Your Guide to Dental Benefits

FARMINGTON PUBLIC SCHOOLS

Group Dental Plan

Updated 05/01/2011

Administered By
ADN Administrators, Inc.

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WELCOME!

Welcome to the Farmington Public Schools Dental Plan.

Farmington 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 Farmington Public Schools Dental Plan allows freedom of choice; you may receive treatment from any licensed dentist or dental specialist. 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: Farmington Public Schools Dental Plan

2. Name, address and telephone number of the Plan Sponsor:

   Farmington Public Schools
   32500 Shiawassee Street
   Farmington, MI 48336
   (248) 489-3354

3. Type of plan: Group Dental Benefit Plan

4. Dental Benefits Administrator: ADN Administrators, Inc.

5. The name, mailing address and telephone number of the Administrator is:

   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 January 1st.

8. Dental Plan Group Number: 9001

THE PLANS AT A GLANCE

Effective Date of Plan

This plan became effective on January 1, 2000 and was last revised on May 1, 2011.

Dental Plan Structures

Farmington Public Schools Dental Plan consists of various levels of dental coverage based upon your employee group (see page 5). The types of dental treatment are indicated by classes, which are explained in detail under Covered Dental Expenses.

Plan A Benefits

Class I – 100%
Class II – 90%
Class III – 90%
Class IV – 90%
Annual Maximum Benefit - $2000
Lifetime Ortho Maximum Benefit - $2000

Plan B Benefits

Class I – 50%
Class II – 50%
Class III – 50%
Class IV – 90%
Annual Maximum Benefit - $2000
Lifetime Ortho Maximum Benefit - $2000

Plan C Benefits

Class I – 50%
Class II – 50%
Class III – 50%
Class IV – Not covered
Annual Maximum Benefit - $500
Lifetime Maximum Benefit – N/A

Covered Employee Groups

Plan A includes benefits for the following employees (without coordinated dental coverage):

FEA – Full and Part Time Teachers
ESP – Full Time Secretaries and Paraprofessionals
CMC – Custodian Maintenance Café Employees
FTA – Full Time Transportation Employees
Administration, FASA and Non-Unit Employees
FAHS Employees
Headstart Employees

Plan B includes benefits for the following employees (with coordinated dental coverage):

FEA – Full and Part Time Teachers
ESP – Full Time Secretaries and Paraprofessionals
CMC – Custodian Maintenance Café Employees
FTA – Full Time Transportation Employees

Covered Employee Groups (continued)

Plan B (continued)

Administration, FASA and Non-Unit Employees
FAHS Employees
Headstart Employees

Plan C includes benefits for the following employees (with or without coordinated dental coverage):

Part-Time Food Service Employees
Part-Time Support Staff

HOW AND WHEN COVERAGE TAKES EFFECT

Initial Employee Eligibility

In cases where the employer pays the full cost of dental plan coverage (non-contributory), an employee shall be eligible for coverage under the Plan provided he/she meets **all** of the following conditions:

1. The Plan is in effect for the employer; and
2. The Employee is included in a class of employees which is eligible for coverage under the plan; and
3. The Employee is "Actively at Work" and meets any applicable minimum hours per week requirements unless a medical treatment or medical condition applies; and
4. The Employee has satisfied the applicable Service Requirement. The Service Requirements are explained in detail in the collective bargaining agreement or the Employer's Personnel Policies.

In cases where the Employee contributes toward the cost of dental plan coverage, an employee shall be eligible for coverage under the Plan provided he/she has met **all** of the requirements above. In addition he/she has completed an enrollment form and authorized the employer, in writing, to deduct the required contribution amount from his/her payroll checks accordingly.

Employees who do not complete a written enrollment and authorization for payroll deduction, if applicable, within thirty-one days after the date of initial eligibility (as defined above) may not enroll for coverage in the Plan until the following Open Enrollment or Open Enrollment periods thereafter. An exception for family changes is provided under **Effective Date of Coverage,** changes in coverage and Open Enrollment.

Dental plan effective date of coverage 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.

How and When Coverage Takes Effect (continued)

Dependent Eligibility

In general, eligible dependents include your:

Spouse: from whom you are not divorced or legally separated (a divorced or otherwise legally separated spouse may be considered your dependent if you are required by a court order or ruling to provide health care benefits).

Dependent Children: which include your natural children, stepchildren, legally adopted children (including children placed for adoption) or legal guardianship (a copy of the court order appointing guardianship must be submitted with the enrollment form) and any other children required to be covered by a Qualified Medical Child Support Order or other court order or ruling, who:

1. Are younger than age 26 (coverage will continue until the end of the year of their 26th birthday)
2. Are any age if they are totally and permanently disabled, either physically or mentally, as long as they became disabled before age 19 and are incapable of self-sustaining employment. The children's disability must be certified by a physician.
3. Over age 26 and have not had a lapse in coverage who:
    a. Are dependent children (see above)
    b. Live with you (this includes children who are away at school);
    c. Not married;
    d. Remain a full-time student;
    e. Are dependent on you for more than half of their support

Note: If your dependent child is now eligible for coverage, but was not eligible before the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, you will be allowed to reenroll at the beginning of the new plan year after September 23, 2010.

Note: If your dependent child is eligible for coverage as a full-time student but is unable to maintain full-time student status due to a medically necessary leave, his or her coverage may continue for up to one year or, if earlier, to the date on which coverage would otherwise end under the Plan.

Principally Supported Children: including children who are not your or your spouse's offspring, but who:

1. Are related by blood or marriage;
2. Are not married;
3. Are under age 19 as of December 31;
4. Are a member of your household;
5. Are claimed as a dependent on your most recent federal income tax return or qualify in the current tax year for dependency status; and
6. You provided support for at least nine consecutive months before requesting the addition of the child. (Following this period, there is a 90-day waiting period for coverage to begin.) You must complete an enrollment and change form and submit a notarized affidavit stating the date principal support began.

Sponsored Dependents: who are dependents who live with you or who are related to you by blood or marriage and who depend on you for more than half of their support, as defined by the U.S. Internal Revenue Code. You must submit and have an application approved by the plan sponsor before a sponsored dependent is eligible for coverage. The employee is responsible for paying the cost of this coverage. (Children who are no longer eligible for coverage as dependent children cannot be insured as sponsored dependents.)

Designated Beneficiaries: To be eligible for coverage, you and your beneficiary must provide a signed, notarized affidavit verifying that:

1. You cannot legally marry in Michigan because you are the same sex;
2. You are both at least age 18 and may legally enter into a contract;
3. Neither of you are married;
4. You share a regular, permanent residence and have done so for at least 12 months (you must continue to share a regular, permanent residence while you are covered under the Plan; coverage will end after the end of the month during which you no longer share a regular, permanent residence);
5. You are, and will continue indefinitely to be, required to financially support one another and share joint responsibility for living expenses (you must provide acceptable evidence that you have shared financial and domestic obligations for at least six months. This evidence may include, for example, a joint mortgage or lease, joint bank or credit card accounts, designation of the partner as beneficiary on insurance or retirement benefits, durable power of attorney, joint ownership of a vehicle, home or other property, designation of the partner as a primary beneficiary on a will, co-parenting or adoption agreements, etc.); and
6. You have not applied for designated beneficiary coverage within the 12-month period ending on the date you apply.
7. A designated beneficiary who meets the Plan's requirements for coverage will be covered the same as a legal spouse. In addition, a covered designated beneficiary's children who meet the Plan's definition of dependents will also be eligible for coverage when all of the following apply:
    a. They are related to the designated beneficiary by birth, legal adoption or legal guardianship;
    b. They are not married;
    c. They are the designated beneficiary's dependents as defined under the United States Internal Revenue Code;
    d. They are claimed as an exemption on the designated beneficiary's tax return.

In some cases, you may owe additional taxes due to covering your beneficiary or his or her children. Also, if your beneficiary does not qualify as a dependent under the Internal Revenue Code, your contributions for that coverage must be made on an after-tax basis. The Plan sponsor will provide you with information to help you determine your beneficiary's dependent status. However, you are solely responsible for determining and meeting your own tax obligations. Neither the Plan nor its Benefit Administrator is responsible for determining your tax liability or for helping either of you meet your tax obligations. You and your beneficiary must indemnify and hold harmless the Plan and its Benefit Administrator for any federal, state or local tax liability, penalties or interest incurred as a result of this coverage. Your employer is responsible for any additional withholding and reporting required because of your election to cover your beneficiary and/or his or her children.

Effective Date of Coverage

Your dependent's coverage will begin on the date your coverage begins, as long as you enroll your dependents at the same time you enroll. If you do not enroll your dependents when you are first eligible, you may enroll them during any later open enrollment period.

If you need to add a new dependent, you may do so. However, you must enroll your new dependent within 30 days of the date he or she first becomes eligible to have coverage. If you do not enroll your new dependent within 30 days, you must wait for an open enrollment period to enroll your new dependent.

Please note that no benefits will be paid until you submit a completed enrollment form for your dependents.

Change(s) in Coverage and Open Enrollment

Employees may enroll and/or make changes (such as the addition of dependents) during Open Enrollment, or at certain other times, subject to the following conditions:

1. An employee, who has declined enrollment for him/herself or dependents (including the spouse) because of other coverage, may in the future elect enrollment in the plan outside of the Open Enrollment period. The employee must submit a completed enrollment form and authorization for any payroll deduction, if applicable, within thirty-one days from the date that the other coverage ends.

2. An employee, who has declined enrollment for him/herself or dependents and has a new dependent as a result of a marriage, birth, adoption, or placement for adoption, may in the future elect enrollment in the plan outside of the Open Enrollment period.

3. Employees who are not included in one of the above events may enroll at Open Enrollment with coverage to begin effective the first day of the month following the Open Enrollment period.

WHEN COVERAGE TERMINATES

Termination of coverage will be effective on the first occurrence of any of the following dates:

1. The first day of the month in which the employer's contributions are no longer current.

2. The first day of the month in which the employee's contributions are no longer current.

3. The first day of the month in which the employee ceases to be an eligible employee in the class for coverage because of termination of employment or for any other reason.

When Coverage Terminates (continued)

4. The first day of the month following the date on which the class of employees to which the employee belongs is no longer eligible for coverage.

5. The date on which the Plan 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 in the class for coverage 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.

An ex-spouse's coverage may be continued beyond the date of divorce if the divorce decree provides that the employee must affect dental coverage for the ex-spouse. The employee will be financially responsible for the sponsored dependent contribution in addition to his/her own normal contribution, if applicable.

Coverage under this provision will terminate on either the date that is twelve-months following the date of the divorce, or the ex-spouse remarries, whichever is earlier

CONTINUATION OF DENTAL PLAN BENEFITS

In the event that dental plan coverage is lost due to any of the qualifying events, a temporary continuation of coverage may be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provisions.

<u>The Covered Employee</u>

An employee may choose to continue coverage under the COBRA provisions when coverage under the dental plan ends due to termination of employment, reduction in hours of employment, layoff, disability, medical leave of absence or retirement.

<u>A Covered Spouse</u>

A spouse of a covered employee may elect to continue coverage under the COBRA provisions for his/herself if coverage under the dental plan ends due to:

1. Death of the covered employee; or
2. Termination of the covered employee's employment, reduction in hours of employment, layoff, disability, medical leave of absence or retirement; or
3. Divorce or legal separation from the employee.

Continuation of Dental Plan Benefits (continued)

A Dependent Child

A dependent child of a covered employee may elect to continue coverage under the COBRA provision for any of the following reasons:

1. Death of that parent; or
2. Termination of that parent's employment, reduction in hours of employment with a contributing employer, layoff, disability, medical leave of absence or retirement; or
3. Divorce or legal separation of that parent; or
4. Termination of that parent's coverage due to Medicare entitlement; or
5. Termination of coverage as a dependent of that parent.

A Newborn or Adopted Child

A newborn child or a child placed for adoption (and for which the eligible enrollee has financial responsibility) while enrolled under the COBRA provision may be added to the coverage. The enrollment must be effected in writing within thirty days of the date of birth or placement. The child will have the same coverage as any child covered by the employee's plan before the COBRA eligibility.

Eligibility for continuation of coverage is determined by and the sole responsibility of the plan sponsor. Please refer to your dental benefits representative in the human resources department for additional information.

COBRA Election

The eligible employee or covered dependent has the responsibility to inform the Farmington Public Schools Benefit Office immediately of the qualifying event as indicated in the previous section.

If an employee, spouse or dependent is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of a qualifying event (or sixty days thereafter) the Benefit Office must be notified within sixty-days of the determination. In addition, the Benefit Office must be notified within thirty-days of a determination that the employee, spouse or dependent is no longer disabled.

Once the employer receives notice of a qualifying event, a right to continuation coverage certificate will be provided to those affected parties. Notification to the employee or custodial parent is considered notice to all eligible dependents.

Failure to report a qualifying event within the sixty-day time limit will render an employee, spouse or dependent ineligible for continuation coverage.

Continuation coverage will be equal to dental coverage in effect at the time of the election and identical to the coverage provided to similarly situated covered employees and their dependents.

Continuation of Dental Plan Benefits (continued)

Duration of COBRA Coverage

Eligible employees and dependents will be afforded the opportunity for continued coverage for thirty-six months from the date of the qualifying event. However, if loss of group coverage is due to termination of the employee's employment, reduction in hours of employment, layoff, strike, medical leave of absence, retirement or disability the continuation coverage period is eighteen months for the employee and his/her eligible dependents.

The eighteen month coverage period may be extended to twenty-nine months under the following conditions: the Social Security Administration (SSA) determines that the employee or eligible dependent was disabled at the time of termination of the employee's employment, reduction in employment hours, layoff, strike, medical leave of absence, disability or retirement or within sixty-days of that date and the Benefit Office is notified in writing within sixty-days after the date of the SSA determination and before the end of the eighteen month period, the continuation coverage may be extended up to a total of twenty-nine months from the date of initial continuation coverage, or until the date of determination by the SSA that the employee or dependent is no longer disabled. The Benefit Office must be notified within thirty-days of a determination that an employee or covered dependent is no longer disabled.

Extension of the eighteen-month continuation coverage period for a spouse or dependent may be allowed should another qualifying event occur during the initial continuation period (i.e. divorce, legal separation, or death of the employee or loss of dependent status). Coverage may be extended to a total of thirty-six months from the date the first qualifying event occurred.

The spouse and dependents of an active employee becoming eligible for Medicare will be eligible for Continuation Coverage for no less than thirty-six months from the date of Medicare entitlement if a subsequent qualifying event occurs, such as termination of employment.

In any event, an individual's Continuation Coverage may be terminated for any of the following reasons:

1. This Plan no longer provides group coverage; or
2. The contributions are not paid timely. A grace period of at least thirty-days may be extended except for the initial enrollment payment, for which there is a one-time forty-five day grace period.
3. The enrollee becomes covered under another employer sponsored group plan as an employee, spouse or dependent, after Continuation Coverage begins. This is provided that continuation will not end for the enrollee for the period of any exclusion or limitations regarding any pre-existing conditions of that employer sponsored group plan.

The enrollee (parent or guardian) must notify the Benefit Office immediately should he/she become covered under another group dental plan.

Continuation of Dental Plan Benefits (continued)

Disability After COBRA Continuation Coverage Begins

If the SSA determines that a COBRA enrollee was totally and permanently disabled on the day eligibility for coverage under the plan as an active employee or dependent was lost, or sixty-days thereafter, the member may elect to keep COBRA coverage for twenty-nine months.

The enrollee must notify the FPS Benefits Department of the SSA determination, in writing, within sixty-days of the determination date and before the end of the initial COBRA coverage period. The enrollee must also notify the FPS Benefits Department of any SSA final determination that he/she is no longer considered disabled, within thirty-days. Dependents awarded extended COBRA coverage past twenty-nine months will not be granted further extensions due to disability. As with all COBRA coverage, eligibility for this extension is dependent upon timely and uninterrupted payment of premium.

Further questions regarding COBRA continuation of coverage, notifications of changes in marital status, dependents, address or coordination of benefits must be directed to the FPS Benefits Department (248) 489-3354.

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 paid 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 Allowed Amount

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 affecting plan payment as listed later in this document.**

Class I Benefits

1. Diagnostic and Preventive Services:

   Oral Examinations, Prophylaxis (cleaning), Periodontal Maintenance, Topical Application of Fluoride, Emergency Palliative Treatment, Bitewing X-rays, Full-Mouth Series X-rays, Panoramic X-rays, Periapical X-rays.

Class II Benefits

1. Preventive and Restorative Services:

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

2. Endodontic Services:

   Pulp Cap, Therapeutic Pulpotomy, Root Canal Therapy, Apicoectomy, Apexification, Hemisection, Retrograde Filling and Root Amputation.

3. Periodontic Services:

   Root Planing, Osseous Surgery, Tissue Grafts, Bone Replacement Grafts, Gingivectomy, Crown Lengthening and Gingival 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:

   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) and Implant supported Single Crowns.

Class IV Benefits

1. Orthodontic Diagnostics Procedures:

   Diagnostic Panoramic and Cephalometric Radiographs, Photographs and Study Models.

2. Harmful Habit Control Appliances:

   Fixed and Removable Appliances for Tongue Thrusting and Thumb Sucking.

3. 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 for the treatment of functionally maloccluded or malpositioned teeth.

Benefits are payable in increments as follows:

Payment for the initial banding fee will be equal to 25% of the allowed amount.

The balance of the total allowed fee will be paid 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, Cleanings (Prophylaxis or Periodontal maintenance) 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 sixty-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 sixty-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), Inlays, Onlays and Substructures for restoration of functional natural teeth are payable for the same tooth, once in any five-year period. Porcelain overlays posterior to the second bicuspid are considered cosmetic. An allowance may be made for the corresponding cast metal 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 primary teeth of patients under age 19 and once in any three-year period.

11. Oral Surgery procedures that are also covered on the Farmington Public Schools Medical/Master Medical benefit plans if any, are payable following the medical plans benefit determination.

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

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

Dental Plan Limitations (continued)

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

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

16. General Anesthesia and IV Sedation are payable in conjunction with certain covered oral surgery procedures and following benefit determination by Farmington Public Schools Medical/Master Medical benefit plans.

17. 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.

18. Complete Dentures to replace missing functional natural teeth are payable once in any five-year period per arch.

19. Removable Partial Dentures to replace missing functional natural teeth are payable once in any five-year 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.

20. Fixed Partial Dentures to replace missing functional natural teeth are payable once in any five-year period. An exception may be allowable in the event that loss of additional tooth/teeth occur that requires fabrication of a new appliance. Porcelain overlays posterior to the second bicuspid are considered cosmetic. An allowance may be made for the corresponding cast metal restoration.

21. Implant supported Single Crowns are payable for the same tooth, once in any five-year period. Porcelain overlays posterior to the second bicuspid are considered cosmetic. An allowance may be made for the corresponding cast metal restoration.

22. Removable Cast Complete or Partial Dentures, Fixed Partial Dentures and Implant supported Crowns are not payable for patients under 16 years of age.

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

24. Reline or Rebase (complete replacement of denture base material) and Tissue Conditioning are payable once in any three-year period and more than twelve months following delivery or insertion of the appliance.

Dental Plan Limitations (continued)

25. Orthodontic (Class IV) benefit limitations:

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

    b. Only those services or treatment actually rendered while the patient is eligible under the plan will be considered for coverage.

    c. 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.

    d. 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.

    e. Comprehensive orthodontic treatment is considered to include charges for retention. Any separate charges for retention will be the responsibility of the patient or responsible party.

    f. 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.

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

27. 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.

28. 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.

Dental Plan Exclusions

The Farmington Public Schools Dental Plan 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.

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 attachments, 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. Repair or replacement of orthodontic appliances.

9. 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.

10. 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.

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

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

13. Appliances, surgical procedures or restorations related to implantology techniques, except as limited by the Class III provision, terms and conditions.

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

Dental Plan Exclusions (continued)

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

15. 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.

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

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

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

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

20. 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.

21. 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.

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

23. 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.

24. 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 allowable 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.

This plan may provide to or obtain from another insurer, any other organization or person any necessary information for the purpose of coordinating benefits. This information may be given or obtained without the consent of or notice to any other person. A covered person must give this plan or cause to be given the information it requests about other plans and their payment of covered services.

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 30-day period measured from the date treatment is begun and not more than thirty-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

The Farmington Public Schools Dental Plan 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

How to File a Claim (continued)

Customary allowable amount (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 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 Farmington Public Schools Dental Plan 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, relationship to the employee and complete date of birth of the patient.

3. Employer name and dental plan group number.

4. Name, address, telephone number, license number and tax identification number of the dental provider.

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

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

7. 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.

8. 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.

The Farmington Public Schools Dental Plan 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 $250. 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, 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 completed and submitted. The predetermination form must provide the completion date of service and the dentist's signature certifying completion of treatment. Assignment of benefits will be the same as the originally submitted predetermination form unless a new claim form is submitted with different information. If any treatment or procedures change from the originally submitted predetermination, the original predetermination will be considered void and the claim will be processed as if it is a newly submitted claim.

Please understand that payment of the predetermined benefits is contingent upon current eligibility, dental plan limitations, fee allowances 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 **Dental Plan 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:

Appeal of Denied Benefits (continued)

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.