

CITY OF CARLSBAD

Benefit Summary - Dental Plan

Benefits effective: August 1, 2021 through July 31, 2022

*****Benefit verification is not a guarantee of payment or eligibility. Benefits will be considered based upon eligibility and plan document provisions once the claim is received.**

Claims should be mailed to:

90 Degree Benefits

PO Box 21548

Eagan, MN 55121

All claims must be filed within 365 days from the date of service.

Or sent via EDI to CAPHP

Schedule of Dental Benefits

The following Deductibles, maximums and benefits are per Participant, per Plan Year, unless otherwise indicated.

SCHEDULE OF DENTAL BENEFITS	
PLAN YEAR DEDUCTIBLE	
The Deductible amount is combined for Medical and Dental benefits. The Tier 2 Plan Year Deductible, noted below, must be satisfied before benefit payments are made. <i>(See also, page 13 for Deductible information.)</i>	
• Per Individual	\$50 (effective 1/1/2022)
• Per Family Unit	\$150 (effective 1/1/2022)
DENTAL BENEFITS	MAXIMUM
○ Class I - Preventive Care	Unlimited <i>(Routine oral examinations and cleanings are limited to twice per Plan Year. See next page, Preventive Care, for further limitations that may apply to these services.)</i>
○ Class II - Basic Services	\$1,500 per Plan Year
○ Class III - Major Services	<i>(combined maximum)</i>
○ Class IV - Orthodontic Services	\$1,700 per Lifetime
BENEFIT	BENEFIT PERCENTAGE – ALL PROVIDERS <i>(What the Plan Pays)</i>
○ Class I - Preventive Care	100% <i>(Deductible waived)</i>
○ Class II – Basic Services	80% <i>(after Deductible)</i>
○ Class III - Major Services	80% <i>(after Deductible)</i>
○ Class IV – Orthodontic Services	50% <i>(after Deductible)</i>

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Plan Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and exclusions set forth in this Article. Covered Expenses Incurred by any Participant and Family Unit in the last three months of any Plan Year which are applied to satisfy the Deductible for that Plan Year/Calendar Year may also be used toward satisfaction of the Deductible in the next Plan Year.

Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Schedule of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary Fees.

Class I Services (Preventive Care)

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than two times per Plan Year;
2. Periapical x-rays, as required, and bitewing x rays not more than two times per Plan Year;
3. Full mouth x rays, but not more than once in a 3 year period;
4. Panoramic x rays, but not more than once in a 3 year period;
5. Sealants for Dependent Children up to age 18, but not more than once in any period of 3 years; and
6. Topical application of fluoride for Dependent Children under age 19, but not more than once per Plan Year.

Class 2 Services (Basic)

1. All Medically Necessary x-rays;
2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore Diseased or accidentally broken teeth. Gold foil restorations are not eligible;
3. Simple extractions;
4. Extraction of one or more teeth;
5. Cutting procedures in the mouth;
6. Dislocations of the jaw, but not including additional charges for removal of stitches or post-operative examinations;
7. Treatment of the gums and supporting structure of the teeth including osseous surgery, gingivectomies, grafts, scaling and root planning;
8. Injectable antibiotics administered by a dentist;
9. Medicines legally obtainable only upon written prescription by a dentist;
10. Nitrous oxide only for an individual who has not attained age seven (7);
11. Laboratory examinations and tests;
12. Endodontics, including pulpotomy, direct pulp capping and root canal treatment;
13. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant;
14. Periodontal examinations, treatment and surgery;
15. Consultations;
16. Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age 19. No payment will be made for duplicate space maintainers; and
17. Palliative Emergency treatment of an acute condition requiring immediate care.

Class 3 Services (Major Dental Repair)

Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 6 months, unless otherwise required by applicable law.

1. Gold fillings (including inlays and onlays) and crowns necessary to restore the structure of teeth broken down by decay or injury, except that: (1) the benefit for a crown or gold filling will be limited to the charge for a silver, porcelain, or other filling unless the tooth cannot be restored with such other material; and (2) the replacement of a crown or gold filling is covered only if the crown or filling is over five (5) years old;
2. Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures;
3. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
 - a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
 - b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 6 months;
4. Re-lines;
5. Post and core;
6. Stainless steel crowns.

Class 4 Services (Orthodontics)

Orthodontic services will be eligible for all Participants.

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan;
2. Interceptive, interventive or preventive orthodontic services;
3. Fixed and removable appliance placement, and active treatment per month after the first month; and
4. Extractions in connection with orthodontic services.

The following exclusions and limitations are in addition to those set forth in the Articles entitled "General Limitations and Exclusions," and "Schedule of Benefits."

Adjustments. Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint.

Administrative Costs. For administrative costs of completing claim forms or reports or for providing dental records.

After the Termination Date. The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses Incurred for the following procedures will be payable as though the coverage had continued in force:

- a. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Participant in the Plan, and delivers and installs the device within two months following termination of coverage;
- b. A crown, if the Dentist prepared the tooth for the crown while the patient was a Participant in the Plan, and installs the crown within two months following termination of coverage; and
- c. Root canal therapy if the Dentist opened the tooth while the patient was a Participant in the Plan, and completes the treatment within two months following termination of coverage.

Athletic Mouth guards.

Broken Appointments. For charges for broken or missed dental appointments.

Cosmetic. Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations. This exclusion will not apply to cosmetic work needed as a result of Accidental Injuries, but damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered Orthodontic Treatment.

Education. Charges for instruction in oral hygiene, plaque control or diet.

Excess Charges. Charges in excess of the Reasonable Charge for the service or supply received or charges in excess of any maximum payable under this Plan.

Experimental. Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association.

Government Provided. Charges for dental care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the Employee or Dependent is legally required to pay.

Hygiene. For oral hygiene, plaque control programs or dietary instructions.

Immediate Relative. Services rendered by a person who is an immediate relative of, or who ordinarily resides with, the Participant requiring treatment. "Immediate relative" means spouse, Child, brother, sister or parent of the Participant, whether by birth, adoption or marriage.

Implants. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants except, first-time non-cosmetic dental implants.

Late Enrollee. Charges for crowns, bridgework, dentures, periodontics and orthodontics Incurred during the first 24 months of coverage for a Late Enrollee, unless such services and supplies are needed as a result of Accidental Injury sustained by the Participant. (Damage resulting from biting or chewing is not considered an Accidental Injury.) "Late enrollee" means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period.

Miscellaneous. The Plan does not cover any charge, service or supply which is:

1. For treatment other than by a Dentist or Physician, except:
 - a. Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and
 - b. Non-Experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services.
2. For local infiltration anesthetic when billed for separately by a Dentist;
3. For oral hygiene or dietary instruction;
4. For a plaque control program (a series of instructions on the care of the teeth);
5. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;
6. For periodontal splinting;
7. For consultations or charges for completion of a claim form;
8. For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;
9. Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;
10. Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured;
11. Covered under the "Medical Benefits" Article of the Plan; and
12. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Missing Appliances. Charges for replacement of lost, missing or stolen appliances or prosthetic devices.

More Expensive Course of Treatment. In all cases involving covered services in which the Provider and the Participant select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, coverage under the Plan will be based upon the charge allowed for the lesser procedure.

Myofunctional Therapy.

No Coverage. Services or supplies for which charges are Incurred at a time when no coverage is in force for that person, or for which charges are Incurred while coverage is in force, but final delivery is made more than 3 months after the date coverage for that person terminated.

No Legal Obligation. Charges for which the person has no legal obligation to pay, or for which no charge would be made in the absence of a treatment plan.

No Listing. For services which are not included in the list of covered dental services.

Not Necessary. Charges for unnecessary care, treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability.

Not Recommended. Charges for services or supplies which are not recommended and approved by a Dentist or Physician.

Occupational. Charges for dental care which results from any employment, if covered to any extent by workers' compensation or similar law.

Orthognathic Surgery. For Surgery to correct malpositions in the bones of the jaw.

Personalization. For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.

Self-inflicted. Charges for care, treatment, services and supplies needed as a result of intentionally self-inflicted Injury or Sickness. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Single Provider Care. In the event a Participant transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan shall consider only such expense as would be appropriate had a single Provider performed the service. An appropriate expense in this case will be the Usual and Customary Fee.

Splinting. For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

War/Riot. Charges for services or supplies needed as a result of war, declared or undeclared, or any act of war or act of aggression by any country; or voluntary participation in a riot.

Pre-determination of Dental Benefits

If a Participant's proposed course of treatment reasonably can be expected to involve dental charges of \$300 or more, a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment.

However, approval is not required prior to treatment. Any pre determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Plan Administrator or Third Party Administrator will notify the Employee, and the Dentist or Physician, of the pre determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post service claim, which will be subject to all applicable Plan provisions.**