Your Guide to Dental Benefits

WATERFORD SCHOOL DISTRICT

Group Benefit Plans

Administered By
ADN Administrators, Inc.

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WELCOME!

Welcome to the Waterford School District Dental Plans.

Waterford School District has chosen to self-fund its dental plan to help minimize health benefit costs. In addition, ADN Administrators has been contracted to provide the benefit plans administration. The selection of ADN Administrators affords access to three dental PPO Networks; ADN Dental Network, DenteMax Dental Network and MDP Network of Providers.

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

The Waterford School District Dental Plan allows freedom of choice; you may receive treatment from any licensed dentist or dental specialty for dental care.

As an added benefit, the dental plan offers the choice of a PPO dental provider which 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 dental 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, DenteMax and MDP Providers, you may choose from providers under any section 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: Waterford School District Dental Plan

2. Name, Address and Telephone number of the Plan Sponsor:

   Waterford School District
   6020 Pontiac Lake Road
   Waterford, Michigan 48327
   (248) 666-4000

3. Type of Plan: Group Dental Benefit Plan

4. Plan Administrator: ADN Administrators, Inc.

5. The Administrator has the exclusive and absolute 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 September 1st.

8. Dental Plan Group Number: 9582

THE PLANS AT A GLANCE

Effective Date of Plan

This plan became effective on July 1, 2007.

Dental Plan Structures

The Waterford School District Dental Plan consists of various levels of dental coverage based upon your employee group (see page 6). Benefits are payable at the applicable percentage level of the Usual and Customary charge for the procedure rendered based upon whether your dental provider is In-Network or Out-of-Network. The types of dental treatment are indicated by classes, which are explained in detail under Covered Dental Expenses.

Plan A Benefits

In-Network	Out-of-Network
Class I – 100%	Class I – 100%
Class II – 80%	Class II – 50%
Class III – 50%	Class III – 50%
Class IV – 70%	Class IV – 70%

Annual Maximum Benefit - $1,100
Lifetime Ortho Maximum Benefit - $800

Plan B Benefits

In-Network	Out-of-Network
Class I – 100%	Class I – 100%
Class II – 80%	Class II – 50%
Class III – 50%	Class III – 50%
Class IV – 70%	Class IV – 70%

Annual Maximum Benefit - $1,000
Lifetime Ortho Maximum Benefit– $700

COVERED EMPLOYEE GROUPS

Each benefit plan indicated below covers the following employee groups:

Dental Benefit Plan A	**Dental Benefit Plan B**
Administrators	All Other Employees
Teachers	

HOW AND WHEN COVERAGE TAKES EFFECT

Coverage becomes effective when the employee enrolls in the benefit plans and meets **all** of the conditions of coverage.

1. The plan is in effect for the employer; and

2. The employee is included in a class of employees eligible for coverage under the plan; and

3. The employee is actively at work and meets any applicable minimum hours per week requirements; and

4. The employee has satisfied the applicable Service Requirement.

All eligible employees may enroll their unmarried eligible dependents in this Plan. The effective date of coverage shall be:

1. The date the employee becomes covered under the plan provided the dependent is properly enrolled on the employee's effective date of coverage.

2. The effective date following the Open Enrollment Period.

3. The date the dependent becomes an eligible dependent, provided he/she is properly enrolled within 31 days of the event. If the application is submitted beyond the 31 day enrollment period, coverage will be effective on the first day of the month following approval of the application.

The dental plan 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

WHEN COVERAGE TERMINATES

directly to the employer. Please refer to your benefits representative in the human resources department for information.
Coverage Termination will be effective on the first occurring date as follows:

1. On the first day of the month for which eligibility requirements are no longer met.

2. On the first day of the month in which the employee ceases to be an eligible employee in the class for coverage due to termination of employment or for any other reason.

3. On the first day of the month following the date on which the employee's class is no longer eligible for coverage.

4. The date on which the Plan terminates.

The dental plan termination is determined by and the sole responsibility of the plan sponsor. Please refer to your benefits representative in the human resources department for information.

WHEN A DEPENDENT'S COVERAGE TERMINATES

Coverage for eligible dependent children may be continued until the end of the calendar year of their 19th birthday. Eligible dependents meeting further plan requirements can remain covered until the end of the calendar year of their 25th birthday, provided all conditions are met.

A dependent's dental coverage terminates at the earliest time shown below:

1. When he/she ceases to be a dependent as defined by the plan sponsor.

2. When he/she ceases to be covered under the group contract.

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

All dental 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.

COBRA coverage is a continuation of coverage when benefits under the Plan would otherwise end due to reduction in hours of employment, termination for any reason other than gross misconduct.

CONTINUATION OF PLAN BENEFITS (Cont'd)

Continuation coverage may also be extended for eligible dependents affected by the following "qualifying events":

1. Death of the employee.

2. Loss of a spouse's coverage through his or her employment due to reduction in hours of employment or loss of employment due to any reason other than gross misconduct.

3. Divorce or Legal Separation from the employee.

4. A dependent child ceases to be an eligible dependent under the Plan.

Strict guidelines exist regarding eligibility for, election of and participation in continuation coverage. Further, there exists Maximum COBRA coverage periods as determined by the type of “qualifying event”.

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, DenteMax 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 a provider of similar training and experience within the same specific geographical area or region.

PPO Allowed Amount

The amount determined by the Dental 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 benefit period which is renewable each year.

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.

DENTAL PLAN BENEFITS

Definitions

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 any applicable 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, vision or hearing aid 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 and Preventive Services:

   Oral Examinations, Consultation, Prophylaxis (Cleanings), Bitewing and Full-mouth X-rays, Topical Application of Fluoride, Pit and Fissure Sealants, Fixed Space Maintainers and Minor Emergency Palliative Treatment.

Class II Benefits

1. Basic Restorative Services:

   Amalgam and Composite Resin Restorations (fillings), Pin Retention, Stainless Steel and Resin Crowns, Acrylic Denture Repairs.

2. Endodontic Services:

   Pulpal Debridement (Emergency Treatment), Pulp Capping, Therapeutic Pulpotomy, Root Canal Therapy, Apicoectomy, Hemisection and Root Amputation.

3. Periodontic Services:

   Emergency Periodontal Treatment, Periodontal Maintenance Procedures (following treatment), Root Planing, Osseous Surgery, Gingivectomy and Flap Procedures.

4. Oral Surgery Services:

   Simple and Surgical Extractions, Root Recovery, Surgical Removal of Impacted Third Molars, Incision and Drainage, Surgical Exposure, Frenulectomy, Reimplantation and Alveoloplasty.

5. Adjunctive General Services:

   Occlusal Guards, Occlusal Adjustment, General Anesthesia (in conjunction with certain covered oral surgery).

Covered Dental Expenses (Cont'd)

Class III Benefits

1. Major Restorative Services:

   Sedative Filling, Core Build-up, Cast Post Core, Resin, Porcelain and Metal Inlay, Onlay and Crown Restorations and Recementations.

2. Removable Prosthetic Services:

   Complete and Partial Dentures, Reline and Rebase, Tissue Conditioning, Denture Adjustments and Repairs, and the Addition of Teeth to Existing Partial Dentures.

3. Fixed Prosthetic Services:

   Fixed Partial Denture Abutments and Pontics (bridges).

Class IV Benefits

1. Orthodontic diagnostic procedures:

   Diagnostic Panoramic Radiographs, Cepholometric Films, Photographs and Study Models.

2. Harmful Habit Control Appliances:

   Removable and Fixed Appliances for Tongue Thrusting and Thumb Sucking.

3. Limited, Interceptive and Comprehensive Treatment (Braces) including retention:

   Removable and Fixed Appliance Therapy

Orthodontic treatment is the corrective movement of teeth by means of an active appliance to affect a predetermined result. Coverage for orthodontic treatment is limited to patients up to (but not including) age 19.

Benefits for covered orthodontic treatment will be based on the usual and customary charge and payable at the orthodontic benefit level. The initial banding down payment will be 25% of the allowed charge followed by equal monthly payments until either the allowable charge, the number of months of treatment is reached or the lifetime orthodontic maximum benefit is satisfied.

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 and Cleanings (Prophylaxis) are payable twice per benefit year.

2. Benefits for Bitewing X-rays are payable twice per benefit year.

3. Topical Application of Fluoride is payable once per benefit year for patients under age 19.

4. Benefits for a Full Mouth Series (which include bitewings) or Panoramic X-rays are payable once in any thirty-six month period. A Panoramic X-ray in addition to Bitewing X-rays and/or single X-rays are considered a Full Mouth X-ray, is payable accordingly and subject to the thirty-six month time limitation.

5. Benefits for Fixed 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.

6. 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.

7. 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 sixty-month period.

7. Benefits for Substructures, Porcelain and Cast Restorations are not payable for patients under 16 years of age.

8. Benefits for Stainless Steel and Resin Crowns are payable for patients under age 19 and once per primary tooth.

9. Benefits for Therapeutic Pulpotomy is payable for patients under age 19 and once per primary tooth.

10. Benefits for Periodontal Root Planing are payable once in any twenty-four month period per quadrant of the dental arch.

11. Benefits for Periodontal Surgery procedures are payable once in any thirty-six month period per quadrant of the dental arch.

12. Miscellaneous Adjunctive Services:

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

Dental Plan Limitations (Cont'd)

Benefits for General Anesthesia are payable, by review and in conjunction with covered oral surgery procedures.

Benefits for Emergency Palliative Treatment are payable to temporarily alleviate pain. Appropriate benefits will be considered for definitive treatment submitted as Palliative Treatment.

13. Prosthodontic (Class III) benefit limitations:

Benefits for Removable Complete Dentures to replace missing functional natural teeth lost while the patient is eligible for dental benefits under this plan are payable once in any sixty-month period per arch.

Benefits for Fixed and Removable Partial Dentures to replace missing functional natural teeth lost while the patient is eligible for dental benefits under this plan are payable once in any sixty-month period.

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

Benefits for Removable or Fixed Dentures or Bridges to replace missing natural teeth lost prior to the patient's dental plan eligibility date are not payable unless the replacement also includes the replacement of a natural functional tooth lost while the patient became eligible for dental benefits under this provision; and the tooth was not an abutment to a partial denture or fixed bridge within the past five years.

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

14. Benefits for Reline or Rebase (complete replacement of denture base material) are payable once in any twenty-four month period and more than twelve months following delivery or insertion of the appliance.

15. Orthodontic (Class IV) benefit limitations:

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.

16. Benefits for certain interrupted treatment or services may be considered at the discretion of the administrator.

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 Waterford School District 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. Restorations or appliances determined to be rendered for cosmetic or aesthetic purposes including but not limited to laminate veneers and personalization or characterization of dentures.

2. 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.

3. Dental procedures or services necessary for the diagnosis or treatment of dental illness, accidental injury or otherwise considered medical.

4. Fixed or removable prosthetic appliances for replacement of natural teeth missing prior to the patient becoming eligible for dental benefits under this plan, unless the appliance also includes replacement of a functional natural tooth; which is missing while the patient became eligible and; was not an abutment to an appliance inserted within the immediately preceding five years.

4. Replacement of lost, missing or stolen prosthesis or appliances of any type.

5. Overdentures and related appliances, restorations, root canals and/or other services.

6. Repair or replacement of orthodontic appliances.

7. Restorations, appliances and surgical procedures related to implantology techniques, their care, maintenance and removal.

8. Diagnostic Casts provided specifically for the fabrication of dental appliances and/or restorations.

9. Treatment or services begun before the patient became eligible under this plan.

General Exclusions (Cont'd)

10. Treatment or services that are determined not necessary and/or customary as generally accepted standards of dental practice, specialized technique, those for which no valid dental need is demonstrated, or that are experimental in nature.

11. Treatment or services for restoring occlusion, increasing vertical dimension, for replacing tooth structure lost due to attrition, abrasion or erosion.

12. Appliances, restorations or services for the correction or treatment of congenital or developmental malformations.

13. Treatment or services that are temporary and/or considered to be an integral component of a final dental treatment or service.

14. Services or treatment based solely upon the patient's age, mental status or physical inabilities.

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.

16. Personal care training, 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 rendered by a member of the employee's household or a member of his/her immediate family.

23. Treatment or services for which no charge is made, for which the patient would not legally be obligated to pay or for which no fee would be charged to the patient in the absence of dental plan coverage.

General Exclusions (Cont'd)

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.

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 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.

Coordination of Benefits (Cont'd)

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:

    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 or vision 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

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 provided the services are completed within a thirty-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 administrator will determine the benefit, if any to be allowed and any remaining balances will be the financial responsibility of the patient.

Extension of Benefits (Cont'd)

This extension will be effective only to the extent that coverage for the service is not otherwise provided by another employer benefit plan. All benefit limitations, exclusions and plan maximums apply.

CLAIM SUBMISSION PROCEDURE

How to File a Claim

The Waterford School District Dental Plan allows benefits for covered treatment rendered by a licensed dentist whether or not he/she is a participant with the ADN, MDP or DenteMax 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, MDP or DenteMax Network fee amount will be accepted as charge and the 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 Waterford School District Dental Plan Coverage. Provide them with your contract number and show your benefit 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 number and address.

2. The patient proper name, relationship to the employee and complete date of birth.

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, vision or hearing provider to certify that treatment is rendered, authorization for release of information and assignment of benefits.

7. All information as requested on the claim form.

How to File a Claim (Cont'd)

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 Waterford School District 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

ADN Administrators strongly recommend predetermination of benefits prior to any dental treatment when proposed procedures exceed $200. This process 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 does not guarantee payment or reserve funds for the treatment approved.

Appeal of Denied Benefits

Familiarize yourself with the benefits and provisions of your benefit plan so that you are aware of the circumstances under which a dental treatment, vision or hearing aid 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.

Appeal of Denied Benefits (Cont'd)

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, then forward the appeal to the Plan Sponsor. Once a decision has been made, we will 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 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.