



**BEREA COLLEGE DENTAL BENEFITS SCHEDULE  
JULY 1, 2021 – JUNE 30, 2022**

	<b>NETWORK</b>
<b>Annual Deductible (Single/Family)</b>	No Deductible
<b>Maximum Annual Benefit Type I, II, &amp; III Services</b>	\$1,000 per Covered Person
<b>Maximum Annual Benefit Type IV Services</b>	\$750 per Covered Person
<b>Maximum Lifetime Benefit Type IV Services</b>	\$1,500 per Covered Person
<b>COVERED BENEFITS</b>	<b>NETWORK</b>
<b>Type I – Preventive &amp; Diagnostic Services</b> <b>Services include:</b> <ul style="list-style-type: none"> <li>• <b>Routine Oral Exams</b> – limited to 2 exams per covered person each 12 months</li> <li>• <b>Dental prophylaxis</b> – maximum of 1 procedure per 6 months</li> <li>• <b>Bitewing x-rays</b> – maximum of 1 series every 12 months, set includes up to 4 films</li> <li>• <b>Fluoride treatment</b> – limited to dependent children under the age of 19.</li> <li>• <b>Sealants</b> – limited to dependent children under the age of 16. Limit of 1 per tooth every 5 years. Applications made to permanent teeth only</li> <li>• <b>Space maintainers</b> – limited to dependent children under the age of 13 to replace primary teeth</li> <li>• <b>Emergency Care Treatment</b></li> <li>• <b>Full Mouth X-Rays</b> – including panoramic films. Maximum of 1 procedure in a 4-year period.</li> </ul>	No Cost Share
<b>Type II – Basic Services</b> <b>Services include:</b> <ul style="list-style-type: none"> <li>• <b>Oral Surgery</b> – limited to removal of teeth, preparation of the mouth for dentures, and removal of tooth-generated cysts of less than ¼ inch</li> <li>• <b>Periodontics</b> (gum treatments)</li> <li>• <b>Endodontics</b> (root canals)</li> <li>• <b>Extractions</b> – includes local anesthesia and routine post-operative care</li> <li>• <b>Re-cementing bridges, crowns, or inlays</b></li> <li>• <b>Amalgams</b> – includes fillings, other than gold</li> <li>• <b>General anesthetics</b></li> <li>• <b>Antibiotic drugs</b></li> </ul>	20%, subject to Deductible

COVERED BENEFITS	NETWORK
<p><b>Type III – Major Services</b>  <b>*All Type III Services require predetermination of benefits</b></p> <p><b>Services include:</b></p> <ul style="list-style-type: none"> <li>• <b>Crowns, Gold Inlays and Onlays</b> – covered when the tooth, as a result of extensive decay or accidental injury, cannot be restored with a direct replacement or restoration. Limited to 1 procedure per tooth in a 7-year period.</li> <li>• <b>Prosthodontics</b> <ul style="list-style-type: none"> <li>○ Initial prosthodontics for complete or partial dentures are covered only after 5 years from previous placement.</li> <li>○ Initial bridge, pontics, and abutment crowns are covered only after 7 years from previous placement</li> <li>○ Maintenance prosthodontics for adjustment or repair covered only after 1 year from initial insertion</li> </ul> </li> <li>• <b>Periodontal</b> <ul style="list-style-type: none"> <li>○ Periodontal Adjunctive Services (scaling and root planing) limited to 1 procedure per quadrant in any 24-month period</li> <li>○ Periodontal maintenance limited to 1 procedure in any 36-month period</li> <li>○ Periodontal Surgical Services are limited to 1 procedure in any 36-month period</li> </ul> </li> <li>• <b>Occlusal Guards</b> – limited to one per lifetime (not covered for TMJ)</li> </ul>	<p>50%, subject to Deductible</p>
<p><b>Type IV – Orthodontic Services (12 Month Waiting Period)</b>  <b>*All Type IV Services require predetermination of benefits</b></p> <p><b>Orthodontic Treatment</b></p> <ul style="list-style-type: none"> <li>• Treatment includes comprehensive full-banded and fixed or cemented appliances for tooth guidance to control harmful habits</li> <li>• Coverage limited to dependent children under age 19 only</li> </ul>	<p>No Cost Share</p>

**NOTES:**

- Twelve month waiting period for Type IV Services applies to newly enrolled dental plan participants, and individuals who have not been covered by the dental plan for at least 12 consecutive months.
- There are no downgrades for posteriors.
- There is no missing tooth clause for this plan.
- An Employee’s Child will be an eligible Dependent until reaching the limiting age of 26. Coverage will end on the last day of the calendar year in which the child ceases to meet the applicable eligibility requirements.

## PLAN EXCLUSIONS

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
- (3) **Broken appointments.** Charges for broken or missed dental appointments.
- (4) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (5) **Excess charge.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (6) **Felonious behavior.** Charges for services received as a result of Injury or Sickness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, assault or other felonious behavior, or by participating in a riot or public disturbance.
- (7) **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.
- (8) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (9) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
- (10) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (11) **No listing.** Services which are not included in the list of covered dental services.
- (12) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (13) **Not Medically or Dentally Necessary.** Care and treatment that is not Medically or Dentally Necessary.
- (14) **Occupational.** Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is arises from work for wage or profit, including self-employment.
- (15) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (16) **Personalization.** Personalization of dentures.
- (17) **Plan design.** Charges excluded or limited by the Plan design as stated in this document.
- (18) **Relative.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (19) **Replacement.** Replacement of lost or stolen appliances.
- (20) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (21) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

- (22) **TMJ.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (23) **War.** Any loss that is due to a declared or undeclared act of war.