Your Guide to Dental Benefits

Trenton Public Schools

Group Dental Plan

Administered By
ADN Administrators, Inc.

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WELCOME!

Welcome to the Trenton Public Schools Dental Plan.

The Trenton Public Schools has chosen to self-fund its dental plan to help minimize dental benefit costs. In addition, ADN Administrators has been contracted to provide the dental plan administration. The selection of ADN Administrators affords access to three dental PPO Networks; ADN Dental Network, DenteMax and MDP Network of Providers.

THERE IS NO OBLIGATION TO USE A PPO DENTAL NETWORK PROVIDER.

The Trenton Public Schools Dental Plan allows freedom of choice; you may receive treatment from any licensed dentist or dental specialty. However, utilization of a PPO dental provider will substantially reduce your out-of pocket dental expenses and overall dental benefit costs. The following information is intended to help you better understand the networks and how you may benefit from your usage of it.

YOU DO NOT HAVE TO CHANGE FROM YOUR CURRENT DENTIST

However, a Participating Provider will accept the PPO fee over his/her own charges. If your dentist is not a Participating Provider, every effort will be made to recruit him/her to join the network on your behalf. Most PPO Networks require that you change to their network participants, but we would prefer to try to add your dentist to the network instead.

PROVIDER DIRECTORY – You may identify any Participating Provider in your area by accessing the ADN web site www.adndental.com, then go to “Provider Search”. Since your group has access to ADN, DenteMax and MDP Providers, you may choose from providers under those networks for the area of your choice.

You may also contact our office at the telephone numbers listed below:

ADN Administrators, Inc.
Local Phone Number: (248) 901-3705
Toll Free Number: (888) 236-1100

SUMMARY PLAN DESCRIPTION

1. Name of the Plan: Trenton Public Schools Dental Plan

2. Plan Sponsor's contact information:

   Trenton Public Schools
   2603 Charlton
   Trenton, MI 48183
   (734) 692-4514

3. Type of Plan: Group Dental Benefit Plans

4. Dental Benefits Administrator: ADN Administrators, Inc.

5. Plan Administrator's contact information:

   ADN Administrators, Inc.
   P. O. Box 610
   Southfield, MI 48037-0610
   Local phone number (248) 901-3705
   Toll free phone number (888) 236-1100

6. The source of contribution to the plan is the Employer

7. The Plan Year begins each September 1st.

8. Dental Plan Group Number: 9090

THE PLANS AT A GLANCE

Effective Date of Plan

This plan became effective on 9/1/2008 and renews each September.

Dental Plan Structures

The Trenton Public Schools Dental Plan consists of various levels of dental coverage based upon the type of treatment. Benefits are payable at the applicable percentage level of the Usual and Customary allowed amount or Fee Schedule allowed amount for the procedure rendered. **There is no difference in the benefit percentage levels for treatment rendered by Network or Non-Network Providers**. The types of dental treatment are indicated by classes, which are explained in detail under Covered Dental Expenses.

Class I – Diagnostic and Preventive Services
Class II – Minor Restorative Services
Class III – Major Restorative Services
Class IV – Orthodontic Services

Plan A Benefits	Plan B Benefits
Class I – 100%	Class I – 70%
Class II – 90%	Class II – 70%
Class III – 90%	Class III – 70%
Class IV – 90%	Class IV – 50%
No Deductibles	No Deductibles
Annual Maximum Benefit - $1200	Annual Maximum Benefit - $1000
Lifetime Ortho Maximum Benefit - $900	Lifetime Ortho Maximum Benefit - $500

Plan A includes benefits for the following employees:
Teachers, Administrators, Professionals and Office Workers

Plan B includes benefits for the following employees:
TESP

HOW AND WHEN COVERAGE TAKES EFFECT

The Dental Plan effective date of coverage for eligible employees and their dependents is determined by and the sole responsibility of the plan sponsor. Any notifications for changes in eligibility and/or status must be made directly to the employer. Please refer to your dental benefits representative in the human resources department for information.

WHEN COVERAGE TERMINATES

The Dental Plan termination date of coverage for previously eligible employees and their dependents is determined by and the sole responsibility of the plan sponsor. Please refer to your dental benefits representative in the human resources department for information.

WHEN A DEPENDENT'S COVERAGE TERMINATES

A dependent's Dental coverage terminates at the earliest time shown below:

1. When the employee ceases to be an eligible employee because of termination of employment or for any other reason.

2. When he/she ceases to be a dependent as defined by the plan sponsor.

3. When he/she ceases to be covered under the group contract.

A dependent who loses coverage due to the above event(s) may be eligible for continuation of dental coverage for a predetermined period of time under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provisions.

All Dental Plan eligibility is determined by and the sole responsibility of the plan sponsor. Please refer to your dental benefits representative in the human resources department for information.

CONTINUATION OF DENTAL PLAN BENEFITS

In the event that dental plan coverage under this provision terminates in accordance with the terms of this benefit plan, you may be eligible for COBRA continuation of benefits. Strict guidelines exist regarding eligibility for, election of and participation in continuation coverage.

The administration of all criteria for continuation of benefit is governed by and the sole responsibility of the plan sponsor. Please refer to your benefits representative in the human resources department for information regarding eligibility for, enrollment and costs of this coverage.

DENTAL PLAN BENEFITS

Definitions

Plan

This dental benefit plan administered by ADN Administrators, Inc. under contract with your employer, the plan sponsor.

Dentist

An individual licensed to practice dentistry within the scope of his/her license in the state or country in which the dental services are performed.

Dental Hygienist

An individual licensed to practice dental hygiene under the supervision and direction of a licensed dentist within the scope of his/her license.

Participating Dentist

A licensed practicing dentist who has signed a participation agreement with ADN, MDP and/or DenteMax Networks to accept the PPO amount allowed by either plan and/or patient as payment in full for dental treatment or services.

Charge

The amount charged by a dentist for a given dental treatment or service.

Usual and Customary Fee

The fee that is allowed by the plan for services rendered by an out-of-network Provider.

PPO Allowed Amount

The amount determined by the PPO Network and agreed upon by the participating dentist to be accepted for dental treatment or services rendered to an eligible patient under the plan.

Benefit Year

The benefit period defined by the plan.

Covered Dental Services

Those dental treatment or services selected by your plan to be considered as covered contingent upon current eligibility, plan limitations and the remaining annual maximum benefit.

Definitions (continued)

Benefit Payment Amount

The dental plan payment amount for covered dental expenses as described in **The Plan at a Glance**, and contingent upon current eligibility, plan limitations and the remaining annual maximum benefit.

Maximum Benefit Amount

The maximum dollar amount of covered dental expenses that the plan will pay for each covered individual in any one benefit year or lifetime contingent upon current eligibility and plan limitations.

Alternative Benefit Allowance

An allowance for a dental treatment or service when it is determined that an alternative treatment may be appropriately provided to treat a dental condition. Payment will be based on the applicable percentage of the allowed fee for the most economical treatment that will produce a reasonably favorable prognosis and result.

Copayment

The percentage of a covered dental treatment or service considered to be the patient's responsibility in addition to payment determined by the plan.

Completion Dates

The date(s) on which a dental treatment or service is considered to be completed. This would be the final cementation date for crowns and fixed partial dentures, delivery date for removable dentures and the date of the final procedure for root canals and periodontal treatment (per quadrant).

Predetermination of Benefits

A process by which the treating dentist may submit their treatment plan and supporting documentation prior to any proposed treatment that is expected to exceed a specific dollar amount. The administrator will review the information submitted and determine whether benefits may be allowed based on the plan guidelines. Payment of approved predetermined benefits are contingent upon continued eligibility, plan limitations and any available annual or lifetime maximum at the time the service(s) is rendered.

Covered Dental Expenses

Following is a summary of dental treatment or services that will be considered as covered for eligible patients under the plan. The plan administrator has the exclusive and absolute discretion to interpret and administer the benefits of this plan in accordance with its terms. **Please note that covered benefits may have limitations or exclusions as listed later in this document.**

Class I Benefits

1. Diagnostic and Preventive Services:

   Oral Examinations, Cleanings (Prophylaxis and Periodontal Maintenance), Topical Application of Fluoride, Space Maintainers, Emergency Palliative Treatment, Orthodontic Diagnostic Procedures.

Class II Benefits

1. Restorative Services:

   Amalgam and Composite Resin restorations (fillings), Stainless Steel and Resin Crowns, Crown build-up, Post-cores, Onlays, Crowns, Recementations, Denture Relines, Repairs and Adjustments.

2. Endodontic Services:

   Root Canal Therapy, Therapeutic Pulpotomy, Apicoectomy, Hemisection, Root Amputation.

3. Periodontic Services:

   Root Planing, Osseous Surgery, Tissue and Bone Replacement Grafts, Gingivectomy and Flap Procedures.

4. Oral Surgery Services:

   Simple and Surgical Extractions, Surgical Removal of Impacted Third Molars, Incision and Drainage, Surgical Exposure, Root Recovery and Alveoloplasty.

5. Adjunctive General Services:

   Emergency Palliative Treatment, All Radiographs, Therapeutic Drugs (limited), Occlusal Adjustment, Occlusal Guards, General Anesthesia and IV Sedation (in conjunction with certain covered oral surgery).

Covered Dental Expenses (continued)

Class III Benefits

1. Removable Prosthetic Services:

   Complete and Partial Dentures and the Addition of Teeth to Existing Partial Dentures.

2. Fixed Prosthetic Services:

   Fixed Partial Dentures (bridges), Endosteal Implants, Implant retained crowns.

Class IV Benefits

1. Limited, Interceptive and Comprehensive Treatment (Braces) including retention:

   Fixed and Removable Appliance Therapy.

Orthodontic treatment is the corrective movement of teeth by means of an active appliance to affect a predetermined result.

Benefits are payable in increments as follows:

A down payment of equal to 25% of the allowed initial banding fee.

Then the balance of the total allowed fee in equal installments over the number of months of treatment until either the lifetime maximum benefit amount or the estimated months of treatment has been reached.

Dental Plan Limitations

Covered dental benefits provided by the Plan for the following treatment or services are limited as follows:

1. Oral Examinations and Cleanings or Periodontal maintenance procedures are payable twice in a plan year.

2. Bitewing X-rays are payable once in any plan year.

3. Full Mouth (which include bitewings) or Panoramic X-rays are payable once in any 60 month period. A Panoramic X-ray in addition to Bitewing X-rays is considered a Full Mouth X-ray and is payable accordingly and subject to the 60 month time limitation.

4. Topical Application of Fluoride is payable twice in any plan year for patients under 19 years of age.

5. Space Maintainers necessitated by pre-maturely lost primary posterior teeth are payable once per affected area for patients under 19 years of age. Allowance includes all adjustments within six months of insertion.

6. Amalgam and Composite Resin restorations are payable once per tooth surface in any twelve-month period. Multiple restorations on a surface are considered a single restoration. Resin restorations for teeth posterior to the second bicuspid are considered cosmetic. An allowance may be made for amalgam materials in accordance with the alternate benefit provision.

7. Porcelain and Cast Restorations (Crowns), Onlays and Substructures for restoration of functional natural teeth are payable for the same tooth, once in any 60 month period. Porcelain overlays posterior to the second bicuspid are considered cosmetic. An allowance may be made for the corresponding metal cast restoration.

8. Benefits for restorations include all preparatory services, gingivectomy, local anesthesia, acid-etch, cement bases, cavity liners, temporary fillings or crowns.

9. Substructures, Porcelain and Cast Restorations are not payable for patients under 12 years of age.

10. Stainless Steel and Resin Crowns are payable for patients under age 19 and once in any thirty-six month period.

11. Periodontal Root Planing are payable once in any twenty-four month period per quadrant of the dental arch for periodontally compromised patients.

12. Periodontal Surgery procedures are payable once in any thirty-six month period per quadrant of the dental arch.

Dental Plan Limitations (continued)

13. Miscellaneous Adjunctive Services:

    a. Consultations are payable for the dentist or dental specialists providing a second opinion and not rendering **any** treatment.

    b. Occlusal Guards are payable under certain circumstances, by report and once per lifetime of the patient.

    c. General Anesthesia and IV Sedation are payable in conjunction with certain covered oral surgery procedures.

    d. Emergency Examination or Palliative Treatment is payable when no other treatment or service is rendered on the same day except radiographs and tests necessary to diagnose the emergency condition. Palliative Treatment is considered for minor non-curative services to temporarily alleviate pain, appropriate benefits will be considered for any definitive treatment submitted as Palliative Treatment.

14. Prosthodontic (Class III) benefit limitations:

    a. Complete Dentures to replace missing functional natural teeth are payable once in any 60 month period per arch.

    b. Removable Partial Dentures to replace missing functional natural teeth are payable once in any 60 month period. An exception may be allowable in the event that the loss of additional tooth/teeth occur that cannot be added to the existing appliance.

    c. Fixed Partial Dentures to replace missing functional natural teeth are payable once in any 60 month period. An exception may be allowable in the event that loss of additional tooth/teeth occur that requires fabrication of a new appliance.

    d. Removable Cast Complete or Partial Dentures and Fixed Partial Dentures are not payable for patients under 16 years of age.

    e. Any Prosthetic benefit allowance includes all preparatory procedures, diagnostic casts and models, occlusal adjustments and post-delivery care within six months of delivery or insertion.

15. Reline or Rebase (complete replacement of denture base material) is payable once in any thirty-six month period and more than twelve months following delivery or insertion of the appliance.

16. Orthodontic (Class IV) benefit limitations:

    a. Orthodontic treatment is payable until the 19th birthday of an eligible patient.

Dental Plan Limitations (continued)

b. If the orthodontic treatment plan is terminated before completion of the case for any reason, the plan's obligation will cease with payment to the date of treatment termination.

c. Termination of the treatment plan must be reported to the plan with written notification. The plan's obligation will cease with payment to the date of the month in which the patient was last treated.

d. Benefits for comprehensive orthodontic treatment are considered to include charges for retention. Any separate charges for retention will be the responsibility of the patient or responsible party.

e. Any charges for repair or replacement of an orthodontic appliance covered by the plan will not be considered a covered benefit and will be the responsibility of the patient or responsible party.

17. Benefits for certain interrupted treatment or services may be considered at the discretion of the administrator.

18. Benefits for terminated treatment or services due to the death of the patient or enrolled employee will be considered completed to the limit of the plan's responsibility for the services actually completed or near completion.

19. Alternate Benefit Allowance:

    An alternate benefit allowance may be provided for treatment under the following circumstances:

    a. When the patient or dentist selects a more costly treatment or service than is routinely or customarily provided.

    b. When a more economical treatment would produce a professionally satisfactory prognosis and result.

    c. When a valid dental need for the treatment rendered is not demonstrated.

General Exclusions

Trenton Public Schools does not include benefits for the following treatment or services. The patient will assume responsibility for any and all charges related to these services.

1. Sealant application.

2. Replacement, repair, reline or adjustment of occlusal guards.

General Exclusions (continued)

3. Restorations or appliances determined to be rendered for cosmetic or aesthetic purposes including laminate veneers, repairs to porcelain/ceramic facings for posterior teeth and personalization or characterization of dentures.

4. Appliances, restorations or services for the diagnosis and/or treatment of Temporomandibular joint dysfunction (TMD/TMJ).

5. Lost, missing or stolen prostheses or appliances of any type.

6. Overdentures and related appliances, restorations, root canals and/or other services. An allowance may be considered for conventional removable dentures.

7. Porcelain restorations or composite resin fillings for teeth posterior to the second bicuspid. An allowance will be considered for full cast gold or amalgam materials accordingly.

8. Inlay Restorations. An allowance may be considered for a corresponding resin or amalgam restoration.

9. Repair or replacement of orthodontic appliances.

10. Treatment or services that are determined not necessary and/or customary for which no valid need can be demonstrated, that are considered specialized technique, that are investigational or experimental in nature as determined by generally accepted standards of dental practice.

11. Appliances, restorations or services for altering, restoring or maintaining occlusion, increasing vertical dimension, for periodontal splinting, for replacing tooth structure lost due to attrition, abrasion or erosion.

12. Appliances, restorations or services for the correction of congenital or developmental malformation or for replacement of teeth beyond the normal complement.

13. Treatment or services that are temporary or considered an integral component of a final dental treatment or service.

14. Appliances, surgical procedures or restorations related to implantology techniques (other than Endosteal), except as limited by the Class III provision, terms and conditions.

15. Treatment or services started before the patient became eligible under this plan, except as limited by the Class IV provision, terms and conditions.

16. Prescription drugs, laboratory tests and/or histopathological examinations, pre-medications, desensitizing medicaments or materials, analgesia, general anesthesia and/or intravenous sedation in conjunction with restorative procedures or surgical services unless medically necessary.

General Exclusions (continued)

17. Personal care or self-applied supplies or equipment, including but not limited to water piks, toothbrushes, flosses, fluoride gels, oral rinses and other inter- dental supplies, preventive control or educational programs including dietary control, tobacco counseling and home care items.

18. Charges for missed appointments, completion of claim forms or submission of supporting documentation required for claim review.

19. Any treatment or services that are not within the classes of dental benefits as defined in the plan.

20. Treatment or services that are covered under a hospital, surgical/medical or prescription drug program.

21. Hospital, laboratory, emergency room or facility charges and related equipment or supplies.

22. Treatment by other than a licensed dentist, except the cleaning of teeth and topical application of fluoride performed by a licensed hygienist under the supervision and direction of a licensed dentist within the scope of his/her license.

23. Treatment or services for which no charge is made, for which the patient would not be legally obligated to pay or for which no charge would be made to a patient in the absence of dental plan coverage.

24. Treatment or services rendered by an immediate family member of the patient.

25. Treatment or services as a result of injury or conditions compensable under Worker' Compensation or Employer's Liability laws and benefits available from any federal, state or municipal government agency.

26. Treatment or services as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

Alternate Benefit Allowance

Benefits may be limited in all cases where there is more than one method of dental treatment or service that may be appropriately provided to treat a dental condition. If the patient or dentist chooses a more costly procedure, benefits will be considered for the most economical treatment or service that would provide a reasonably favorable prognosis and result, in accordance with generally accepted standards of dental practice.

Alternate Benefit Allowance (continued)

For example, if the patient or dentist chooses a crown restoration for a tooth that can be satisfactorily restored by a filling restoration, the plan will consider benefits for the least costly restoration. The patient will be responsible for the excess charges between the cost of the filling and the crown.

However, a participating provider may charge the patient only the difference between the network allowed fee for the filling and the network allowed fee for the crown in addition to any co-payments.

Coordination of Benefits

A patient covered by more than one dental benefit plan may be entitled to as much as, but not more than 100% of the covered charges for dental services included in both dental benefit plans.

The coordination of benefits provision was designed to establish an order by which benefits are determined under each plan and to assure that each plan offers the maximum coverage without exceeding the total allowable charge for the service rendered.

Each plan determines its benefits based on the following order:

1. The plan without a coordination of benefits provision.

2. The plan covering the patient directly as a current employee, rather than as a dependent.

3. The plan covering the patient directly as a current employee for the longer period of time. However, the plan that covers the patient as a laid-off or retired employee will be considered secondary to the plan that does not.

4. The plan covering the patient as a spouse, rather than as an employee.

5. The plan covering the patient as dependent child of the employee whose birthday occurs earliest in the calendar year, except as provided in section 6. This birthdate rule does not apply when parents are divorced or separated. Unless the terms of the divorce decree or child support order dictate that the parents will share legal and physical custody without stating that one parent is primarily responsible for health and dental care expenses of the child.

6. In the case of dependent children of divorced or separated parents:

    a. The plan covering the child as a dependent of the parent who, under the terms of a court order (divorce decree or child support order), has the primary responsibility for medical, health and/or dental care of the child.

    b. The plan that covers the child as a dependent of the custodial natural or legal parent.

Coordination of Benefits (continued)

c. The plan that covers the child as a dependent of the spouse of the custodial natural or legal parent.

d. The plan that covers the child as a dependent of the non-custodial natural or legal parent.

e. The plan that covers the child as a dependent of the spouse of the non-custodial natural or legal parent.

7. If one or more of the dental benefit plans is lawfully issued in a state other than Michigan and that policy or certificate does not have a provision the same as indicated above, the following order applies:

a. The plan that has a higher priority according to the coordination of benefits rules on the plan issued in a state other than Michigan.

b. The plan that has covered the patient for the longer period of time.

Extension of Benefits

If a patient loses eligibility for dental benefits while receiving dental treatment, only those covered services actually received and completed while coverage is in force will be considered a covered expense.

However, certain procedures begun before the loss of eligibility may be covered partially or in whole provided the services are completed within a 60-day period measured from the date treatment is begun and not more than sixty-days following the loss of coverage.

The submitted claim form must include the preparation and progression dates for each portion of the treatment as rendered. The administrator will determine the benefit, if any, to be allowed and any remaining balances will be the financial responsibility of the patient.

CLAIM SUBMISSION PROCEDURE

How to File a Claim

Trenton Public Schools allows benefits for covered treatment rendered by a licensed dentist whether or not he/she is a participant with the ADN, DenteMax or MDP Networks of Providers.

If the dentist does not participate with any network, payment for covered dental treatment will be based on the appropriate benefit level (percentage) of the Usual and Customary charge (UCR). Any differences in this amount and the actual fee charged will become the financial responsibility of the patient.

However, if the dentist participates with any PPO network, the patient may have a smaller out-of-pocket expense. The ADN, DenteMax or MDP Network fee amount will

How to File a Claim (continued)

be accepted as the allowed amount and the patient's responsibility will be only the difference between the plan payment and the allowed network fee, if any.

When you visit your dental office, notify them of your Trenton Public Schools Coverage. Show your dental plan identification card, which will provide all of the necessary information for claim submission.

The dental office may use any standard American Dental Association (ADA) Claim form. Each claim should be **completely** filled out and include the following:

1. The enrolled employee's full name, contract/ssn number and address.

2. The proper name and complete date of birth of the patient.

3. Employer name and dental plan group number.

4. Completion date of service, ADA dental procedure code, tooth number, dental quadrant or arch and fee for each service rendered.

5. All pertinent supporting documentation, radiographs, date (age) of existing restorations, charting and lab reports necessary for benefit determination.

6. Signatures of the patient (or parent for a minor child) and the treating dentist to certify that treatment is rendered, authorization for release of information and assignment of benefits.

7. All information as requested on the claim form.

A claim form is not considered a claim until all information necessary for benefit determination is received. Once the claim is processed, approved benefit payment will be sent to the dentist, as long as benefits are assigned. An explanation of benefits is sent to the employee. Otherwise, approved benefit payment is issued directly to the employee.

Trenton Public Schools will not honor claims and no benefit payment will be made for claims received more than twelve months following the completion date of service. Requests for re-review, reconsideration and adjustment of processed claims must be received within 90-days of the notice/explanation of benefits.

Predetermination of Benefits

ADN Administrators strongly recommends predetermination of benefits prior to any treatment when proposed procedures exceed $200. This process allows the administrator to review the dentist's treatment plan and determine allowable benefits before any costs are incurred.

The treating dentist should submit a claim form indicating his/her proposed treatment plan and include all necessary documentation such as pre- and/or post-operative x-rays,

Predetermination of Benefits (continued)

study models, photographs, charts, laboratory reports and written documentation of need. The administrator will review all pertinent information and make a determination of benefits based on the information submitted. A written predetermination will be sent to the treating dentist and patient to inform them of the benefits determined.

To receive the predetermined benefits, once treatment has been completed, the predetermination notice must be attached to a completed claim form and submitted. The claim form must provide the completion date of service, the patient and dentist's signatures certifying completion of treatment and for assignment of benefits.

Please understand that payment of the predetermined benefits is contingent upon current eligibility, dental plan limitations and available maximum at the time treatment is actually rendered. A predetermination does not guarantee payment or reserve funds for the treatment approved.

Appeal of Denied Benefits

Familiarize yourself with the benefits and provisions of your dental plan so that you are aware of the circumstances under which a dental treatment or service may be considered for coverage. Most importantly, request a predetermination of benefits whenever possible to avoid denials of benefits. Benefits denied for those treatments or services listed under **General Exclusions** or for reasons indicated in **Dental Plan Limitations** do not qualify for appeal.

Before following the appeal procedure, either the dentist or patient should resubmit the claim with any additional information or documentation to support the need for treatment rendered. Attention must be given to the claim billing limitations of the plan as addressed under **How to File a Claim**.

If the denial of benefits is continued, the patient or authorized representative may submit a written appeal within 90 days of the denial notice/explanation of benefits. The written appeal must include employee name and contract/ssn, patient name, date of service, the procedure rendered, the reasons that the benefit denial is being disputed and all pertinent information, radiographs, charts, laboratory reports, photographs, etc. Mail the appeal to the administrator as follows:

ADN Administrators, Inc.
Attn: Dental Claims Manager – Appeals
P. O. Box 610
Southfield, Michigan 48037-0610

The administrator will review all information, request additional information as necessary and provide a written notice within 90 days, indicating the outcome of the review. If the denial of benefits is overturned in full or part, the claim will be reprocessed accordingly and the patient will receive a new explanation of benefits along with a written notice of the benefit determination.

If the denial of benefits is upheld, the requestor will receive a written notice indicating the specific reason for the denial of benefits and reference to the pertinent plan provision under which benefits are being denied.