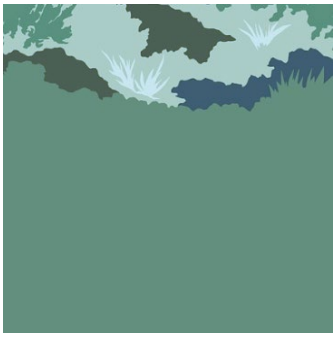
PEBP DENTAL PLAN AND BASIC LIFE INSURANCE MASTER PLAN DOCUMENT

PLAN YEAR 2026

(EFFECTIVE JULY 1, 2025 – JUNE 30, 2026)





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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

1. May 9, 2025 – Corrected Out of Pocket Maximum Dental Benefits to Play Year Maximum Dental Benefits on page 8 and in the table of contents.

2. July 3, 2025 – Correct Basic Life Insurance Amounts on page 30 for non-state active employees and non-state retirees.

Overview

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP is a group sponsor of health coverage which includes medical, vision, dental, and life insurance, in addition to flexible spending accounts, and other voluntary benefits. This series of benefits is referred to as a health plan. Throughout this document, "Plan" will be used to represent this document. This document does not provide details of eligibility and enrollment, only components of the health plan.

The Plan is available to all eligible state and local government employees, retirees, and their eligible dependents. All individuals on the Plan are referred to as "participants".

An eligible dependent is:

- A natural child up to age 26.
- The child(ren) of a domestic partner up to age 26 as long the domestic partnership is not terminated.
- A stepchild up to age 26 if the marriage is not terminated.
- A legally adopted child up to age 26 or child placed in anticipation for adoption.
- A child under permanent guardianship up to age 26.
- A child who qualifies for benefits under a Qualified Medical Child Support Orders (QMCSO) up to age 26. A QMCSO is a court order that requires health insurance for a child. Members must be notified if a QMCSO court order has been received requiring enrollment of the child/ren on their health insurance plan. The notice shall detail the child's information and the coverage required by the order.
- A domestic partner pursuant to NRS 122A.030 (the domestic partner is no longer eligible at termination of this partnership).
- A legal spouse. (A divorced spouse or legally separated spouse is not eligible).
- A child under permanent guardianship (may be covered up to age 26 with some parameters).
- A disabled child. (A determination by the Plan Administrator or its designee (after evaluation by a physician) that a person has permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having physical or mental impairment such as intellectual disability, cerebral palsy, epilepsy, neurological disorder, or psychosis).

PEBP acts as the Plan Administrator which is the legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

All plans run on a Plan Year which is a 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

An independent Third-Party Claims Administrator (TPA) pays the claims for the medical, dental and vision benefits. An independent Pharmacy Benefit Manager pays the claims for prescription drug benefits. These are PEBP vendors.

Introduction

Master Plan Documents are a comprehensive description of the benefits available to participants. Relevant statutes and regulations are noted for reference. It is the participant's responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

This Master Plan Document describes the Consumer Driven Health Plan (CDHP). The CDHP Plan offers In-Network and Out-of-Network benefits and is a self-funded plan. This plan offers medical, behavioral health, prescription drug, and vision benefits. Additional benefits include basic life insurance for active employees and eligible retirees. This document outlines medical, behavioral health, prescription drug and vision benefits.

The CDHP provides a Health Savings Account (HSA) for eligible employees or a Health Reimbursement Arrangement (HRA) for eligible retirees and active employees who are ineligible for the HSA.

The Plan and this document are intended to comply with Chapter 287 of the Nevada Revised Statutes (NRS), Chapter 287 of the Nevada Administrative Code (NAC), and all other applicable provisions of Nevada law. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which is a federal regulation affecting portability of coverage; electronic transmission of claims and other health information; and privacy and confidentiality of health information.

The Plan described in this document is effective **July 1, 2025**, and unless stated differently, replaces other CDHP medical and prescription drug benefit plan documents/summary plan descriptions previously provided to participants.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Participant Rights

- Participate with their health care professionals in their health care decisions and have their health care professionals provide information about their condition and treatment options.
- Receive the benefits for which they have coverage.
- Be treated with respect and dignity.
- Privacy of their personal health information, consistent with State and Federal laws, and the Plan's policies.
- Express, respectfully and professionally, any concerns participants may have about PEBP or any benefit or coverage decisions the Plan, or the Plan's designated administrator, makes.
- Refuse treatment for any conditions, illness, or disease without jeopardizing future treatment and be informed by their physician(s) of the medical consequences.

Summary of PPO Dental Benefits

The Dental Plan is a PEBP administered Preferred Provider Organization (PPO) High-Deductible Health Plan which provides In-Network and Out-of-Network benefits. A PPO is a group or network of dental providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.
This is an open-access PPO Plan and does not require a referral to see a dental specialist.
The Plan includes:

- Coverage statewide.
- Coverage nationwide.
- Coverage worldwide for those residing or traveling outside of the United States. See below for out of Country Dental Benefits.
- In- and Out-of-Network benefits.
- Preventive Care/Wellness Services

Out-of-Country Dental Benefits

The PPO Dental Plan provides coverage worldwide. Dental care services received outside the country may be eligible for reimbursement of the cost.

Typically, foreign countries do not accept payment directly from PEBP and must be paid for up front. Dental services received outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review if necessary and determination of medical necessity. The review may include application of pertinent Food and Drug Administration (FDA) regulations.

Prior to submitting receipts from a foreign country to PEBP's third party administrator, participants must complete the following (PEBP and this Plan's third-party administrator reserve the right to request additional information if needed):

- Proof of payment to the provider of service.
- Itemized bill to include a complete description of the services rendered.
- Itemized bill must be translated to English.
- Any costs associated with the reimbursement request must be converted to United States dollars.

Any foreign purchases of dental care and services will be subject to Plan limitations such as:

- Benefits and coverage under the Plan
- Deductibles
- Coinsurance
- Frequency maximums
- Annual benefit maximums
- Medical necessity
- FDA approval

- Usual and Customary (U & C)

Once payment is made, PEBP and its vendors are released from any further liability for the out-of-country claim. PEBP has the exclusive authority to determine the eligibility of dental services rendered by an out-of-country provider. PEBP may or may not authorize payment to you or to the out-of-country provider if the requirements of this provision are not satisfied.

Note: Please contact this Plan's third-party administrator before traveling or moving to another country to discuss any criteria that may apply to a dental service reimbursement request.

Dental Pretreatment Estimates

Participants are encouraged to obtain a pretreatment estimate for any treatment with an estimated cost of $300 or more. This allows participants to know the total cost and their responsibility.

To obtain a pretreatment estimate, a dental provider should complete the regular dental claim form (available from and to be sent to the third-party claims administrator, whose name and address are listed on the *Participant Contact Guide* in this document), indicating the type of work to be performed also referred to as a treatment plan, along with supporting x-rays and the estimated cost. Once it is received, the TPA will review the treatment plan and then send the dental provider a statement within the next 60 days showing what the Plan may pay. The dental provider may request prompt determination directly through the TPA.

Prescription Drugs Needed for Dental Purposes

Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the prescription drug benefit provided under your medical plan.

NOTE: Some medications for dental purposes are not payable, such as fluoride or periodontal mouthwash.

Voluntary PPO Dental Plan Option for Medicare Retirees Enrolled through VIA Benefits

Medicare retirees enrolled in a medical plan through VIA Benefits (Medicare Exchange) and those retirees with Tricare for Life and Medicare Parts A and B who are eligible for a Medicare Exchange Health Reimbursement Arrangement (HRA) have the option to enroll in PEBP's PPO Dental Plan. Enrollment in PEBP's PPO Dental Plan requires automatic dental premium reimbursement from the retiree's Health Reimbursement Arrangement (HRA). The dental premium will only be reimbursed up to the amount in retiree's HRA. When the amount of the dental premium is more than the unused amount in the retiree's HRA, the amount of the premium will be carried forward in the retiree's HRA until the unused amount in the HRA is sufficient to reimburse for the dental premium.

Deductibles

A deductible is an amount a participant may owe during a coverage period (usually one year) for covered health care services before the Plan begins to pay. An overall deductible applies to all or almost all covered

items and services. In this Plan, there are both an individual deductible, a family deductible, and out of pocket maximums for both individual and family. Deductibles and out-of-pocket maximums apply to both in-network and out-of-network providers.

The Plan Year Deductibles (combined medical and prescription drug) includes two tiers:

- **Individual Deductible**: Applies when only one person is covered on the Plan (self-only coverage).
- **Family Deductible**: Applies when two or more individuals are covered on the same Plan (e.g., Employee plus Spouse, Employee plus Spouse and Child, etc.). The Family Deductible may be met through a combination of *Eligible Medical Expenses* from covered family members.

The Individual and Family Deductibles start July 1st (the first day of the Plan Year) and reset the following Plan Year on July 1st. This Plan does not include a Deductible carryover or rollover provision.

The Plan's Individual Deductible is $100. The Family Deductible is the maximum amount a family of three or more is required to pay in a Plan year. **The plan's family Deductible is $300**. The Family Deductible is cumulative meaning that one member of the family cannot satisfy the entire Family Deductible. Both in- and out-of-network services are combined to meet your Plan Year Deductible.

Coinsurance

Coinsurance is the participants share of the cost of a covered service.
There is no Coinsurance amount for preventive services unless a non-PPO dental provider renders services.

For Basic or Major dental services, once a participant has met their Plan Year Deductible, the Plan pays its percentage of the eligible Usual and Customary dental expenses, and the participant is responsible for paying the rest (the applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits).

Plan Year Maximum Dental Benefits

The Plan Year maximum dental benefits payable for any individual covered under this Plan is **$2,000**. The Plan Year maximum dental benefit is combined to include both in-network and out-of-network services. **Under no circumstances will the combination of in-network and out-of-network benefit payments exceed the Plan Year maximum benefit.**

This maximum does not include Deductibles or any amounts over and above what is Usual and Customary. Benefits paid for eligible preventive dental services do not apply to the annual maximum dental benefit.

There is no plan year maximum for dependent children under age 19.

Covered dental services and billing for services use standards such as medically necessary and usual and customary.

Medically Necessary

Health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

1. Provided in accordance with generally accepted standards of medical practice.
2. Clinically appropriate regarding type, frequency, extent, location and duration.
3. Not primarily provided for the convenience of the patient, physician or other provider of health care.
4. Required to improve the specific health condition of an insured or to preserve the existing state of health of the insured; and
5. The most clinically appropriate level of health care that may be safely provided to the insured.

A medical or dental service or supply will be appropriate if:

- It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- It is care or treatment that is likely to produce a significant positive outcome; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- A medical or dental service or supply will be cost-efficient if it is no costlier than any alternative appropriate service or supply when considered in relation to health care expenses incurred in connection with the service or supply. The fact that a physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be medically necessary if it is furnished in a hospital or health care facility or other costlier facility:
- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital, or health care facility.

Usual and Customary

To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.
Usual and customary" in the context of healthcare and insurance refers to the typical fees charged by providers for a specific service or procedure in a particular geographic area. Insurance companies often use this as a benchmark to determine how much they will reimburse for a service.

Dental Network

This plan uses a preferred provider organization (PPO) network which is a list of the dental providers that the Plan has a contract with to provide dental care for Plan members. These providers are called "network providers" or "In-Network providers." Out-of-network providers are accessible if necessary. Network providers are not the Plan's employees or employees of any Plan designee.

- **In-Network:** A provider who has a contract with the TPA and has agreed to provide services to participants of a plan. Participants will pay less if they see a provider in the network. Also called "preferred provider" or "participating provider."
- **Out-of-Network:** A provider who doesn't have a contract with the TPA to provide services. Participants will usually pay more to see an out-of-network provider than an in-network provider. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

This Plan includes a PPO network for members residing in-and outside-of Nevada. To locate an In-Network provider visit the PEBP website at https://pebp.nv.gov/ or contact the third-party claims administrator. Information regarding the PPO network is also available in the *Participant Contact Guide* section of this document.

The TPA is responsible for managing network providers by confirming public information about the providers' licenses and other credentials but does not guarantee the quality of the services provided.

In-Network Benefits

When a participant uses the services of a PPO network (In-Network) health care provider, the participant is responsible for paying the applicable cost-share (Deductible, Copay, and/or Coinsurance) on the discounted fees for medically necessary services or supplies, subject to the Plan's coverage, limitations, and exclusions.

Out-of-Network Benefits

Out-of-Network Eligible Medical Expenses are subject to applicable Deductibles and a Coinsurance rate of 50% of eligible billed charges and subject to the Plan's Maximum Allowable Charge, except when prohibited by law.

Out-of-Network health care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will pay benefits based on the Plan's Maximum Allowable Charge on non-discounted medically necessary services or supplies, subject to the Plan's cost-share (Deductibles, Copay, and/or Coinsurance).

Out-of-Network Benefit Exceptions

If there is no In-Network provider within 50 miles of the participants home of record, participants may be eligible to receive benefits for certain Allowable medical expenses paid at the In-Network level, subject to the Plan's Maximum Allowable Charge (with exception of services subject to the No Surprises Act). Benefits that

fall under this category must be approved prior to receipt of the care and are subject to any Plan Benefit Limitations and Exclusions set forth in this MPD.

Participants who are traveling outside the network and need non-emergency medical care should contact the third-party administrator at the telephone number appearing on the medical identification card for assistance in locating the nearest In-Network provider.

Payment of Dental Benefits

When charges for dental services and supplies are incurred, services and supplies are considered to have been incurred on the date the services are performed or on the date the supplies are furnished. However, this rule does not apply to the following services because they must be performed over a period of time.

- Fixed partial dentures, bridgework, crowns, inlays and onlays: Services related to installation of fixed partial dentures, bridgework, crowns, inlays and onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.
- Removable partial or complete dentures: Services related to the preparation of removable partial or complete dentures are considered to have been incurred on the date the impression for the dentures is taken.
- Root canal treatment (endodontics): Services related to root canal treatment are considered incurred on the date the tooth is opened for the treatment.

Schedule of Dental Benefits

Schedule of Dental Benefits		
Benefit Description	**In-Network**	**Out-of-Network**
Preventive Services	No Deductible 100% of the discounted allowed fee schedule	No Deductible 80% of the in-network provider fee schedule for the Las Vegas service area

Explanations and Limitations

Preventive services include Oral examination, Prophylaxis (routine cleaning of the teeth without the presence of periodontal disease), Bitewing X-Rays, Topical application of sodium or stannous fluoride, Space maintainers, Application of sealants

- Preventive services are not subject to the individual out of pocket maximum dental benefit.
- Oral examinations are limited to four times per Plan Year.
- Prophylaxis, scaling, cleaning, and polishing is limited to four times per Plan Year. Any additional cleaning recommended by the dental providers are the responsibility of the participant.
- Bitewing x-rays are limited to twice per Plan Year.
- Fluoride treatment for individuals aged 18 years and under is payable twice per Plan Year.
- Application of sealants for children under the age of 18 years.
- Initial installation of a space maintainer (to replace a primary tooth until a permanent tooth comes in) is payable for individuals under the age of 16 years. Plan allows fixed, unilateral (band or stainless-steel crown type), fixed cast type (distal shoe), or removable bilateral type.

Out-of-Network: The Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area.

For services outside of Nevada, the Plan will reimburse at the usual and customary rate.

Benefit Description	**In-Network**	**Out-of-Network**
Basic Services	After the Deductible is met, the Plan pays 80% of the discounted allowed fee schedule	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area.

Explanations and Limitations

- Plan Year Deductible applies
- Dental visit during regular office hours for treatment and observation of injuries to teeth and supporting structures (other than for routine operative procedures)
- After hours for emergency dental care
- Consultation by a specialist for case presentation when a general dentist has performed diagnostic procedures
- Emergency treatment

- Film fees, including examination and diagnosis, except for injuries
- Dental CT scans are allowed at varying frequencies depending on the type of service.
- Periapical, entire dental film series (14 films), including bitewings as necessary every 36 months **or** panoramic survey covered once every 36 months
- Basic services are subject to the individual Plan Year maximum dental benefit.
- Full-mouth periodontal maintenance cleanings, payable four times per Plan Year. Even if your dentist recommends more than four periodontal maintenance cleanings, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year
- Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition
- For multiple restorations, one tooth surface will be considered a single restoration
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.
- Biopsy, examination of oral tissue, study models, microscopic exam.
- Emergency palliative treatment for pain.
- Uncomplicated oral surgery is surgery not identified as "complex oral surgery." Oral surgery is limited to removal of teeth, incision, and drainage.
- Complex oral surgery means procedures including surgical extractions of teeth, impactions, alveoloplasty or alveolectomy, vestibuloplasty, and residual root removal, including local anesthesia and postoperative care.
- Amalgam restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings, retention pin when used as part of restoration other than a gold restoration
- Appliance for thumb sucking (individuals under 16 years of age)
- Occlusal guard or night guard.
- Dental CT scans, depending on the type and necessity, are allowed by the Plan. Contact the claims administrator for more information. You must have the CDT code of your requested procedure before calling
- Initial installation of a removable, fixed or cemented inhibiting appliance to correct thumb sucking is payable for individuals under age 16 years
- No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began

Out-of-Network: After deductible, the Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area.

For services outside of Nevada, the Plan will reimburse at the usual and customary rate.

Benefit Description	In-Network	Out-of-Network
Major Services	After the Deductible is met, Plan pays 50% of the discounted allowed fee schedule.	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area

Explanations and Limitations

- Plan Year Deductible applies to Major services
- Major services are subject to the individual Plan Year maximum dental benefit
- No coverage for a crown, bridge, or gold restoration when the tooth was prepared before coverage under the dental Plan began
- Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. Gold restorations (inlays and onlays) covered only when teeth cannot be restored with a filling material
- Repair or re-cementing of inlays, crowns, bridges, and dentures which are 5 years old or more and cannot be repaired.
- Initial installation of fixed or removable bridges, dentures and full or partial dentures (except for special characterization of dentures) including abutment crowns
- Bridgework, dentures, and replacement of bridgework and dentures which are 5 years old or more and cannot be repaired. Covered expenses for temporary and permanent services cannot exceed the usual and customary fees for permanent services
- Dental implants (endosseous, ridge extension, and ridge augmentation only) which are 5 years old or more and cannot be repaired.
- Post and core on non-vital teeth only
- Denture relining and/or adjustment more than six months after installation
- Prosthodontics (artificial appliance of the mouth). No coverage of fees to install or modify an appliance for which an Impression was made before coverage under this dental plan began
- Crown (acrylic, porcelain, or gold with gold or non-precious metal), including crown build up only when teeth cannot be restored with a filling material
- Teeth added to a partial denture to replace extracted natural teeth, including clasps if needed
- If payment is requested for temporary appliances, the cost of the temporary appliance will be deducted from the benefits payable for the permanent appliance, meaning the Plan will not pay for both a temporary and a permanent appliance
- Under no circumstances will the benefit paid for a temporary appliance and permanent appliance exceed the PPO allowed amount or usual and customary allowance

Out-of-Network: After deductible, the Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area.

For services outside of Nevada, the Plan will reimburse at the usual and customary rate.

Benefit Limitations and Exclusions: PPO Dental Plan

The following is a list of dental services and supplies or expenses not covered by the PPO Dental Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

Any treatment or service for which you have no financial liability or that would be provided at no cost in the absence of dental coverage.

Concierge membership fees: Membership, retainer or premiums that are paid to a concierge medical practice are not covered.

Cosmetic Services: Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to veneers regardless of medical necessity, and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and are not covered under your medical expense coverage:

- Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part.
- Surgery or treatment to correct deformities caused by sickness.
- Surgery or treatment to correct birth defects outside the normal range of human variation.
- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

Costs of Reports, Bills, etc.: Preparation of medical reports, billing or claim forms, mailing, shipping, handling, charges for broken/missed appointments, general telephone calls not including telehealth, and photocopying fees are not covered.

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits (as described in the *Dental Expense Coverage* section).

Drugs and Medicines: Expenses for prescription drugs and medications that are covered under your medical expense coverage, and for any other dental services or supplies if benefits as otherwise provided under the Plan's medical expense coverage; or under any other plan or program that the PEBP contributes to or otherwise sponsors (such as HMOs); or through a medical or dental department, clinic or similar facility provided or maintained by the PEBP.

Duplication of Dental Services: If a person covered by this Plan transfers from the care of one dentist to the care of another dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one dentist rendered the services during each course of treatment, nor will the Plan be liable for duplication of services.

Duplicate or Replacement Bridges, Dentures or Appliances: Expenses for any duplicate or replacement of any lost, missing, or stolen bridge, denture, or orthodontic appliance, other than replacements described in the *Major Services* section of the *Schedule of Dental Benefits*.

Education Services and Home Use: Supplies and/or expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss, etc.

Expenses Exceeding Usual and Customary or the PPO Allowable Fee Schedule: Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the usual and customary charge or PPO fee schedule (as defined in the Definitions section of this document).

Expenses for Which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party (see the provisions relating to Third Party Liability in the section on *Coordination of Benefits*).

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the Plan or after the date the patient's coverage ends, except under those conditions described in COBRA Continuation Coverage.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs, or medicines that are determined by the Plan Administrator, UM company or its designee to be experimental and/or investigational services.

Frequent Intervals Services: Services provided at more frequent intervals than covered by the PPO Dental Plan as described in the *Schedule of Dental Benefits*.

Gnathological Recordings for Jaw Movement and Position: Expenses for gnathological recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.

Hospital Expenses Related to Dental Care Expenses: Expenses for hospitalization related to dental surgery or care, except as otherwise explained in this document. Contact the claims administrator for more information if you require this service.

Hypnosis and Hypnotherapy: An artificially induced alteration of consciousness in which the patient is in a state of increased suggestibility is not covered.

Illegal Act Exclusion: Injuries sustained during the course/because of committing illegal acts is not covered.

Installation or Replacement of Appliances: Restorations or procedures for altering vertical dimensions.

Medically Unnecessary Services or Supplies: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary.

Mouth Guards: Expenses for athletic mouth guards and associated devices.

Myofunctional*:* Therapy expenses for myofunctional therapy.

Non-Dental Expenses: Services rendered or supplies provided that are not recommended or prescribed by a dentist.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: Expenses incurred by you or any of your covered dependents arising out of or in the course of employment (including self-employment) if the injury, illness, or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law.

Orthodontia: Expenses for any services relating to orthodontia evaluation and treatment even if the orthodontia services are provided as the result of an injury or illness are not covered.

Periodontal Splinting: Expenses for periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability).

Personalized Bridges, Dentures, Retainers or Appliances: Expenses for personalization or characterization of any dental prosthesis, including but not limited to any bridge, denture, retainer, or appliance.

Reconstructive Dental Surgery: When that service is:

- Incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part.
- Surgery or treatment to correct deformities caused by sickness.
- Surgery or treatment to correct birth defects outside the normal range of human variation.
- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

Services Not Performed by a Dentist or Dental Hygienist: Expenses for dental services not performed by a dentist (except for services of a dental hygienist that are supervised and billed by a dentist and are for cleaning or scaling of teeth or for fluoride treatments).

Treatment of Jaw or Temporomandibular Joints (TMJ): Expenses for treatment of jaw joint problems including temporomandibular joint (TMJ) dysfunction disorder and appliances associated with dental procedures and orthodontia. TMJ may be evaluated for medical necessity under the medical plan if it does not relate to dental procedures or orthodontia.

Claims Administration

How Dental Benefits are Paid

A claim is an invoice or bill that is submitted by a medical provider to PEBP's TPA after participants have received a service. Each claim has unique codes that describe the service participants received.

When participants receive care from an in-network provider, that provider will submit the claim to the TPA, but if participants receive care from an out-of-network provider, that provider may bill participants directly. If this occurs, participants should follow the steps outlined in this section regarding How to File a Claim.

When charges for dental services and supplies are incurred, services and supplies are considered to have been incurred on the date the services are performed or on the date the supplies are furnished. However, this rule does not apply to the following services because they must be performed over a period.

- Fixed partial dentures, bridgework, crowns, inlays and onlays: Services related to installation of fixed partial dentures, bridgework, crowns, inlays and onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.
- Removable partial or complete dentures: Services related to the preparation of removable partial or complete dentures are considered to have been incurred on the date the impression for the dentures is taken.
- Root canal treatment (endodontics): Services related to root canal treatment are considered incurred on the date the tooth is opened for the treatment.

How to File a Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

Most providers send their bills directly to the TPA; however, for providers who do not bill the Plan directly, participants may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party administrator or in your E-PEBP portal member account (see the *Participant Contact Guide* in this document for details on address, phone, and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains the following information:
    - A description of the services or supplies provided including appropriate procedure codes.
    - Details of the charges for those services or supplies.
    - Appropriate diagnosis code.
    - Date(s) the services or supplies were provided.
    - Patient's name.

- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

To ensure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny deductible credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list.

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.

Claims are processed by the TPA in the order that they are received. Participants will know within 30 business days of receipt of the claim if it is accepted or denied. However, claim processing may take much longer if the claim was not completed correctly or if all necessary information was not provided with the claim.

The last component of claims processing is verification of the participant's coinsurance status; whether the member has met their deductible and determining what portion in the member's responsibility.

Once the claim has been processed, an Explanation of Benefits (EOB) will be provided to participants. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to participants Deductible, if participants out-of-pocket maximum has been reached, if certain services were denied and why, amounts participants need to pay to the provider, etc.

Where to Send the Claim Form

Send the completed claim form, a copy of the bill you received, and any other required information to the third-party administrator at the address listed in the *Participant Contact Guide* in this document.

Extension of Dental Coverage

If dental coverage ends for any reason, the Plan will pay benefits for you or your covered dependents through the last day of the month in which the coverage ends. The Plan will also pay benefits for a limited time beyond that date for the following:

- A prosthesis (such as a full or partial denture) if the dentist took the impressions and prepared the abutment teeth while you or your dependents were covered and installs the device within 31 days after coverage ends.
- A crown, if the dentist prepared the crown while you or your dependent(s) were covered and installs it within 31 days after coverage ends.

- Root canal treatment, if the dentist opened the tooth while you or your dependent(s) were covered and completes the treatment within 31 days after coverage ends.

Dental Appeal Process

Participants have the right to appeal any claim or an Adverse Benefit Determination resulting in a denial, reduction, or termination.

All participants will receive an EOB for each processed claim. The EOB will explain the reasons for the Adverse Benefit Determination, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a **Level 1 Claim Appeal.** When applicable, the EOB will explain what additional information is required from participants and why it is needed. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

Written Notice of Denial of Claim

The EOB serves as the written notice of an Adverse Benefit Determination which is **a** determination that is a covered benefit has been reviewed, and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, and the requested service or payment for the service is therefore denied, reduced, or terminated.

Level 1 Claim Appeal (NAC 287.670)

Participants have 180 days of the date they received the Explanation of Benefits (EOB) to request a Level 1 Claim Appeal. Participants forfeit the right to submit a Level 1 Claim appeal after 180 days have passed. Level 1 Claim appeals must be sent to PEBP's TPA.

The Level 1 Claim appeal must be in writing and include:

- The name and Social Security Number, or identification number of the participant.
- A copy of the EOB related to the claim being appealed; and
- A detailed written explanation of why the claim is being appealed.

The TPA will review a participants claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process the request for appeal, it will be requested promptly.

Participants have the right to review documents applicable to the denial and to submit comments in writing. The TPA will review a participants claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process the request for appeal, it will be requested promptly.

The TPA will issue a Level 1 Claim Appeal decision in writing within 20 days after receipt of the request for appeal. The Appeal Decision shall include an explanation of the appeal determination and references to Plan rules, Master Plan Documents, or other relevant documentation.

The Appeal Decision will explain the steps necessary to proceed to a Level 2 Appeal if participants are not satisfied with the response of the Level 1 Claim Appeal.

Level 2 Claim Appeal (NRS 287. 880)

Level 2 Claim Appeals must be sent to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request form*s are available at https://pebp.nv.gov/ or by contacting PEBP Customer Service.
A Level 2 Appeal must be submitted to PEBP within 35 days after receipt of the Level 1 Appeal determination. The Level 2 Appeal request **must** include a copy of:

- Any document submitted with your Level 1 Appeal request.
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use resources available to ensure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal Decision will be provided to participants, in writing, by certified mail within 30 days of receipt by the Executive Officer or designee.

The Appeal Decision shall include an explanation of the appeal determination and references to Plan rules, Master Plan Documents, or other relevant documentation.

The Appeal Decision will explain the steps necessary to proceed to an External Review if participants are not satisfied with the response of the Level 2 Claim Appeal.

External Review (NAC 287.690)

The right to request an independent external review may be available for an adverse benefit determination involving medical judgement, rescission, or a decision based on medical information, including determinations involving treatment that are considered experimental and investigation.

An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process.

The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. The independent review organization will use medical necessity as a component of their review which means health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the participant.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. The OCHA will assign an independent external review organization within five 5 days after receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form.

- a copy of the EOB(s) related to the claim(s) being reviewed.
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
7150 Pollock Dr
Las Vegas, NV 89119
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/

Coordination of Benefits (COB)

For information, refer to the separate PEBP Health and Welfare Wrap Document available at https://pebp.nv.gov/ under "4.4 Coordination of Benefits" (NAC 287.755).

Which Benefits are Subject to Coordination?

For the purposes of this COB section, the word "plan" refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

When participants have medical, dental or vision coverage from more than one source, a of Benefits (COB) determination is used to identify which payer will pay first (i.e., the primary plan) and which payer will pay second (i.e., the secondary plan). In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred.

Participants must let the TPA, or its designee, know about other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the participant is still required to meet their PEBP Plan Year medical and dental deductibles.

Which Plan Pays First: Order of Benefit Determination Rules

PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), to determine the primary plan and the secondary plan. Any plan that does not use these same rules will always be the primary plan.

The order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

Coordination with Medicare

Coordination with Medicare is not applicable for retirees and their dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange.

This Plan has coordination of benefits for Medicare as it relates to:

- Entitlement to Medicare Coverage,
- When the Participant Is Not Eligible for Premium Free Medicare Part A,
- Coverage Under Medicare and This Plan When a Participant has End-Stage Renal Disease (ESRD),
- How Much This Plan Pays When It Is Secondary to Medicare,
- When the Retiree or the Retiree's Covered Spouse or Domestic Partner is Enrolled in Medicare Part B,
- When the Participant Enters Into a Medicare Private Contract

For details, refer to the separate PEBP Health and Welfare Wrap Document available at https://pebp.nv.gov/ under "4.4 Coordination of Benefits" (NAC 287.755).

Coordination with Other Government Programs

This Plan has coordination of benefits as it relates to:

- Medicaid,
- Medicare,
- Tricare,
- Veterans Affairs,
- Worker's Compensation, and
- Medicare Disability.

For more details, refer to the separate PEBP Health and Welfare Wrap Document available at https://pebp.nv.gov/ under "4.4 Coordination of Benefits" (NAC 287.755).

Third Party Liability and Subrogation

Subrogation in healthcare is a legal process that allows health insurance companies to recover costs from third parties who are responsible for illness or injury due to negligence by the third party.

Participants must comply with all recovery efforts of the Plan and do whatever is necessary or requested to secure and protect the subrogation rights of the Plan.

Basic Life Insurance

This section provides a summary of the fully insured group basic life insurance available from PEBP. Since this is only a summary, for complete information you must refer to the Certificate of Coverage Booklet available from the insurance company who insures this benefit. Their name and contact information are listed in the *Participant Contact Guide* section of this document.

Eligibility for Life Insurance

To be eligible for the basic life insurance, you must be enrolled under the PEBP sponsored medical Plan, and be in one of the following classes:

- Full-time employees of the State of Nevada, professional full-time employees of the Nevada System of Higher Education (under annual contract), and members of the Nevada Senate or Assembly are eligible for this benefit. Your employer pays the full cost of Basic Life Insurance.
- Full-time employees of any non-State agency approved by the PEBP board. Your employer pays the full cost of Basic Life Insurance.
- Retirees of the State of Nevada receiving PERS, judicial and legislative retirement systems (in accordance with NRS 287.045), professional employees qualifying per NAC 287.135, and retirees eligible to join PEBP upon retirement pursuant to NRS 287.023 are eligible for this benefit. Certain retirees pay a contribution toward the cost of basic life insurance.

Reinstated retirees are not eligible for basic life insurance benefits or voluntary life Insurance coverage (NRS 287.0475).

Coverage

Basic Life Insurance Benefits are as follows:

Basic Life Insurance	Life insurance Benefit Amount
Full-time employees of the State	$25,000
Full-time employees of non-State agency	$25,000
Retirees of the State of Nevada	$12,500
Retirees of non-State agency	$12,500

Legislatively approved amounts, such as basic life insurance amounts may be subject to change in subsequent plan years.

Key Terms and Definitions

The following terms or phrases are used throughout the MPD. These terms or phrases have the following meanings. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Appliance (dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, after calculation of Deductibles, Coinsurance, and/or copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Bitewing X-Rays (dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework (dental) Fixed: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the *Coordination of Benefits* section).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Course of Treatment (Dental): The planned program of one or more services or supplies, provided by one or more dentists, to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

Crown (Dental): The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, decay, malformation, disease or infection. Dental services and supplies are covered under the dental expense coverage plan and

are not covered under the medical expense coverage of the Plan unless the medical plan specifically indicates otherwise in the Schedule of Medical Benefits.

For injury to teeth see *Injury to Sound and Natural Teeth*, below.

Dental Care Provider: A dentist, dental hygienist nurse, or other health care practitioner (as those terms are specifically defined in this section of the document) who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty Area	Services related to the diagnosis, treatment, or prevention of diseases
Endodontics	The dental pulp and its surrounding tissues.
Implantology	Attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	Extractions and surgical procedures of the mouth.
Orthodontics	Abnormally positioned or aligned teeth.
Pedodontics	Treatment of dental problems of children.
Periodontics	Structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	Construction of artificial appliances for the mouth (bridges, dentures, crowns, implants).

Dental Implant: A dental implant is an artificial tooth root that is placed into your jaw to hold a replacement tooth or bridge.

Denture: A device replacing missing teeth.

Eligible Dental Expenses: Expenses for dental services or supplies, but only to the extent that they are medically necessary, as defined in this *Key Terms and Definitions* section; and the charges for them are usual and customary, as defined in this *Key Terms and Definitions* section; and coverage for the services or supplies is not excluded, as provided in the *Dental Exclusions* section of this document and the Plan Year maximum dental benefits for those services or supplies has not been reached.

Explanation of Benefits (EOB): When the claims administrator processes a claim you will be sent a form called an explanation of benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if your Out-of-Pocket Maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

FAIR Health: FAIR Health is an independent nonprofit organization that collects data for and

Fixed Appliance: A device that is cemented to the teeth or attached by adhesive materials.

Fluoride: A solution applied to the surface of teeth, or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Impression: A negative reproduction of the teeth and gums from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Injury to Teeth: An injury to the teeth caused by trauma from an external source.

Benefits for injury to teeth are payable under the medical plan.

Inlay: A restoration made to fit a prepared tooth cavity and then cemented into place (see the definition of restoration).

Onlay: An inlay restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthodontics, Orthodontia: The science of the movement of teeth to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as prognathism, retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Partial Denture: A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Periodontal Disease: Bacterial gum infections that destroy gum tissue and supporting bone that hold teeth in place.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Post-Service Claim: Means any claim for benefits under a health benefit plan regarding payment of benefits that is not considered a pre-service claim or an urgent care claim.

Pre-Service/Dental Pre-Estimate: Means any estimate for benefits under a health benefit plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Prophylaxis: The removal of tartar and stains from the teeth. A dentist or dental hygienist performs the cleaning and scaling of the teeth.

Prosthesis (dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (dental): A removable device that replaces a missing tooth or teeth.

Removable: A prosthesis that replaces one or more teeth and which are held in place by clasps. The patient can remove the prosthesis.

Restoration: A broad term applied to any filling, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissue. The term applies to the result of repairing and restoring or reforming the shape and function of part or all the tooth or teeth.

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Root Canal (Endodontic) Therapy: Treatment of a tooth having damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Root Planning and Scaling: Also known as conventional periodontal therapy, non-surgical periodontal therapy, or deep cleaning, is the process of removing or eliminating dental plaque and calculus, which cause inflammation.

Sound and Natural Teeth: Natural teeth (not dentures, bridges, pontics or artificial teeth) that are free of active or chronic clinical decay; and have at least 50% bone support; and are functional in the arch; and have not been excessively weakened by previous dental procedures.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Topical: Painting the surface of teeth, as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.