



University of the Incarnate Word Dental Plan

General Provisions

Benefit

Aither Advocate Phone Number	866.776.4270
Benefit Period	Calendar Year Accumulators (01/01 - 12/31)
Deductible (per Calendar Year) Individual Family	\$50 \$150
Annual Benefit Maximum	\$1,500 per individual Type I, Type II, & Type III combined

Alternative Benefits: When two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out of pocket expense. Actual payments may vary from the pretreatment estimate depending on annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

The service categories and plan limitations shown below represent an overview of your plan of benefits. This document presents many services within each category, but is not a complete description of the plan. Please see your plan description/insurance certificate for complete details.

Dental Services	Important Plan Provisions	Benefit
TYPE I: Diagnostic & Preventive Services including:		
Oral Examinations	Limit 2 per calendar year	No Cost Share
Full Mouth X-Rays	Limit 1 every 3 calendar years	No Cost Share
Bitewing X-Rays (Adult/Child)	1 every calendar year	No Cost Share
Prophylaxis – Cleaning	Limit 2 per calendar year	No Cost Share
Topical Fluoride Applications	Limit 1 per calendar year For children up to age 16	No Cost Share
Sealants	Limited to permanent molars only Limit 1 per tooth every 3 calendar years For children up to age 16	No Cost Share
Space Maintainers	Limit 1 per calendar year for initial appliances and all adjustments within 6 months after after installation For children up to age 16	No Cost Share
Consultations	1 every calendar year	No Cost Share
TYPE II: Basic Services including: No Benefit for first 12 months for Late Enrollees		
Amalgam, Silicate, Acrylic and Composite Fillings		Deductible then 20%
Crowns (Stainless steel)	Limit to 1 replacement, if crown is unserviceable, every 8 calendar years	
Endodontics Root Canal	1 per tooth per lifetime	Deductible then 20%
Full Mouth Debridement	Limit 1 per lifetime	Deductible then 20%
Harmful Habit Appliances		Not Covered
Nitrous		Not Covered

Non Routine Visits (observation)		Deductible then 20%
Occlusal Guards	For Bruxism (adjustments covered if in conjunction with periodontal surgery)	Deductible then 20%
Oral Surgery (Simple Extractions)		Deductible then 20%
Oral Surgery (Surgical Extractions)	excludes wisdom teeth	Deductible then 20%
Other Oral Surgery		Deductible then 20%
Periodontal Maintenance	2 every calendar year includes cleaning	Deductible then 20%
Periodontal Surgery	1 every 3 calendar years per quadrant	Deductible then 20%
Periodontal Scaling and Root Planing	1 every 2 calendar years per quadrant	Deductible then 20%
Pin retention (filing)		Deductible then 20%
Pulp Test		Deductible then 20%
Splinting		Deductible then 20%
Emergency Palliative Treatment		Deductible then 20%
General Anesthesia	Covered only for children age 4 or younger, or for any member if in connection with	Deductible then 20%
TYPE III: Major Services including: No Benefit for first 24 months for Late Enrollees		
Bridges	Replacements allowed 1 every 8 calendar years 1 tooth must be extracted while covered for bridge to be covered	Deductible then 20%
Crowns (other than stainless steel)	Replacements allowed every 8 calendar year	Deductible then 20%
Dentures (full or partial) Including rebase and reline denture	Replacements allowed 1 every 8 calendar years 1 tooth must be extracted while covered for entire dentures to be covered	Deductible then 20%
Extaction of a third molar		Not Covered
Implant Services		Not Covered
Inlays / Onlays		Deductible then 20%
Pontics (at least one tooth must have been extracted while covered under this plan for the pontics to be covered)		Deductible then 20%
Post & Core, including pin retention (combine with charge for a crown if done in connection with a crown)		Deductible then 20%
Prefabricated Crowns	1 per tooth every 10 calendar years	Deductible then 20%
Repairs	1 per calendar year	Deductible then 20%
Tissue Conditioning (not covered within 6 months of initial placement of denture)		Deductible then 20%
Veneers	Limited to upper and lower anterior teeth Limit 1 every 8 calendar years	Deductible then 20%
Orthodontia (Children up to the age of 20) No benefit for first 12 months for Late Enrollees	\$1,500 lifetime maximum	50 % coinsurance
Temporomandibular Joint Disorder (TMJ)		Not Covered