SCHEDULE OF DENTAL EXPENSE BENEFITS

CITY OF BROWNSVILLE

Benefits Effective: October 1, 2018

This schedule represents a summary of dental benefits. For complete details of benefits and requirements, please refer to the Dental Benefits Booklet.

Calendar Year Deductible

Preventive & Diagnostic ---------- *Waived*

Basic and Major Services

Individual ---------- $50

Family ---------- N/A

Orthodontia

Individual ---------- $0

Family ---------- N/A

Maximums

Preventive, Basic and Major Services (Calendar Year Maximum) ---------- $2,000

Orthodontia (Lifetime Maximum) ---------- $1,500

Covered Services	Benefit Level
Preventive & Diagnostic Services	100%
Basic Services	80%
Major Services	50%
Orthodontic Services	50%

Please Note

Late Entrant Limit ---------- This plan does **not** have a Late Entrant clause.

Orthodontia Age Limits ---------- Limited to Dependents under the age of nineteen (19).

DENTAL BENEFITS

For You and Your Dependents

Covered Services

Preventive & Diagnostic Covered Services

1. Oral Examinations limited to two (2) exams per calendar year
2. Prophylaxis limited to two (2) treatments per calendar year
3. Fluoride Treatments limited to children under the age of eighteen (18) and two (2) treatments in a calendar year
4. Sealants for children under the age of sixteen (16)
5. Bitewings X-Rays limited to once in a calendar year
6. Full mouth X-Ray limited to one (1) series in a sixty (60) consecutive month period, or Panoramic X-Ray limited to one (1) series in a sixty (60) consecutive month period
7. Periapical and Intraoral X-rays

Basic Covered Services

1. Emergency oral exams, palliative treatments
2. X-rays (Intraoral/Extraoral and Cephalometric (non-preventive))
3. Diagnostic casts
4. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed teeth. (Multiple restorations on the same tooth on the same day, which are billed independently of each other, will be recoded into the most appropriate procedure code as established by the American Dental Association (ADA))
5. Stainless steel crowns – primary/permanent tooth
6. Pin retention
7. Extractions – uncomplicated (single); each additional tooth; surgical removal of erupted or impacted tooth (including tissue flap and bone removal); postoperative visit (sutures and complications) after multiple extractions of impactions
8. Anesthesia – general, in conjunction with surgical procedures only; analgesia; non- intravenous and intravenous sedation
9. Endodontics treatment – (root canal treatment and pulp capping when not provided on the same day as a permanent restorative service)
10. Periodontics – treatment of periodontal and other disease of the gums and supporting structures of the mouth including but not limited to the following:
    a. Periodontal maintenance procedure limited to two (2) treatments per calendar year following active periodontal therapy
    b. Periodontal scaling and root planing – limited to no more than four (4) quadrants in twenty four (24) months
    c. Full mouth debridement
11. Oral surgery
12. Occlusal adjustment if in active periodontal treatment

Major Covered Services

1. Space Maintainers – initial appliance only for children under age sixteen (16)
2. Removable mouth guards and all appliances used to alleviate thumb sucking, tongue thrashing and bruxism
3. Repair or recementing of crowns, inlays and onlays and bridges
4. Reline and adjustments of partial and complete dentures after six (6) months.
5. Onlays/Inlays

6. Crown Build-ups
7. Crowns – Necessary replacement of crowns or laboratory fabricated restorations, only when the crown or laboratory fabricated restoration is over five (5) years old

   The following information must be provided if it is a replacement:

   a. Date of prior placement; and
   b. Reason for replacing crown.
8. Bridges-Partial Dentures – Full Dentures – Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace teeth
9. Replacement of an existing partial or full removable denture or fixed bridge; the addition of teeth to an existing partial or removable denture; or bridgework to replace teeth which were extracted if satisfactory evidence is presented to the Plan that:

   a. The replacement or addition of teeth is necessary to replace teeth extracted after the existing denture or bridgework was installed
   b. The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to the replacement date

   The following information must be provided:

   a. Initial placement – provide which teeth are being replaced
   b. Replacements – provide which teeth are being replaced and the Date of the prior placement and reason for this replacement
10. Gold restorations
11. Dental implants – benefits are available when there is no alternate form of therapy to treat the dental condition.

Orthodontic Covered Services

The Orthodontic Care benefit is only available to covered Dependent child(ren) who are less than nineteen (19) years of age. This benefit ends on the child's nineteenth (19th) birthday even if ongoing orthodontic treatment is in progress.

When all of the provisions of this Plan are satisfied, the Plan will provide benefits as outlined on the Schedule of Dental Benefits for the dental services and supplies listed in this section. This list is intended to give you a general description of orthodontic services and supplies covered by the Plan.

Subject to a lifetime deductible – only children under the age of nineteen (19) are eligible.

1. Limited Orthodontic Treatment
2. Interceptive Orthodontic Treatment
3. Comprehensive Orthodontic Treatment

Covered Services

1. Necessary services related to an active course of orthodontic treatment
2. The initial and subsequent, if any, installation of orthodontic appliances for an active course of orthodontic treatment
3. Adjustment of active orthodontic appliances

Orthodontic services shall be covered only if such services are required for:

1. Overbite/underbite or overjet/underjet of at least four (4) millimeters; or
2. Maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp; or
3. Cross bite; or
4. An arch length discrepancy of more than four (4) millimeters in either the upper or lower arch.

Orthodontic Treatment Plan

An Orthodontic Treatment Plan must be submitted to the Benefits Administrator by the dentist before dental work starts or with the initial claim for service. An estimated statement of benefits will be sent to the dentist by the Benefits Administrator.

The following information must be included:

1. Classification of the malocclusion;
2. Description of the proposed treatment;
3. Estimate of how many months the treatment will take;
4. Estimate of the total charges.

Payment Schedule

Payment for charges made in accordance with an approved Orthodontic Treatment Plan shall be made in installments over the estimated duration of treatment. The first installment is eligible for consideration on the date the orthodontic appliance is installed and initial payment cannot exceed 25% of total estimated treatment plan subject to the deductible and benefit percentage. Remaining balance will be divided by the estimated months of treatment and equal monthly payments will be payable at the benefit percentage level on the month upon receipt of evidence of continuing treatment. The remaining balance will be reviewed for payment upon receipt of the bill for services rendered.