BENEFIT TRANSMITTAL SHEET – NVDEN02
NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

CONFIDENTIAL

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Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
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HealthSCOPE BENEFITS

BENEFIT COVERAGE INFORMATION

Verification of coverage or eligibility is not a guarantee of benefits. All claims are subject to review in accordance with the plan's provisions, limitations and exclusions.

Network:	Diversified Dental Services & Principal Preferred Provider Dental Network	
Deductible	Individual - $100 Family - $300 Deductible waived for Preventive Eligible expenses incurred buy all family members combined will be used to satisfy the Family amount (aggregate)	
Plan Year Maximum	$1,500 – Basic, Major and Periodontal service only	
Missing Tooth Clause	Does not apply	
	IN NETWORK	**OUT OF NETWORK**
Coinsurance	Preventive – 100% Basic – 80% Periodontal – 80% Major – 50% Orthodontial – Not covered TMJ – Not covered under Dental plan, covered under Medical plan	Preventive – 80% Basic – 50% Periodontal – 50% Major – 50% Orthodontial – Not covered TMJ – Not covered under Dental plan, covered under Medical plan
Preventative Services		
Routine Oral Exam	100% no deductible	80% no deductible
	4 exams per benefit period	
Prophylaxis	100% no deductible	80% no deductible
	Cleanings and Periodontal cleanings are separate – allow 4 exams per benefit period	
Bitewing X-rays	100% no deductible	80% no deductible
	Twice per benefit period	
Fluoride	100% no deductible	80% no deductible
	Covered to age 18 Twice per benefit period	
Sealants	100% no deductible	80% no deductible
	Children to age 18	
Space Maintainers	100% no deductible	80% no deductible
	Children to age 16 Types covered – bilateral, unilateral, fixed and removable	

Basic Services		
Full Mouth X-ray	80% after deductible	50% after deductible
	Once every 3 benefit periods (36 months) combined with Panoramic Film	
Panoramic Film	80% after deductible	50% after deductible
	Once every 3 benefit periods (36 months) combined with Full Mouth X-ray	
Harmful Habit Appliance	80% after deductible	50% after deductible
	Children under age 16 Removable or fixed appliances covered	
Office visits	80% after deductible	50% after deductible
Consultations	80% after deductible	50% after deductible
House/Extended Care Facility Call	Not covered	Not covered
Hospital Call	Not covered	Not covered
Palliative (Emergency treatment of pain)	80% after deductible	50% after deductible
Occlusal X-rays	80% after deductible	50% after deductible
Periapical X-ray	80% after deductible	50% after deductible
Tomographic X-rays	80% after deductible	50% after deductible
	Unless specified, all other types of x-rays not covered	
Injections	80% after deductible	50% after deductible
	Only covered when prescribed for a dental condition	
Caries Susceptibility Test	Not covered	Not covered
Pulp Vitality Test	80% after deductible	50% after deductible
Diagnostic Casts	80% after deductible	50% after deductible
Labs	80% after deductible	50% after deductible
Fillings	80% after deductible	50% after deductible
Endodontic Treatment	80% after deductible	50% after deductible
	Root canal treatment – all services related to root canal treatment are considered incurred on the date of the tooth was opened for treatment	
Oral Surgery	80% after deductible	50% after deductible
	Covers the followign services: • Surgical extractions and impacted wisdom teeth • Alveoloplasty (w/extractions) • Alveolectomy • Excision of bone tissue/torus	

Occlusal Adjustments	80% after deductible	50% after deductible
	Chilren up to age 16	
Occlusal Guard	80% after deductible	50% after deductible
Anesthesia	80% after deductible	50% after deductible
	Covered services – local, regional block, trigeminal division block Covered in conjunction with a surgical procedure – general and IV sedation	

Periodontal Services		
Periodontics	80% after deductible	50% after deductible
	Periodontal splinting not covered All 4 quadrants can be completed in the same visit	

Major Services		
Rebasing	50% after deductible	50% after deductible
Prefabricated Stainless Steel Crowns	50% after deductible	50% after deductible
Tissue Conditioning	50% after deductible	50% after deductible
Recementation	50% after deductible	50% after deductible
Repairs	50% after deductible	50% after deductible
Adjustments	50% after deductible	50% after deductible
	Cannot be completed until at least 6 months after installation	
Relining	50% after deductible	50% after deductible
	Cannot be completed until at least 6 months after installation	
Gold Foil Restorations	50% after deductible	50% after deductible
	Only covered when tooth cannot be restored with a filing material No coverage when the tooth was prepared before coverage under this dental plan began	
Inlay & Onlay Restorations	50% after deductible	50% after deductible
	Only covered when tooth cannot be restored with a filing material Inlay & Onlay restoration paid based on prep date	
Crowns	50% after deductible	50% after deductible
	No coverage when the tooth was prepared before coverage under this dental plan began Crowns paid based on prep date	
Bridges	50% after deductible	50% after deductible
	No coverage when the tooth was prepared before coverage under this dental plan began Bridgework paid based on prep date	

Pontics	50% after deductible	50% after deductible
	No coverage when the tooth was prepared before coverage under this dental plan began Replacement is only eligible if more than 5 years have elapsed since original placement Pontics posterior to the second bicuspid are considered cosmetic and not covered	
Dentures	50% after deductible	50% after deductible
	Replacement is only eligible if more than 5 years have elapsed since original placement Dentures paid based on date impression was taken	
Partial Dentures	50% after deductible	50% after deductible
	Replacement is only eligible if more than 5 years have elapsed since original placement Fixed Partial Dentures paid based on prep date Removable Partial Dentures paid based on date impression was taken	
Prosthodontics	50% after deductible	50% after deductible
	Replacement is only eligible if more than 5 years have elapsed since original placement	
Maxillofacial Prosthetics	Not covered	Not covered
Implants	50% after deductible	50% after deductible
	Endosseus ridge extension and ridge augmentation only covered D5982 – surgical stent - covered	
Labial Veneers (Laminates)	Not covered	Not covered

Orthodontia		
Orthodontics	Not covered	Not covered

Mailing Address: HealthSCOPE Benefits PO Box 91603 Lubbock, TX 79490-1603	
Do you need help understanding this form?	Please call HealthSCOPE Benefits Customer Service at 888-7NEVADA or 888-763-8232