Transwestern Insurance Administrators, Inc.

Vessey & Company, Inc.
Dental Plan
Summary of Benefits
Open Network

Deductible Amount	Mexico	U.S.
Individual/Family	$10/$30	$50/$150
Preventative	100%	100%
Basic	80%	80%
Major	60%	60%
Annual Maximum	$1,000 per Family Member	
Percentage Payable	Refers to the percentage of "Reasonable & Customary" as noted below	

Remember – This is an Open Network Plan, meaning you can obtain services from a Provider of Choice but claims will be paid as noted under Percentage Payable & per Plan Design.

Description	Percentage Payable
Visits and Examinations……	100%
X-Rays ……	100%
Prophylaxis / Cleanings ……...	100%
Restorative Dentistry ……	80%
Crowns ……...	60%
Endodontics ……..	80%
Periodontics ……...	80%
Dentures & Bridges ……..	60%
Extraction / Oral Surgery ……..…	80%
General Anesthesia ……..……	80%
Orthodontia ……	Not Covered

Dental Expense Limitations

Covered Expense for the following services is limited as shown below:

1. **Examinations and/or Prophylaxis** – limited to 2 routine exams and 2 prophylaxes (with or without fluoride) in any 1 Calendar year.
2. **Topical Fluoride** – limited to children under age 19. Only 1 treatment of topical fluoride is allowed in any 6 month period.
3. **Diagnostic X-rays** – limited to 1 full mouth X-ray series in a 36-month period and 2 supplemental bitewings in any 12 consecutive months.
4. **Dentures or Dental Appliances** – limited as follows:
   1. Benefit payment for any denture or bridge includes all repair or adjustments within 6 months of the date of placement.
   2. Services necessary to replace teeth extracted prior to your effective date under the Plan will be paid at 50% of the regular plan benefits.

Pre-Existing Condition

A pre-existing dental condition is any planned "treatment program", which was proposed, or teeth which were missing prior to the date the person became eligible under the Plan.

Dental Benefits Extension

If your eligibility ends after a "treatment program" has begun for you or one of your eligible dependents, benefits will be extended for a maximum of 90 days to allow completion of any dental work which was part of that "treatment program" only.

Covered Dental Expense

Unless specifically excluded or limited by the Plan provisions, covered expense includes charges made by a:

Dentist for diagnostic x-rays, cleanings, fluoride treatments for children under age 19, routine exams and emergency palliative treatment.
Dental Hygienist for cleaning, if the hygienist is working under the supervision of a dentist.
Technician or Laboratory for materials or X-rays ordered by a dentist as long as they do not duplicate charges for services billed by the dentist.

Actual payment for covered expenses listed above is limited to customary & reasonable or contracted fees for the services performed, subject to any deductible, percentage payable and benefits maximums shown on the "schedule of dental plan benefits".

Dental Expense Not Covered

The following services are not covered under the Dental Plan:

1. Services performed for correction of congenital malformations or solely for Cosmetic reasons.
2. Replacement of a bridge or denture within 5 years of the originals date of installation for any reason, including loss or theft, unless:
   a) Necessary because of placement of a new opposing appliance;
   b) Due to extraction of additional natural teeth; or,
   c) The appliance, while in a patient's mouth was damaged beyond repair by an Accidental injury which occurred while covered by the Plan.
3. Replacement of any bridge or denture which is satisfactory or can be made satisfactory.
4. Any appliance or restoration, except full dentures, where the primary purpose is to change position of the teeth, stabilize teeth involved in periodontal or restore occlusion.
5. Duplicate dentures or appliance, dental implants, regardless of the diagnosis, or protective mouth guards.
6. Experimental procedures, training in plaque control or oral hygiene, or dietary instruction.
7. Charges for a patient's failure to keep a scheduled appointment or for completion of claim forms.
8. Orthodontic services, except space maintainers, regardless of the diagnosis.

Nothing in this section of the plan affects coverage under any medical or vision care benefits included in your health package.

Please call your TWIA customer service department at (800) 221-8942 for further information.

Note: This outline is for use as a reference only and is a summary of available benefits. It is not a contract. All benefits referenced are subject to ay applicable exclusions and/or limitations in your Transwestern Insurance Summary Benefits Description and member eligibility at the time services are rendered.