UNIVERSITY OF THE INCARNATE WORD S2855
DENTAL PLAN

BENEFIT SHEET

*An expense is incurred, for purposes of this section, on the date a service is performed or a supply is furnished, with the following exceptions, for which the expense will be deemed to be incurred as described:

1. For an appliance or modification of an appliance, on the date the master impression is made;
2. For a crown, a bridge, or an inlay or onlay restoration, on the date the tooth is prepared; and
3. For root canal therapy, on the date the pulp chamber of the tooth is opened.

If a particular service is listed under more than one type, the expenses for that service will be covered only under the listing for which you receive the greatest benefit.

Because many dental problems can be resolved in more than one way, the Plan Administrator reserves the right to determine the dental procedure codes as it deems appropriate that will represent the lowest-cost treatment which adequately restores the mouth to normal form and function. The codes used are based on nationally established standards of the dental profession.

GENERAL PLAN INFORMATION	
Coordination of Benefits	Standard COB
Dependents	Children birth to 26
Filing Limit	365 days
Mailing Address & PPO Company. **Remit claims to:** **Payer ID: 64884** **PO Box 211440 Eagan, MN 55121** **Don't forget to get a copy of the Patient's ID Card for claim filing directions in order to expedite claims processing** **Please do not send x-rays or study models with claims submissions. The plan does not routinely use x-rays or study models to determine benefit payments. Unless we ask for films or models, we cannot be responsible for returning them.**	

DENTAL BENEFITS			
BENEFIT DESCRIPTION	**BENEFIT PERCENTAGE**	**MAXIMUM BENEFIT**	**ADDITIONAL BENEFIT LIMITS FOR LATE ENROLLEES**
Type I – Preventive	100%, no deductible	$1,500 Calendar Year maximum for Types I, II and III combined.	No limits
Type II – Basic Restorative	80% after deductible		No benefits for the first 12 months
Type III – Major Restorative	80% after deductible		No benefits for the first 24 months
Type IV – Orthodontics (including down payment) (for covered dependent children to age 20) Coverage is not based on medical necessity Coverage for work in progress Claims must be filed monthly	50%, no deductible	$1,500 Lifetime maximum	No benefits for the first 12 months
Wisdom Teeth Removal (Impacted)	Covered under the medical plan		

Deductible	Per Participant - $50 Per Family - $150 4th quarter carryover does not apply

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BENEFIT DESCRIPTION	SERVICE	PLAN LIMITS / ADDITIONAL NOTES
Preventive	**Bitewing**	Max 1 procedure per calendar year
	Exams-Comprehensive or Periodic	Max 2 procedures per calendar year
	Fluoride	Max 1 procedure per calendar year, Limited to Dependent Children under age 16
	Non-routine Visits-Consultation	Covered
	Other-Pre-diagnostic detection of abnormal cells (VizLite)	Max 1 procedure per calendar year
	Prophylaxis	Max 2 procedures per calendar year
	Sealants	Max 1 procedure per tooth every 3 calendar years. Limited to Dependent Children to age 16*;* further limited to permanent molars only
	Space Maintainers	Max 1 every calendar year. Further limited to dependent under age 16; further limited to initial appliances and all adjustments within 6 months after installation.
	X-ray Films (other)	Max 1 full mouth/panoramic x-ray every 36 month (13 periapical abscess x-ray is considered full mouth) Cone Beam Computed Tomography is Not Covered

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Basic Restorative	**Anesthesia**: IV Sedation or General anesthesia	Only covered in connection with a surgical procedure. Also covered for dependent children age 4 or younger.
	Amalgam, silicate, acrylic and composite fillings. Gold foil restorations are not covered	Covered
	Antibiotic Injections	Oral antibiotics are not covered
	Emergency Palliative Treatment	Covered
	Endodontics (root canals)	Covered
	Extractions	Covered
	Harmful Habit Appliances	Not Covered
	Nitrous	Not Covered
	Non-routine Visits-Observation	Covered
	Occlusal Adjustments	Covered when done in conjunction with Periodontal surgery
	Occlusal Guards	For Bruxism
	Oral Surgery	Excluding surgical extraction of wisdom teeth
	Other Dental Testing (including Pulp Tests)	Covered
	Periodontics	Full mouth debridement-max 1 per lifetime. Periodontal Maintenance-max 2 treatments every calendar year. Periodontal Scaling-max 1 per quadrant every 2 calendar years Periodontal Splinting-covered. Periodontal surgery-max 1 per quadrant every 3 calendar years.
	Stainless Steel Crowns	Max 1 replacement, if crown is unserviceable, per 8 Calendar Years

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Major Restorative	**Bridge, including Pontic**	Replacements allowed 1 every 8 years (if unserviceable). At least 1 tooth must be extracted while covered for entire bridge to be covered
	Crown	Replacements allowed 1 every 8 years (if unserviceable)
	Dentures	Removable partial or complete dentures. Replacements allowed 1 every 8 years (if unserviceable). A least 1 tooth must be extracted while covered for entire denture to be covered
	Inlay/Onlay	Covered
	Implants	Not Covered
	Maintenance -including repair of crown, bridgework and dentures	Reline/rebase -N/A Tissue conditioning (but not within 6 months of initial placement)
	Post & Core, including pin retention	Combine with charge for filling if done in connection with a filling
	Recementing Bridges, Crowns or Inlay/Onlays	Covered
	Veneers	Limited to upper & lower anterior teeth; further limited to 1 every 8 calendar years

Orthodontia (for covered dependents up to age 20. Appliance must be placed prior to age 20.	**Cephalometric X-rays**	When performed for Orthodontia
	Extractions	Covered under Basic