Your Guide to Dental and Vision Benefits

CITY OF BERKLEY

Group Benefit Plan

Administered By
ADN Administrators, Inc.

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WELCOME!

Welcome to the City of Berkley Dental and Vision Benefit Plans.

City of Berkley has chosen to self-fund its dental and vision plans to help minimize benefit costs. In addition, ADN Administrators has been contracted to provide the dental and vision plan administration. The selection of ADN Administrators affords access to two dental PPO Networks; ADN Dental Network and DenteMax Network of Providers.

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

The City of Berkley Dental and Vision Plans allow freedom of choice; you may receive treatment from any licensed dentist or dental specialist for dental treatment and optometrist or ophthalmologist for vision services. 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 and DenteMax 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: City of Berkley Dental and Vision Plans

2. Plan Sponsor's contact information:

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

3. Type of Plan: Group Benefit Plans

4. Plan Administrator: ADN Administrators, Inc.

5. Plan Administrator's contact information:

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

6. The Plan Year begins each November 1st

7. Plan Group Number: 9479

THE PLAN AT A GLANCE

Effective Date of Plan

This plan became effective on July 1, 2005

Dental Plan Structures

The City of Berkley Dental Plan consists of various levels of dental coverage based upon the type of treatment. Benefits are payable at the applicable percentage level of the Usual and Customary allowed amount or PPO Fee Schedule allowed amount for the procedure rendered. The types of dental treatment are indicated by classes, which are explained in detail under Covered Dental Expenses.

Please refer to your plan summary (The Plan at-a-Glance) for the classes and benefit levels of your plan's coverage. If you do not have your plan summary, please contact your Benefit Department for a copy.

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

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

DENTAL/VISION PLAN BENEFITS

Definitions

Plan

This dental and vision benefit plans 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 DenteMax Networks to accept the PPO allowed amount paid by either plan and/or patient as payment in full for dental treatment or services.

Optometrist

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

Ophthalmologist

A licensed medical doctor specializing in the structure, function and treatment for diseases of the eye.

Charge

The amount charged by a dental or vision provider for a given 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 or lifetime maximum benefit.

Covered Vision Services

Those vision care services selected by your plan to be considered as covered contingent upon current eligibility and plan limitations.

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 or lifetime 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 amount for the most economical treatment that will produce a reasonably favorable prognosis and result.

Copayment

The percentage of a covered dental treatment or vision 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 plan 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.**

<u>Class I Benefits</u>

1. Diagnostic and Preventive Services:

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

<u>Class II Benefits</u>

1. Restorative Services:

   Amalgam and Composite Resin restorations (fillings), Prefabricated 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:

   Additional Periodontal Maintenance Procedures (see Dental Plan Limitations), 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. **Note: Orthodontic related Oral Surgery covered at Orthodontic Benefit Level and counts against Orthodontic Lifetime Maximum.

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).

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 related Oral Surgery Procedures and Extractions.

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:

> Allowance for an initial banding fee will be an amount equal to 25% of the total allowed amount and payable at the orthodontic benefit level.
>
> The balance of the total allowed amount will be paid at the appropriate benefit level in equal installments over the number of months of treatment until either the estimated months of treatment or the lifetime maximum benefit amount has been reached.

Dental Plan Limitations

Unless stated below, the benefit level, frequencies and/or age limits for these services are listed on your Plan Summary:

1. Oral Examinations, Cleanings (Prophylaxis or Periodontal maintenance)

2. Bitewing X-rays.

3. Full-Mouth (which include bitewings) or Panoramic X-rays. A Panoramic X-ray in addition to Bitewing X-rays is considered a Full Mouth X-ray.

4. Topical Application of Fluoride.

5. Space Maintainers necessitated by pre-maturely lost primary posterior teeth. Allowance includes all adjustments within six months of insertion.

6. Sealant Application for permanent molar teeth.

7. Amalgam and Composite Resin restorations. 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.

8. Porcelain and Cast Restorations (Crowns), Inlays, Onlays and Substructures for restoration of functional natural teeth. Porcelain overlays posterior to the second bicuspid are considered cosmetic. An allowance may be made for the corresponding cast metal restoration.

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

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

11. Stainless Steel and Resin Crowns are payable for primary teeth on patients under age 19 and once in any thirty-six month period. Resin for posterior teeth is considered cosmetic and alternate benefit applies.

12. Periodontal Maintenance procedures (following active treatment) and Periodontal Root Planing is payable for periodontally compromised patients. First and Second Periodontal Maintenance occurrences are covered at the Class I benefit level. Second and Third occurrences are covered at the Class II benefit level.

13. Periodontal Surgery procedures for periodontally compromised patients.

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.

16. General Anesthesia and IV Sedation are payable in conjunction with certain covered oral surgery procedures unless medically necessary.

Dental Plan Limitations (continued)

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 on delivery date of the appliance.

19. Removable Partial Dentures to replace missing functional natural teeth are payable on delivery date of the appliance. An exception may be allowable in the event that 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 on delivery date of the appliance. 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. Removable Cast Complete or Partial Dentures and Fixed Partial Dentures are not payable for patients under 16 years of age.

22. 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.

23. Reline or Rebase (complete replacement of denture base material) is payable more than six months following delivery of the appliance.

24. Tissue Conditioning is payable once in any thirty-six month period and more than twelve months following delivery or insertion of the appliance.

25. Orthodontic (Class IV) benefit limitations:

    a. 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.

    b. 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.

    c. 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.

    d. 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 (continued)

26. Benefits for certain interrupted treatment or services may be considered at the discretion of the plan 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 City of Berkley Dental Plan does not include benefits for the following treatment or services. The patient will assume responsibility for any and all payments related to these services.

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

2. 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.

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

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

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

6. Porcelain restorations or composite resin fillings for teeth posterior to the second bicuspid. An allowance will be considered for corresponding cast metal or amalgam materials.

7. Repair or replacement of orthodontic appliances.

8. 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.

9. 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.

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

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

12. Appliances (fixed or removable), surgical procedures or restorations related to implantology techniques, except as limited by the Class III provision, terms and conditions.

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

14. Benefits for Oral Surgery procedures that are also covered on the City of Berkley Medical/Master Medical benefit plans, if any, are payable following the medical plan determination.

Dental Plan Exclusions (continued)

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

16. 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.

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 limitations or 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 rendered by an immediate family member of the patient.

24. 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.

25. 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.

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 PPO allowed amount for the filling and the PPO allowed amount 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 amount 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 amount 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/or dental care expenses of the child.

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

Coordination of Benefits (continued)

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.

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 plan 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 City of Berkley Dental Benefit Plan allows benefits for covered treatment rendered by a licensed dentist whether or not he/she is a participant with the ADN or DenteMax Networks of Providers. The vision plan does not utilize any Networks and covered patients may be treated by any licensed optician or ophthalmologist.

If your dentist does not participate with any listed PPO network, payment for covered dental treatment will be based on the appropriate benefit level (percentage) of the Usual and 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 or DenteMax PPO allowed amount will be accepted as the allowed amount and the patient's responsibility will be only the difference between the plan payment and the PPO allowed amount, if any.

When you visit your dental or vision provider's office, notify them of your City of Berkley 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 and a vision provider may use either ADN vision claim forms or standard American Medical Association (AMA) HCFA claim forms. 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 benefit plan group number.

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

5. For Dental Claims:

   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.

   For Vision Claims:

   Completion date of service, AMA Current Procedural Terminology (CPT) vision procedure codes, Diagnostic Codes (ICD-9) and fee for each service provided.

   If submitting your own vision claims, obtain an itemized statement from the vision provider's office including provider name and address, attach a

copy to a completely filled out ADN Vision Claim Form. **If you have already paid the provider and wish to be reimbursed directly, PLEASE DO NOT SIGN THE SECOND SIGNATURE LINE AUTHORIZING BENEFITS TO THE PROVIDER. Doing so will result in payment being issued to the provider.** Submit to ADN at the address on the claim form.

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 provider 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 or vision care provider, as long as benefits are assigned. An explanation of benefits (EOB) is made available to the employee. Otherwise, approved benefit payment is issued directly to the employee.

The City of Berkley 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 Dental Benefits

ADN Administrators strongly recommends predetermination of dental benefits prior to any treatment when proposed procedures exceed $250. This process allows the plan 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 plan 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.

Predetermination of Dental Benefits (continued)

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

Before following the appeal procedure, either the provider 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 an 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 plan administrator as follows:

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

The plan 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.

VISION PLAN BENEFITS

The City of Berkley vision benefits plan provides coverage for vision examination and corrective prescription vision devices as outlined below. Benefits are payable for the allowable charges of covered services up to the twenty-four month benefit period maximum.

Please refer to your plan summary (The Plan-at-a-Glance) for the benefits levels of your plan's coverage. If you do not have your plan summary, contact your Benefit Department for a copy.

Vision Benefit Plan Period

Twenty-four consecutive month period from date benefits were first utilized

Covered Vision Services

Vision Diagnostic Services

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

Prescription Eyeglass Lenses

Single vision
Bifocal
Trifocal
Progressive

Eyeglass Frames

Wire, Plastic or Metal

Contact Lenses

Hard, Soft, Disposable and Extended Wear Single or Bifocal vision lenses

Extra Prescription Lens Features

Photochromic (Transition)
Polycarbonate
Polarization
Oversize and Blended Lenses
Coatings (Anti-Reflective, Ultra Violet, Scratch Resistant)

Laser surgery

LASIK, LASEK and PRK
Limited to Active Duty PSCO Officers

*All Benefits payable are based upon Reasonable & Customary (R&C) Allowed Amounts

Vision Benefit Limitations

1. Benefits for contact lenses include prescription and fitting charges.

2. 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.

3. Benefits for vision services may be adjusted for Coordination of Benefits (COB) when the patient is covered by a primary vision benefit plan. Benefits are coordinated and may not be used separately. COB may not exceed the maximum benefit level under either vision plan or the charge for the service.

Vision Benefit Exclusions

City of Berkley Vision Plan Benefits is not payable and coverage is not provided for services rendered as follows:

1. Cosmetic lenses or processes such as, but not limited to colored tints and non-corrective colored contact lenses.

2. Orthoptics, Vision Training or Therapy, Subnormal Vision Aids, Aniseikonic Lenses, Tonography or photographs of the eye.

3. Non-Prescription Lenses of any type, or services not intended to improve or correct vision.

4. Any Services or treatment not specifically listed on this plan as a covered Vision Care Benefit.

5. Eye examinations required by an employer as a condition of employment.

6. Medical or Surgical diagnostic services or treatment of the eyes, except PRK, LASEK or LASIK Surgery for Active Duty Public Safety Command Officers.

7. Medications administered during any service except during and included in a routine vision examination.

8. Services not prescribed by an ophthalmologist or optometrist; or rendered by persons not legally qualified or licensed to provide such services.

9. Services or supplies available at no cost; or for which the patient is not required to pay; or for which no charge would be made in the absence of vision care coverage.

10. Charges for missed or broken appointments, completion of insurance claim forms or for submission of supporting documentation for benefit determination.

11. Care, Services, Supplies or Devices that are of a personal or convenience nature, including but not limited to clip-on sunglasses, eyeglass cleaning kits, eyeglass carrying cases or warranty replacement plans.

12. Services or Materials ordered or provided before the effective date of coverage, during a period of ineligibility or began during a period of eligibility but delivered more than 30 days after coverage terminates.

13. Treatment of work-related injuries covered by workers' compensation laws or due to injury arising out of or in the course of employment or for work-related services received through a medical clinic or similar facility provided or maintained by an employer.

14. Services payable by Federal, State or other Municipal government sponsored health care programs.

15. Services received as a result of disease, defect or injury caused by military action or due to an act of war, declared or undeclared.

Vision Claim Information

The Claim submission procedures for vision services are described in **"How to File a Claim"** beginning on Page 19.

In the event that your vision care provider does not submit vision benefit claims, you or an authorized representative may submit the claim to ADN. Request an itemized statement from the provider to be attached to an ADN vision claim form and submit to the address on the claim form. If direct reimbursement of vision benefits is desired, **DO NOT** sign the authorization of benefit payment section authorizing payment to the vision provider. Your signature in this section will result in payment to the provider.

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 treatment record/charts, lab reports, written documentation, etc.

Attention must be given to the claim billing limitations of the plan as addressed under **How to File a Claim**. The Vision Benefit 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.