

City of Carrollton
Coverage Summary
Schedule of Dental Expense Benefits – Effective January 1, 2016

Description of Benefits

Benefit Percentage

Preventive Dental	100%
Basic Dental	80%
Major Dental	50%
Orthodontic (no age limit)	50%

Benefit Deductibles and Maximums

Individual Deductible Amount (<i>waived for Preventive</i>)	\$50 per calendar year
Preventive, Basic and Major Dental Expense Benefit	\$1,500 per calendar year
Orthodontic Benefit	\$1,000 per lifetime
All Covered Dental Expenses	Unlimited lifetime benefit while covered under the Plan

Dental Expense Benefits

The dental expenses described in this section are designed to be used in conjunction with the medical expense benefits of this Plan. If you elect dental coverage under this Plan, and do not elect medical coverage under this Plan, you will experience some gaps in coverage. For example, medications prescribed for dental services or treatment will only be payable if you are covered for medical benefits under this Plan. Also, only those oral surgeries specifically listed in the Dental Schedule of Benefits will be payable under your dental coverage. No other surgical procedures will be payable unless the procedure is a covered medical expense under this Plan, and you have elected medical coverage under this Plan. All dental charges and orthodontic charges are subject to reasonable and customary guidelines. You may use the dental provider of your choice regardless of plan.

Pre-Treatment Estimate

While a Pre-Treatment Estimate is not required for any dental treatment, it is **recommended** that you obtain a Pre-Treatment Estimate for any dental treatment other than a routine cleaning or filling so that you will know in advance of receiving the treatment whether or not the dental procedure is a Covered Expense, **and** if there is an alternate and professionally adequate treatment (one that is usually less expensive) that could be substituted for the dental procedure you are considering. By obtaining a Pre-Treatment Estimate, you will avoid being surprised with any benefit reductions once the claim is processed.

Covered Dental Expenses

Covered Expenses will include the Reasonable and Customary charges incurred for Preventive (deductible waived), Basic, Major, and Orthodontic Services in excess of the Deductible. The Percentage Payable, Deductibles, and any Maximum Amounts are given in the Dental Schedule of Benefits.

If a Covered Person has Medical and Dental Coverage, or Medical Coverage only, benefits for cutting procedures in the oral cavity for cysts and tumors will be payable as a Medical benefit **only**.

1. Preventive Benefit includes:
 - a. two routine dental examinations per Calendar year;
 - b. two prophylaxis (teeth cleaning) treatments per Calendar year;
 - c. two (2) routine bitewing x-rays (four films) twice each Calendar year; and
 - d. Fluoride treatments if less than 18 years old.

2. Basic Benefits includes:
 - a. extractions;
 - b. treatment of tooth pulp, including root canal therapy;
 - c. oral surgery - apicoectomies and extractions of impacted or erupted teeth (including alveolectomy, alveoplasty, and tori removal in connection with extractions);
 - d. local anesthesia or I.V. sedation for covered oral surgery;
 - e. general anesthesia when medically indicated and administered by a Physician other than the operating dentist;
 - f. restorative services (fillings) using amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations, but excluding gold and baked porcelain fillings;
 - g. periodontal scaling, treatment, diagnosis, and surgery;
 - h. full mouth series of x-rays limited to one series in any 36 month period, and other diagnostic x-rays, provided no x-rays are in connection with a program of orthodontics;
 - i. antibiotic injections;
 - j. repair or recementation of crowns, inlays, onlays, bridgework or dentures; and relining or rebasing of dentures 6 months after the denture is installed, limited to one relining or rebasing within any 36 month period;
 - k. initial installation of partial or full removable dentures, including precision attachments and any adjustments during the first 6 month period following installation;
 - l. replacement of an existing full or partial removable denture or fixed bridgework by a new denture or new bridgework due to the extraction of teeth after the denture or bridgework was installed;
 - m. replacement or modification of existing bridgework or denture which cannot be made serviceable, and which are installed more than 5 years prior to replacement or modification;
 - n. space maintainers for missing primary teeth for a Covered Person younger than 14 years of age;
 - o. emergency palliative treatment; and
 - p. sealants
3. Major Benefit includes:
 - a. initial fixed bridgework, including inlays and crowns as abutments;
 - b. initial inlays, onlays, gold fillings or crown restoration; and
 - c. Removable mouth guard to alleviate bruxism.
4. Orthodontic Benefit includes:
 - a. Essential services required for the straightening of misaligned teeth, by use of braces. Related Covered Expenses are:
 - initial diagnostic procedures;
 - orthodontic diagnostic procedures and treatment, including oral examination, surgery and extractions for Covered Persons;
 - removal of teeth;
 - the first essential appliances;
 - correction of misaligned teeth; and
 - Correction of malocclusion by wire appliances, braces and other mechanical aids.

Exclusions and Limitations Applicable to Dental Benefits

There are certain expenses that the Plan will not pay. The Plan will not pay any expenses incurred by you or your Dependents for any illness, accidental bodily injury or disability or any charge for care or services which is:

1. dental treatment received from a dental or medical department maintained by the Employer, a mutual benefit association, labor union, trustee, or similar type of group;
 2. education counseling with regard to dietary planning, plaque control, or oral hygiene instruction;
 3. congenital or developmental malformation existing when the person became covered under this Plan;
 4. the replacement of lost, missing, or stolen prosthetic devices;
 5. dental treatment involving the use of gold if such treatment could have been rendered at a lower cost by means of a reasonable substitute;
 6. installation of an initial prosthodontic appliance when such charges are incurred for replacement of congenitally missing teeth or replacement of teeth all of which were lost while the individual was not covered by this Plan;
 7. replacement of an existing prosthodontia appliance unless:
 - a. necessitated by the extraction of additional natural teeth while covered under this Plan, or
 - b. the existing appliance is at least 5 years old and cannot be made serviceable and 12 months have elapsed since the effective date of coverage, or
 - c. the replacement appliance is made necessary as a result of an initial placement of an opposing denture while covered;
 8. any expenses incurred for treatment rendered after the date of termination of an individual's coverage, except that Covered Expenses incurred after coverage has terminated for laboratory work for:
 - a. dentures,
 - b. fixed bridgework (including pontics and retaining crowns), and
 - c. restorative crowns, inlays, or onlays that were ordered prior to termination of coverage and delivered within 30 days following such termination.
- Ordered** means for dentures, that impressions have been taken from which the denture will be prepared; or for the other types of services, that the teeth which will serve as retainers or support or which are being restored have been fully prepared to receive, and impressions have been taken from which the fixed bridgework, restorative crowns, inlays or onlays will be prepared;
9. dental treatment other than by a duly licensed dentist or Physician, except for work done by a dental hygienist, technician, or laboratory that is within the scope of their license and which is performed under the direction of a Dentist or Physician;
 10. temporary restorations;
 11. any duplicate prosthetic device or any other duplicate appliance;
 12. implantology;
 13. charges for care or treatment of occlusion by adjustment, appliance, or restorations, except for orthodontics, if provided;
 14. any expense incurred prior to becoming covered or any dental work in progress at the time a patient becomes covered under this Plan;
 15. any charges in excess of the charges customarily made when alternate services or supplies are customarily available for such treatment, beyond the charge for the least expensive service or supply resulting in professionally adequate treatment, unless alternate services or supplies have previously been utilized and have subsequently proven to be unsuccessful;
 16. services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures, unless such charges are:
 - a. because of an accidental bodily injury which took place while the patient was covered under this Plan,

- b. for facings for crowns on molar teeth if needed as a result of an accidental bodily injury, or
 - c. for a birth defect or illness of a Covered Dependent born to you or your spouse while covered for Dependent's Coverage;
17. for periodontal splinting.
 18. for any condition, illness, injury or complication thereof arising out of or in the course of employment;
 19. for any condition, illness, injury or complication thereof which could or might have been furnished if pursued, or sought, according to the provision of any workers' compensation or occupational disease law, or any other law or regulation of the United States or of a state, territory or subdivision thereof, or under any policy of workers' compensation or occupational disease coverage, or according to any recognized legal remedy available to a Covered Person;
 20. the result of an act of war, declared or undeclared, or any type of military conflict, nor loss caused by any means for disease contracted or injuries sustained in any country while such country is at war or while en route to or from any such country at war;
 21. rendered on an unproven, research basis when not generally accepted medical or dental practice;
 22. not actually rendered;
 23. for any services or supplies furnished to an individual prior to the date coverage became effective for such individual or subsequent to termination of the individual's coverage under this Plan, except as provided in any subsection of this Plan;
 24. rendered by a member of your family or close relative, including a person related by blood or marriage;
 25. not specifically listed as a Covered Dental Expense;
 26. the result of travel outside the United States or its territories specifically to receive medical or dental treatment; however, the Plan does provide benefits for you and your Covered Dependents for covered medical treatment which you receive while traveling outside the United States on a trip whose purpose is other than specifically to receive medical care;
 27. filed later than twelve (12) months from the date the expense was incurred;
 28. the result of:
 - a. mandibular or maxillofacial surgery to correct growth defects, jaw disproportion's or malocclusions, except for correction of a congenital anomaly in a child who was covered under this Plan from birth, or
 - b. appliances or restorations used solely to increase vertical dimension, reconstruct occlusion or correct or treat dysfunction pain syndromes to include temporomandibular joint (TMJ) dysfunction, or
 - c. Hospital confinements for the treatment or correction of any conditions excluded in a. or b. above.
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