan allowance, with no deductible, up to a maximum lifetime benefit of \$1,500. You pay any portion of the provider fee in excess of the plan allowance.

Deductible

The deductible is the amount you and each covered family member must pay each plan year for out-of-network covered dental care before the plan begins to pay certain benefits. There is no deductible for in-network care or preventive dental services — whether in- or out-of-network.

A \$100 individual deductible applies separately to you and to each of your covered family members, up to a total of \$300 maximum per family. A new deductible applies each plan year, except for orthodontic services — the \$50 orthodontic deductible is per case.

Alternate Benefit

If more than one type of dental service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice. In the case of bilateral, multiple adjacent missing teeth, the benefit will be based on a removable partial denture.

Coinsurance

Once you meet the deductible (if applicable), the plan pays a percentage (100%, 80% or 50%, depending on the dental service) of the plan allowance for most covered expenses. The remaining percentage you pay is called your coinsurance.

Maximums

About the Plan Allowance

The percentages shown in the table are percentages of the plan allowance — preset fees on which plan benefits are based.

- Allowed amounts will not exceed contracted rates.
- If you use an out-of-network provider who charges more than the plan allowance, you are responsible for paying 100% of the difference between the plan allowance and the provider's fee, in addition to the portion of the plan allowance that the plan does not pay.

- Annual maximum — The maximum reimbursement you can receive each plan year for covered dental service (other than orthodontia) is \$1,500 per participant. Once you reach the maximum, you pay the full cost for all services for the remainder of the plan year.
- Lifetime maximum — There is a separate lifetime limit of \$1,500 per covered child, through age 18, for orthodontic services.

Other Coverage

The MPTN Dental Plan has a coordination of benefits feature to prevent duplication of payments when you or your family members are covered by another group dental plan.

Preventive Services

The plan pays 100% of the plan allowance, with no deductible, for:

- one initial exam per office, per person,
- routine exams (up to twice a year, including the initial exam),
- comprehensive periodontal exam (once every 12 months),
- bitewing X-rays (once every 12 months),
- full mouth series X-rays (once every 36 months),
- Panorex (once every 36 months)
- cleanings (once every six months),
- fluoride treatments (once every six months, through age 18),
- space maintainers (through age 13), and
- sealant for first and second permanent molars (through age 15, one time per tooth, with no decay).

*Please note: Multiple X-rays taken on the same day by the same provider may be combined to an alternate benefit. A Panorex and full mouth series will not be payable to the same provider within a 36-month period.

X-rays and/or documentation may be requested for any treatment in order to provide clarification for a claim.

Basic Services

The plan pays 80% of the plan allowance, after a deductible (if out-of-network), for:

- fillings,
- simple extractions,
- oral surgery, including removal of impacted teeth,
- anesthetics (in conjunction with oral surgery),
- treatment of the gums (periodontics), and
- root canal therapy and other endodontic care.

Major Services

The plan pays 50% of the plan allowance, after a deductible (if out-of-network), for:

- caps and crowns,
- bridges and dentures (prosthodontics),
- replacement of caps, crowns, bridges and dentures (once every five years), and
- implants (once every five years), to replace extracted permanent teeth

Orthodontic Services

The plan pays 50% of the plan allowance, up to a lifetime maximum benefit of \$1,500, after a deductible (if out-of-network), for orthodontic services for covered children through age 18.

In-Network Advantages

Choosing a network provider for dental care offers the following advantages:

- No deductible
- Fees for services are agreed upon in advance, and that savings is passed on to you in the form of reduced rates
- Allowed amounts will not exceed the provider's contracted rates
- MPTN will pay the provider directly, so you only pay your share of the cost

X-Ray Requirements

To receive benefits from the plan, X-rays are required for the following procedures:

- Root canals — pre-op and post-op
- Crown/bridge — pre-op
- Periodontics — pre-op
- Oral surgery — pre-op
- Anterior composite restorations that involve four or more surfaces or that involve incisal angle.

What's Not Covered

The MPTN Dental Plan does not cover the following treatments and services:

- Dental services received from a dental or medical department on behalf of an employer (other than MPTN), mutual benefit association, labor union, trustee or similar person or group.
- Dental services for which you incur no charge.
- Dental services for which coverage is available, in whole or in part, under any Workers' Compensation Law or similar legislation, whether or not you claim compensation or receive benefits under that law, and whether or not any recovery is had by you against a third party for damages resulting from a condition, disease, ailment or accidental injury necessitating dental services.
- Dental services with respect to some congenital malformations or primarily for cosmetic or esthetic purposes (i.e., replacement of congenitally missing teeth or retained deciduous teeth).
- Dental services furnished or available in whole or in part under the laws of the United States, or any state or political subdivision thereof, or for which you would have no legal obligation to pay in the absence of this or any similar coverage.
- Appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ), with the exception of a night guard (bruxing appliance).
- Dental services to replace tooth structure lost due to abrasion or attrition.
- Services rendered by a dentist beyond the scope of his or her license.
- Dental services to the extent that charges for the services are greater than the charge that would have been made and actually collected if no dental coverage existed.
- Dental care or treatment not specifically listed as a covered expense.
- Dental services resulting from loss or theft of a denture, crown or bridge.
- Provisional splinting.
- Courses of treatment which were undertaken before the person became covered under this plan.
- Any services performed after the last day of the month during which any person ceases to be eligible for coverage under this plan.
- Services for, or related to, the instruction for oral hygiene or plaque control.
- Dental services which do not have uniform professional endorsement as a covered dental expense.
- Cosmetic dentistry.
- Services not medically necessary or not at the most appropriate level of care.
- Restorative, endodontic, or prosthetic services performed on teeth with moderate to severe periodontal involvement.
- Temporary services.

Avoid Claim Delays

To ensure that your claims are processed quickly and accurately, answer all questions on the form. Ask your provider to complete the appropriate sections, such as:

- the date care is received,
- the patient's name, address, and ID number,
- the provider's name, address, and taxpayer ID number,
- the procedures performed and the supplies furnished, and
- the amount charged for each procedure or supply.

Filing a Claim

Generally, you pay all or a portion of the cost of your dental care at the time you receive it, then submit a claim for reimbursement:

- **For in-network care:** You pay just your share of the cost; your dentist files a claim for his or her reimbursement.
- **For out-of-network care:** You pay the cost, then file a claim to be reimbursed for your share.

You must submit a separate claim form for each family member, but you can include more than one dental expense on each form.

The plan pays benefits for covered treatment only upon the completion of that treatment.

If you are not satisfied with the outcome of a benefits claim you have submitted, you can ask that the claim be reviewed. See “Claims Review and Appeals Procedures” in the *Rules and Regulations* section.