

Independence Dental

Indemnity and PPO dental insurance for individuals and families

Underwritten by Independence American Insurance Company (IAIC) The Independence Dental plan series is administered by The Loomis Company.

Independence American Insurance Company

Brochure Independence Dental 0122

Indemnity Plan Design

	Independence 1000	Independence Ultra 1500	Independence 1500
Copay[1] *(limit 1 per day, per provider)* Applies to all covered procedures.	$20	$20	None
Calendar-year Deductible	$50	$50	$50
Maximum Benefit *(per covered person, per calendar year)*	$1,000	$1,500	$1,500
	Coinsurance percentage *(listed per covered person)*		
Preventive Care: • Routine oral exams • Cleanings (Prophylaxis) *(limited to two per calendar year)* • Topical Fluoride *(for dependent children, limited to one per calendar year)* • Sealants *(one per tooth every three years for specific permanent molars)* • Space maintenance, including the initial appliance and adjustments *(within six months of installation for a dependent child up to age 16)*	100%[2]	100%[2]	100%
Diagnostic Care: • Bitewing X-rays *(limited to one per calendar year)* • Full-mouth X-rays *(limited to one every three years)*	100%[2]	100%[2]	80% 6 month waiting period
Basic Care: • Simple extractions • Fillings » Amalgam restorations » Composite restorations, which are limited to anterior teeth and bicuspids • Emergency palliative treatment to temporarily relieve pain	50% 6 month waiting period	80% 6 month waiting period	80% 6 month waiting period
Major Care: • Endodontic services • Periodontic services • Oral surgery • Surgical extractions • Dentures and maintenance prosthodontics • Inlays, onlays and crowns • Bridges	50% 6 month waiting period	50% 6 month waiting period	50% 6 month waiting period

Coinsurance and waiting periods for diagnostic, basic and major vary by state.

[1] In CT, the copay only applies to Preventive Care.

[2] Calendar-year deductible does not apply

PPO Plan Design

	Independence PPO 1000	Independence Ultra PPO 1500	Independence PPO 1500
Copay[1] *(limit 1 per day, per provider)* Applies to all covered procedures.	$20	$20	None
Calendar-year Deductible	$50	$50	$50
Maximum Benefit *(per covered person, per calendar year)*	$1,000	$1,500	$1,500
	Coinsurance percentage *(listed per covered person)*		
Preventive Care: *(In-Network/Out-of-Network)*[3]			
• Routine oral exams	100%[2]/100%[2]	100%[2]/100%[2]	100%/100%
• Cleanings (Prophylaxis) *(limited to two per calendar year)*	100%[2]/100%[2]	100%[2]/100%[2]	100%/100%
• Topical Fluoride *(for dependent children, limited to one per calendar year)*	100%[2]/100%[2]	100%[2]/100%[2]	100%/100%
• Sealants *(one per tooth every three years for specific permanent molars)*	100%[2]/100%[2]	100%[2]/100%[2]	80%/80%
• Space maintenance, including the initial appliance and adjustments *(within six months of installation for a dependent child up to age 16)*	100%[2]/100%[2]	100%[2]/100%[2]	80%/80%
Diagnostic Care:			
• Bitewing X-rays *(limited to one per calendar year)*	100%**/100%**	100%**/100%**	80%/80%
• Full-mouth X-rays *(limited to one every three years)*			6 month waiting period
Basic Care:			
• Simple extractions	50%/50%	80%/80%	80%/80%
• Fillings » Amalgam restorations » Composite restorations, which are limited to anterior teeth and bicuspids			
• Emergency palliative treatment to temporarily relieve pain	6 month waiting period	6 month waiting period	6 month waiting period
Major Care:			
• Endodontic services	50%/50%	50%/50%	50%/50%
• Periodontic services			
• Oral surgery			
• Surgical extractions			
• Dentures and maintenance prosthodontics			
• Inlays, onlays and crowns			
• Bridges	12 month waiting period	12 month waiting period	12 month waiting period

Coinsurance and waiting periods for diagnostic, basic and major vary by state.

[1] In CT, the copay only applies to Preventive Care.

[2] Calendar-year deductible does not apply

[3] Covered out-of-network expenses are limited to the maximum allowable charge.

When choosing a PPO plan design

When utilizing **in-network** dental providers:

Network providers have agreed to a negotiated, discounted dollar amount for each covered charge. Therefore, if all dental services are received from network providers, you will not be billed for any charges above the allowed amount, or maximum allowable charge.

When utilizing **out-of-network** providers:

If you receive dental services from a provider that is not included in the network, covered expenses are limited to the maximum allowable charge. You will receive a bill from the provider if out-of-network expenses exceed the maximum allowable charge.

The PPO network available with Independence Dental varies by state. Please refer to the provider directory for a complete list of available network dental providers in your area.

Eligibility

Independence Dental is available to the primary applicant age 18 to 99, their spouse age 18 to 99, and dependent children under the age of 26.

Covered charges

Expenses must be medically/dentally necessary and incurred by a covered person while the plan is inforce. A covered procedure must be performed by a licensed dentist acting within the scope of his or her license, a licensed physician performing dental services within the scope of his or her license, or a licensed dental hygienist acting under the supervision and direction of a dentist.

Coordination of benefits

This plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. Coordinating benefits is not permitted in all states.

Termination

The plan will continue as long as premium is paid and the primary insured does not become ineligible.

10-day right to return period

If you are not satisfied with this Policy for any reason, you may return it to us within 10-days after you receive it. We will refund any premium paid and your coverage issued under the Policy will be void, as though we had not issued coverage

Alternative benefits

If we determine that a less expensive service or supply can be used in place of the proposed treatment based on broadly accepted standards of dental care, the benefit payment will be limited to the Reasonable and Customary Charge.

Pre-treatment estimate

Except in an emergency, before a covered person may begin treatment that will cost more than the predetermination amount shown on the Schedule of Benefits, the dentist must submit a claim to us describing the treatment necessary and the cost. This estimate is not a guarantee of payment. We will still consider a claim for which the covered person has not obtained an estimate; however, the claim may be subject to reduced benefits based on our determination of the maximum allowable charge and medically necessary treatment.

Exclusions for Dental

Exclusions and limitations may vary by state.

- Treatment, services or supplies which:
  - Are not medically/dentally necessary;
  - Are not prescribed by a dental provider;
  - Are determined to be experimental or investigational in nature by us;
  - Are received without charge or legal obligation to pay;
  - Would not routinely be paid in the absence of insurance;
  - Are received from any family member;
  - Are not rendered in accordance with generally accepted standards of dental practice; or
  - Are not covered services
- Expenses resulting from:
  - Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane
  - War, or from voluntary participation in a riot or insurrection;
  - Engaging in an illegal act or occupation, the commission of a felony or assault;
  - Fixed or removable bridgework involving replacement of a natural tooth or teeth that were lost prior to the covered person's effective date of coverage;
  - Telephone consultations, failure to keep a scheduled appointment, completion of claim forms or attending dental provider statements;
  - Use of materials, other than fluorides or sealants, to prevent tooth decay
  - Cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury, or for teeth that can be restored by other means;
  - Replacement of third molars;
  - Crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology; or
  - Any service not specifically listed in the Schedule of Benefits
- Expenses incurred by a covered person while on active duty in the armed forces
- Expenses for which benefits are paid or payable under Workers' Compensation Act or similar laws
- Treatment that began before the covered person's effective date of coverage or after the covered person's termination of coverage
- Congenital or developmental malformations existing on the covered person's effective date
- Periodontal splinting
- Replacement of partial or full dentures, fixed bridgework, crowns, gold restorations and jackets more often than once in any 60-month period per tooth
- Relining of dentures more often than once in any 24-month period
- Expenses for lost, stolen or missing appliances of any type, or for duplicates
- Prescription drugs and analgesia pre-medication
- Dental education or training programs, diet and nutrition counseling
- Expenses resulting from the following, unless stated on the Schedule of Benefits:
  - Prosthodontics;
  - Orthodontia;
  - Implants of any type 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; or
  - Porcelain on crowns, or pontics posterior to the second bicuspid
- Cosmetic dentistry
- Charges that are payable under any other insurance, unless specifically available under the Coordination of Benefits provision in the Policy
- Charges made by any government entity unless the covered person is required to pay, or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made
- Bite registrations
- Bacteriologic cultures
- Temporomandibular joint syndrome (TMJ), unless coverage is required by state mandate

This brochure provides a very brief description of the important features of Independence Dental. This brochure is not a certificate of coverage or policy and only the actual certificate or policy provisions will control. The certificate or policy itself sets forth in detail the rights and obligations of both the certificate holder or policy holder and the insurance company. It is, therefore, important that you READ THE CERTIFICATE OR POLICY CAREFULLY. For complete details, refer to the Individual Dental Policy, Policy form number (IAIC IDEN POL 0414).

Not all plans or combinations of benefits are available in all states.

About Independence American Insurance Company

Independence American Insurance Company is domiciled in Delaware and licensed to write health and property & casualty insurance in all 50 states and the District of Columbia. Its products include short-term medical, hospital indemnity, fixed indemnity limited benefit, group and individual dental, and pet insurance. Located at 485 Madison Ave., Floor 14, New York, NY 10022.

About The Loomis Company

The Loomis Company (Loomis), founded in 1955, has been a leading Third Party Administrator (TPA) since 1978. Loomis has strategically invested in industry leading ERP platforms, and partnered with well-respected companies to enhance and grow product offerings. Loomis supports a wide spectrum of clients from self-funded municipalities, school districts and employer groups, to large fully insured health plans who operate on and off state and federal marketplaces. Through innovation and a progressive business model, Loomis is able to fully support and interface with its clients and carriers to drive maximum efficiencies required in the ever evolving healthcare environment.

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