BEREA COLLEGE DENTAL PLAN SUMMARY OF BENEFITS

	NETWORK	NON-NETWORK
Annual Deductible (Single/Family)	No Deductible	$100/$300
Maximum Annual Benefit Type I, II & III	$1,000 Per Covered Person	
Maximum Annual Benefit Type IV Services	$750 Per Covered Person	
Maximum Lifetime Benefit Type IV Services	$1,500 Per Covered Person	
COVERED BENEFITS	YOUR COST SHARE RESPONSIBILITY	
Type I Basic Services* Office Visit Copayment Services Include: • Clinical Oral Exams • Dental Prophylaxis • Bitewing X-Rays • Fluoride Treatment (Child Only) • Sealants (Child Only) • Space Maintainers (Child Only) • Emergency Care Treatment • Full Mouth X-Rays	No Cost Share	50%
Type II Minor Services** Services Include: • Oral Surgery • Periodontal Minor Services • Endodontic Minor Services • Extractions • Re-Cementing Crowns, Bridges, Inlays • Amalgams • General Anesthesia Administration • Antibiotic Drugs	20%	50%
Type III Major Services*** Services Include: • Crowns • Prosthodontic Services • Periodontal Adjunctive Services • Periodontal Surgical Services • Occlusal Guards	50%	Not Covered
Type IV Orthodontic Services****	$750 Annually/$1,500 Lifetime	Not Covered

The Twelve Month Waiting Period For Orthodontia Applies to:

- **Newly Enrolled Dental Plan Participants**
- **Individuals Who Have Not Been Covered By The Berea College Dental Plan For Twelve Consecutive Months**

The Maximum Combined Benefit Per Year Per Individual Is $1,000 Regardless Of Type Of Service

Effective Benefit Plan Year July 1, 2013 – June 30, 2014

Notes:

Type I Limitations*Clinical Oral Examinations are limited to two (2) in any twelve (12) month period; Dental Prophylaxis is limited to one (1) procedure in any six (6) month period; Bitewing X-Rays are limited to one (1) set in any twelve (12) month period (set includes up to four (4) films); Fluoride Treatment limited to dependent children under age sixteen (16) and one (1) procedure in any twelve (12) month period; Sealants limited to dependent children under age sixteen (16) and one (1) per tooth every five (5) years; Space Maintainers Treatment limited to dependent children under age thirteen (13) to replace primary teeth and Full Mouth X-Rays (including panoramic films) limited to one (1) every four (4) years.

Type II Limitations** Oral Surgery is limited to the removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch.

Type III Limitations*** Crowns, Gold Inlays and Onlays are covered when the tooth, as a result of extensive decay or accidental injury, cannot be restored with a direct replacement restoration and limited to one (1) procedure per tooth in a seven (7) year period. Initial Prosthodontics for complete or partial dentures covered with replacement covered only after five (5) years from previous placement. Initial bridge, pontics and abutment crowns are covered with replacement covered only after seven (7) years from previous placement. Maintenance prosthodontics for the adjustment of or repairs performed covered only after one (1) year from initial insertion.

Periodontal Adjunctive Services (scaling and root planing(limited to one (1) procedure per quadrant in any twenty-four (24) month period; Periodontal Maintenance is limited to one (1) procedure per quadrant in any thirty-six (36) month period and Periodontal Surgical Services are limited to one (1) procedure in any thirty-six (36) month period.

Occlusal guards are covered and limited to one (1) every five (5) years and are covered for Temporomandibular Joint (TMJ) Disorder.

Type IV Limitations**** Treatment includes comprehensive full banded and fixed or cemented appliances for tooth guidance to control harmful habits. Orthodontia is limited to dependent children under age 19 only.

Dental Implants Are Not Covered

Dental Benefit Year Is July 1st – June 30th