



***Your Guide to Benefits***

# **CITY OF BERKLEY**

**Group Dental and Vision Plans**

**Administered By  
ADN Administrators, Inc.**

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## ***WELCOME***

Welcome to the ADN Dental Network.

The City of Berkley has chosen to participate in the ADN Dental Network PPO Program to help minimize out-of-pocket dental costs. In addition, utilization of a PPO dental program will substantially reduce overall dental benefit costs. The following information is intended to help you better understand the network and how you may benefit through your usage of it.

ADN is a national dental PPO network which is constantly growing through the addition of the dental providers used by the employees of each group that use the Network.

### **YOU DO NOT HAVE TO CHANGE FROM YOUR CURRENT DENTIST**

However, usage of a Participating Provider means that the dentist will accept the PPO fee over his/her own charges. If your dentist is not an ADN 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 ADN Participating Provider in your area by accessing the ADN web site [www.adndental.com](http://www.adndental.com). then go to “Provider Search”. Since your group has access to both ADN and MDP Providers, you may choose from providers under both sections 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: City of Berkley Dental and Vision Plans
2. Name, address and telephone number of the Plan Sponsor:

City of Berkley, City Manager  
3338 Coolidge Highway  
Berkley, Michigan 48072  
(248) 658-3350

The Plan Sponsor has the exclusive and absolute discretion for final interpretation of the Plan in accordance with its terms.

3. Type of plan: Group Dental and Vision Benefit Plans
4. Dental Plan Administrator: ADN Administrators, Inc.
5. The Plan Administrator has the discretion to interpret and administer the Plan in accordance with its terms and may delegate all or any part of its authority to other persons or parties. 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 November 1<sup>st</sup>.
8. Dental and Vision Plan Group Number: 9479

## THE PLANS AT A GLANCE

### Effective Date of Plan

This plan became effective on July 1, 2005.

### Dental Plan Structures

City of Berkley Dental Plan consists of various levels of dental coverage based upon the employee group. Dental procedures are divided into types of service or classes. The amount payable for dental treatment is determined by the employee group and class of service. The dental procedures covered under each class are explained in detail under Covered Dental Expenses.

#### Merit System

Class I - 100%

Class II - 80%

Class III - 60%

Class IV - 50%

#### DPW

Class I - 100%

Class II - 80%

Class III - 50%

Class IV - 50%

#### Public Safety Officers

Class I - 100%

Class II - 80%

Class III - 60%

Class IV - 50%

#### Public Safety Command Officers

Class I - 100%

Class II - 80%

Class III - 50%

Class IV - 50%

### Maximum Benefit Allowances

Annual Maximum Benefit - All Employees

\$1,500 per benefit year for Class I, II and III dental services combined

Lifetime Orthodontic Maximum - By Employee Groups

Orthodontic Maximum per employee group as follows:

Merit System Employees - \$500

Public Safety Officers - \$600

DPW Employees - \$1000

Public Safety Command Officers - \$600

The orthodontic maximum applies per each eligible patient's lifetime for Class IV orthodontic services.

## **HOW AND WHEN COVERAGE TAKES EFFECT**

An eligible employee may enroll him/herself and eligible dependents in the Dental and Vision Benefit Plans. Coverage begins on the first day of work. An employee is considered eligible as follows:

1. An employee eligible under a collective bargaining agreement with the City of Berkeley; or
2. An employee eligible under the Merit System of Personnel Management; or
3. As indicated by a resolution adopted by the City Council.

An employee who does not meet the definition of Actively at Work on the date of eligibility, will not receive coverage until able to report to work.

## **ELIGIBLE DEPENDENTS**

An eligible dependent is:

1. An eligible employee's lawful spouse
2. An eligible employee's unmarried dependent children under age 19. See "Continuation of Coverage" later in this document. Eligible dependent children may include stepchildren who reside with the employee; legally adopted children; and children over whom the employee maintains legal guardianship and provided they are dependent upon the employee for support and maintenance.
3. An eligible employee's unmarried dependent children age 19 and over who are dependant upon the employee for support and maintenance and are full time students in an educational institution. In addition, the eligible dependent must be under age 25 (See "Continuation of Plan Benefits" later in this document).

An otherwise eligible dependent (except a newborn child) confined for medical care or treatment in any institution or at home when coverage would normally start, will not be covered until given a final release from that confinement by the treating Physician.

A dependent child who is physically or mentally incapable of self-support upon attaining age 19 may be continued under this Plan while remaining incapacitated and unmarried, subject to the eligibility of the employee. Proof of incapacity must be received by the Plan Sponsor

No dependent child will be eligible while covered by another benefit plan as an Employee or while in the Military Service.

The dental and vision plans' 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.

## **WHEN COVERAGE TERMINATES**

Coverage for employee and eligible dependents will end:

1. On the date of termination of the Plan; or
2. The day following the date the covered person no longer meets the eligibility requirements; or
3. The day following the date of termination of employment.

The dental and vision plans' termination 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 and vision coverage terminates at the earliest time shown below:

1. On the date of termination of the Plan; or
2. When he/she ceases to be a dependent as defined by the plan sponsor; or
3. When the Employee's coverage terminates.

Continuation of dental and vision plan coverage lost due to the above events may be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provisions.

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

## **CONTINUATION OF PLAN BENEFITS**

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

The administration of all criteria for continuation of benefits 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 continuation 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 and/or MDP to accept the PPO amount allowed by either as payment in full for dental treatment or services.

#### Fee Charged

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

#### Reasonable and Customary Fee

The amount charged by a dentist for a dental treatment or service that is reasonable and justifiable considering any special circumstances of a particular treatment. In addition, it is the fee that is customarily charged for the same service by dentists of similar training and experience within the same specific geographical area or region.

#### 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 an eligible patient under the plan.

#### Benefit Year

The dental plan annual benefit period, which is renewable November 1, of each year.

## DENTAL PLAN BENEFITS

### Definitions

#### Covered Dental Services

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

#### 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 annual maximum benefit remainders.

#### 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 most economical treatment that will produce a reasonably favorable prognosis and result.

#### Copayment

The amount 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) 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 is contingent upon continued eligibility, plan limitations and available annual or lifetime maximum benefits at the time the service 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 Services:

Oral Examinations; Single Periapical and Bitewing Radiographs; Full-Mouth Series or Panoramic Radiographs.

2. Preventive Services:

Prophylaxes or Periodontal Maintenance (cleanings); Topical Application of Fluoride; Sealant Application; Space Maintainers and Minor Emergency non-curative Treatment for relief of pain.

### Class II Benefits

1. Restorative Services:

Amalgam and Composite Resin Restorations (fillings); Pin Retention; Stainless Steel and Resin Crowns; Crown Build-up, Post-Cores; Inlays, Onlays, Permanent Crowns; Recementations; Denture Relines, Rebases, Denture Repairs and Adjustments.

2. Endodontic Services:

Root Canal Therapy; Therapeutic Pulpotomy; Apicoectomy; Hemisection and Root Amputation.

3. Periodontic Services:

Additional Periodontal Maintenance Procedures (see Dental Plan Limitations); Root Planing; Osseous Surgery; Soft 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.

**\*\*Note: Orthodontic related oral surgery covered at Orthodontic Benefit Level and from Orthodontic Lifetime Maximum.**

5. Adjunctive General Services:

Therapeutic Drugs (limited); Occlusal Guards; Occlusal Adjustment; General

## **Covered Dental Expenses (Cont'd)**

Anesthesia and IV Sedation (in conjunction with certain covered oral surgery).

### 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).

### Class IV Benefits

1. Orthodontic Diagnostic Procedures, Related Oral Surgery Procedures and Extractions.

2. Interceptive and Comprehensive Orthodontic Treatment and Appliances (braces); Functional and Myofunctional Therapy in conjunction with Appliance Therapy.

3. Harmful Habit Control Appliances.

Orthodontic treatment is the corrective movement of teeth by means of an active appliance and/or therapy to effect a predetermined result.

## Dental Plan Limitations

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

1. Benefits for Oral Examinations, Prophylaxes (cleanings) and/or Periodontal Maintenance Procedures are payable twice in each benefit year (two additional Periodontal Maintenance Procedures may be allowable per benefit year for established Periodontal patients).
2. Benefits for Bitewing X-rays are payable twice in each benefit year.
3. Benefits for a Full Mouth Series (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 Series of X-rays and is payable accordingly and subject to the sixty-month time limitation.
4. Benefits for Topical Application of Fluoride are payable once in each benefit year for patients under 19 years of age.
5. Sealant Application is payable once in a thirty-six month period for permanent molar teeth; for patients under age 14.
6. Benefits for Space Maintainers necessitated by pre-maturely lost primary posterior teeth are payable once per affected area for patients under age 19. Allowance includes all adjustments within six months of insertion.
7. Benefits for Amalgam and Composite Resin restorations are payable once per tooth, per surface in any twelve-month period. Multiple restorations on a surface are considered a single restoration. Composite Resin restorations for posterior teeth are not covered benefits; an allowance will be made for amalgam materials.
8. Benefits for 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 for posterior teeth are not covered. Benefits will be allowed for the corresponding metal restoration.
9. Benefits for Substructures, Porcelain and Cast Restorations are not payable for patients under 12 years of age.
10. Benefits for Stainless Steel and Resin Crowns are payable for patients under age 19 and once in any thirty-six month period.
11. Benefits for Periodontal Root Planing are payable once in any twenty-four month period per quadrant of the dental arch.
12. Benefits for Periodontal Surgery procedures are payable once in any thirty-six month period per quadrant of the dental arch.

## Dental Plan Limitations (Cont'd)

### 13. Miscellaneous Adjunctive Services:

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

Benefits for General Anesthesia and IV Sedation are payable in conjunction with covered oral surgery procedures.

Benefits for Emergency Palliative Treatment are payable for non-curative minor services rendered to temporarily alleviate pain. Appropriate benefits will be considered for definitive treatment submitted as Palliative Treatment.

### 14. Prosthodontic (Class III) benefit limitations:

Benefits for a Complete Denture to replace missing functional natural teeth are payable once per arch in any five-year period.

Benefits for Removable Partial Dentures to replace missing functional natural teeth are payable once per arch in any five-year period.

Benefits for Fixed Partial Dentures to replace missing functional natural teeth are payable once in any five-year period.

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

Any allowance includes all adjustments within six months of delivery or insertion.

### 15. Benefits for Reline or Rebase (complete replacement of denture base material) are 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:

Orthodontic benefits are limited to Covered Dependent children under 19 years of age.

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

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.

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.

## **Dental Plan Limitations (Cont'd)**

17. 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.

18. Alternate Benefit Allowance:

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

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

When a more economical treatment would produce a professionally satisfactory result.

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

## **General Exclusions**

The City of Berkley Dental Plan does not include benefits for the following treatment or services. The patient will be responsible for any and all charges related to these services.

1. Replacement of Occlusal Guards and their repair, reline or adjustment.
2. Restorations or appliances determined to be rendered for cosmetic or aesthetic purposes including laminate veneers and personalization or characterization of dentures.
3. Appliances, restorations or services for the diagnosis and/or treatment of the Temporomandibular Joint; Temporomandibular Joint Dysfunction (TMJ/TMD).
4. Dental procedures or services necessary for the diagnosis or treatment of dental illness, accidental injury or otherwise considered medical.
5. Overdentures and related appliances, restorations, root canals and/or other services.
6. Lost, missing or stolen prosthesis or appliances of any type.
7. Repair or replacement of orthodontic appliances.
8. Porcelain overlays or composite resin fillings for teeth posterior to the second bicuspid. An allowance will be considered for full cast gold or amalgam materials accordingly.
9. Treatment or services that are determined not necessary and/or customary as generally accepted standards of dental practice, those specialized technique, for which no valid dental need is demonstrated, or that are experimental in nature.

### **General Exclusions (Cont'd)**

10. Treatment or services for restoring occlusion, increasing vertical dimension, for replacing tooth structure lost due to attrition, abrasion or erosion.
11. Appliances, restorations or services for the correction of congenital or developmental malformations.
12. Treatment or services that are temporary and/or considered to be an integral component of a final dental treatment or service.
13. Restorations, appliances or surgical procedures related to implantology techniques.
14. Treatment or services started before the patient became eligible under this plan.
15. Prescription drugs, laboratory tests and/or examinations, pre-medications, analgesia, general anesthesia and/or intravenous sedation in conjunction with restorative procedures or surgical services unless medically necessary, preventive control or educational programs including home care items.
16. Personal care supplies or equipment, including but not limited to water piks, toothbrushes, flosses, fluoride gels, mouth rinses and other interdental supplies.
17. Charges for missed appointments, completion of claim forms or submission of supporting documentation required for claim review.
18. Any treatment or services that are not within the classes of dental benefits as defined in the plan.
19. Treatment or services that are covered under a hospital, surgical/medical or prescription drug program.
20. Hospital, laboratory, emergency room or facility charges and related equipment or supplies.
21. 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.
22. 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.
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.

## **Alternative Benefit Allowance**

In all cases where there are more than one method of dental treatment or service that may be appropriately provided to treat a dental condition, benefits may be limited. 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.

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 only the difference between the network allowed amount for the filling and the network allowed amount for the crown.

## **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 offer 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:

## **Coordination of Benefits (Cont'd)**

- 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.
  - 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**

In the event that 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.

If eligibility is lost due to a death, the plan will pay for the covered services begun prior to the date of death as if the proposed treatment had been completed.

## **CLAIM SUBMISSION PROCEDURE**

### **How to File a Claim**

The City of Berkley Dental Plan allows benefits for covered treatment rendered by a licensed dentist whether or not he/she is a participant with the ADN or MDP Networks.

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

However, if the dentist participates, the patient may have a smaller out-of-pocket expense. The ADN or MDP Network fee amount will be accepted as charge and the

## How to file a Claim (Cont'd)

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 City of Berkley 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. Completion date of service, ADA Current Dental Terminology (CDT) dental procedure code, tooth identification (number or letter), dental quadrant or arch and fee for each service rendered.
5. All pertinent supporting documentation, radiographs, photographs, charting and lab reports necessary for benefit determination.
6. Signatures of the patient (or parent if 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.** This includes, but is not limited to supporting radiographs, photographs, charts, lab reports, written documentation, etc.

Once the claim is processed, approved benefit payment will be sent to the dentist, as long as benefits are assigned. An explanation of benefits (EOB) is sent to the employee. Otherwise, approved benefit payment is issued directly to the employee. All supporting documentation (radiographs, models, photographs, etc.) received with the claim will be returned to the sender.

The City of Berkley Dental Plan will not honor claims and no 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

The City of Berkley and ADN Administrators strongly recommend predetermination of benefits prior to any treatment when proposed procedures exceed \$200. This process

## **Predetermination of Benefits (Cont'd)**

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 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 notice of 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 neither guarantees payment nor reserves 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 treatment 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 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 - Appeal  
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

## **Appeal of Denied Benefits (Cont'd)**

denial of benefits is overturned in full or part, the claim will be reprocessed for the approved payment and the patient will receive a new explanation of benefits.

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.

## **VISION CARE BENEFITS**

The City of Berkley Vision Care Benefit Plan provides coverage for vision examinations and corrective prescription eyeglasses and contact lenses. Benefits are payable for the following basic services as follows:

Coverage Includes: Vision Examinations, Frames, Eyeglass and Contact Lenses. \*\*Effective 07/01/09 LASIK, LASEK and PRK laser surgery included for Active Duty Public Safety Command Officers only.

Vision Benefits are limited by a maximum benefit amount for a consecutive 24-month period by employee group as follows:

Merit System Employees	\$450 per 24-month period
DPW	\$450 per 24-month period
Public Safety Officers	\$300 per 24-month period
Public Safety Command Officers	\$350 per 24-month period

## **Time Limitations**

Necessary corrective vision care services are covered during the benefit period. Coverage may be allowed for eyeglasses, contact lenses, and where eligible, laser surgery for covered employee members not to exceed the maximum benefit in the twenty-four consecutive month period. The twenty-four month period is measured from the last date vision services were rendered.

## **Covered Vision Services**

Vision benefits include coverage for the following services:

### Diagnostic Services

Visual acuity tests  
External eye examination  
Tonometry (glaucoma testing)  
Binocular Measure  
Ophthalmoscope  
Patient history.

## **Covered Vision Services (Cont'd)**

### Corrective Treatment

Contact Lenses	Hard, Soft or Extended Wear; Single or Bi-focal vision
Eyeglass Lenses	Single, Bi-focal, Tri-focal and Progressive Lenses
Eyeglass Frames	Wire, plastic or metal frames – standard size to fit standard lenses
Laser Surgery	LASIK, LASEK and PRK surgery for covered employee groups (Active Duty PSCO)

### **Vision Plan Exclusions**

The City of Berkley vision care plan does not cover and no benefits are payable for additional charges for the following services:

1. Eyeglass or Contact Lens Tints;
2. Orthoptics or Vision Training, Subnormal Vision Aids, Aniseikonic Lenses or Tonography;
3. Cosmetic lenses or processes, Non-Prescription lenses or services not intended to improve vision;
4. Eye examinations required by an employer as a condition of employment;
5. Medical or Surgical treatment of the eyes, except covered laser surgery for active PSC officers;
6. Medications administered during any service except during and included in an eye examination;
7. Services not prescribed by an ophthalmologist or optometrist; or rendered by persons not legally qualified or licensed to provide such services;
8. Services available at no cost or for which no charge would be made in the absence of vision care coverage;
9. Charges for missed or broken appointments, completion of insurance claim forms or submission of supporting documentation;
10. Care, Services, Supplies or Devices that are of a personal or convenience nature;
10. Services or materials ordered or provided before the effective date of coverage or during the period of eligibility but delivered more than 60 days after coverage terminates;

### **Vision Plan Exclusions (Cont'd)**

11. Treatment of work-related injuries covered by workers' compensation laws or for work-related services received through a medical clinic or similar facility provided or maintained by an employer;
12. Services payable by federal, state or other municipal government sponsored health care programs;
13. Services received as a result of disease, defect or injury due to an act of war, declared or undeclared.

### **Additional Vision Services**

The City of Berkley Vision Care Benefit Plan includes coverage for prescription safety eyeglasses payable under following guidelines:

1. Benefits must be pre-approved by the City of Berkley whose written authorization must accompany all claims for benefit payment.
2. Prescription Safety Glasses are payable for employee only; no coverage for spouse and/or dependent children.
3. Benefits are limited to one pair of prescription safety glasses per year.