City of Winston-Salem Dental Reimbursement Plan
Claim Instructions and Plan Details

Schedule of Benefits

The tables below outline the plan benefits.

Type of Service	Paid by Plan	Limitations
First $300 of eligible expenses.	100%	
Next $50 of eligible expenses.	0% - this is employee responsibility.	
Next $250 of eligible expenses.	80%	
Final $1600 of eligible expenses.	50%	
Annual Maximum	$1300 per covered person.	Separate maximum for Orthodontia.
Orthodontia	50% of initial down payment.	Covered dependents under age 19
	50% of monthly payments.	
Orthodontia Lifetime Maximum	$1500 per covered person.	

Covered Services

Preventive	Oral Examinations; Prophylaxis (cleaning and scaling of teeth);
	Space Maintainers for Dependents under age 19; Topical Fluoride Applications;
	Full Mouth and Bitewing X-Rays; Sealants.
Basic	Fillings; Extractions; Endodontics (Root Canals); Periodontics;
	Anesthesia; Injections of Antibiotic Drugs; Oral Surgery; Emergency Palliative Treatment;
	Repair of Crowns, Dentures, Inlays, Onlays, or Bridgework.
Major	Bridgework, Crowns, Onlays, Inlays, Dentures.

Exclusions

Cosmetic services, including but not limited to teeth bleaching and whitening,
and surgeries covered by a health plan are not covered by the Dental Reimbursement Plan.
See the Summary Plan Description for complete details.

When Submitting Dental Claims, Please Remember the Following…

1. Complete Sections A and B of the Dental Reimbursement Plan (DRP) Claim Form. Incomplete information will delay the reimbursement request.
2. The Employee and/or the Dental Provider may complete Section C of the Claim Form to request that Savers Admin send the reimbursement check directly to the Dental Provider on behalf of the Employee. Incomplete information will delay the request.
3. For funds sent to the Employee, indicate by the check box on the claim form if funds should be sent by direct deposit. A voided check or equivalent must be provided with the claim. Also, indicate by the check box to request that any eligible unreimbursed expenses be paid from the Employee's FSA plan, if they are not fully paid by the dental plan. The Employee must be enrolled in the current FSA plan and must have adequate funds available.
4. Always submit with the claim form a copy of a detailed billing statement from the dental provider. A credit card receipt alone does not contain adequate information. A billing statement from the dental provider is required.
5. Submit completed dental claim form(s) and provider billing statement(s) to Savers Admin via email to claims@saversadmin.com or by fax to 336-759-3999, attention CWSDRP, or by postal mail to the address below. Retain a copy of all mailed claims. Savers Admin cannot be responsible for misdirected or lost claims.
6. A complete dental claim submission received in the Savers Admin offices by 11:00 AM on a business day will be processed the same day. Claims received in our office after 11:00 AM, or on weekends or holidays, will be processed the next business day.

If you have any questions about completing your claim form, please contact us by email at claims@saversadmin.com, or by phone at 336-837-6712 or 800-949-0311, during regular business hours: 8:00 AM to 5:00 PM, Monday through Thursday, and 8:00 AM to 1:00 PM, Friday.

Additional Information and an online Benefit Estimator are available at www.SaversAdmin.com/CWSDental

SaversAdmin
PAYROLL HR + BENEFITS
635 W. Fourth Street, Suite 201 • Winston-Salem, NC 27101-2740
336.759.3888 local • 800.949.0311 toll-free • 336.759.3999 fax
www.saversadmin.com • claims@saversadmin.com

City of Winston-Salem
Dental Reimbursement Plan (DRP) Claim Form

SECTION A – Employee/Subscriber Information

Company/Employer Name CITY OF WINSTON-SALEM			
Employee / Subscriber Information -- About the Employee of the above named Employer:			
First Name / Middle Initial	Last Name	Social Security Number	City of W-S Employee ID Number
Subscriber's Mailing Address	City	State	ZIP Code
Subscriber's E-mail Address *(Will only be used to contact you about your account or your claim.)*		Phone number ( )	

SECTION B – Dependent Information -- Complete if the patient is a dependent of the above Employee / Subscriber.

Dependent Information -- About the person incurring the expense that gives rise to this claim:		
First Name / Middle Initial	Last Name	Relationship to Employee: ___Spouse ___Child
4. Dependent's Date of Birth (mm/dd/yyyy)	5. Dependent's Gender ___Male ___Female	6. Dependent's Social Security Number

SECTION C – Pay Provider – The Employee or the Dental Provider may complete this section only if claim funds should be sent directly to the Dental Provider. Leave blank if claim funds should be sent to the above named Employee.

Provider Information -- About the Dental Provider to which this claim's reimbursement funds are to be paid:			
Name of Dental Provider / Dental Practice		Your Account # at Dentist Office *(if applicable)*	
Dental Provider's Mailing Address	City	State	Zip Code

(Dental providers may submit with this form a completed ADA Approved Dental Claim Form.)

Employee: Your reimbursement claim must include a detailed billing statement from your dental provider. ***The statement must clearly indicate: (1)*** *name of dental provider;* ***(2)*** *date service(s) was provided;* ***(3)*** *description of service(s) provided;* ***(4)*** *dollar amount(s) for service(s) provided, indicating the amount you owe.* ***Claims submitted without proper supporting documentation will be delayed.***

☐ **Direct Deposit:** By checking this box, I request that claim funds be sent to the Employee by direct deposit. Attached is a copy of a voided check or a form/letter from my bank showing my account and routing numbers. (Without direct deposit, claim funds will be mailed by check to the Employee's address above.) *Note:* Direct deposit information provided on an earlier claim or FSA plan will apply. Notify Savers Admin of any bank account changes to avoid banks fees and delays in receiving claim funds.

☐ **Pay Claim Balance from my FSA:** By checking this box, I request that any eligible dental expenses associated with this claim, which are not fully reimbursed by my Dental Reimbursement Plan, should be reimbursed from my Medical FSA plan. I understand that I must be currently enrolled in my employer's Medical FSA plan and there must be adequate funds in my account.

Please read this section carefully before signing: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was an eligible employee covered under the Employer's Dental Reimbursement Plan (DRP) with respect to such expenses and that the expenses **have not and will not be reimbursed under any other insurance plan or other similar reimbursement arrangement**. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for repayment to the Plan any or all amounts paid from the Plan which relate to such expense.

_____ _____

Employee's Signature (*Required*) **Date**

Submit your claim: (Always keep a copy of your paperwork for your records.)
Mail: Claims Processing, Savers Admin, 635 W. Fourth Street, Suite 201, Winston-Salem, NC 27101-2740
Fax: 336-759-3999, attention CWSDRP Claims.
Email: claims@saversadmin.com – Scan and send as attachments your claim form and billing statement from your dental provider.

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