CALIFORNIA SERVICE EMPLOYEES
SUMMARY OF INDEMNITY DENTAL PLAN BENEFITS
SELF-FUNDED DENTAL PLAN VII

You must refer to the Collective Bargaining Agreement or Subscriber Agreement with your Employer to determine if you are eligible to enroll in the Indemnity Dental Plan. You may also have a choice of a pre-paid dental plan.

Definitions

The term **"Calendar Year"** means the twelve-month period beginning on January 1 and ending at midnight on December 31 of each year.

The term **"Covered Dental Expense"** means only expenses incurred for necessary treatment which is received by an Eligible Individual from a Dentist, or a dental hygienist under the supervision of a Dentist, and which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. A Covered Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

The term **"Dental Consultant"** means a Dentist who reviews and advises the Board of Trustees on dental procedures submitted to the Claims Administration Office by another Dentist.

The term **"Fee Schedules"** means the description of dental procedures and the amount allowable for each procedure as approved by the Board of Trustees and amended from time to time.

Pre-authorization Requirement

Any claims for dental treatment that will cost $500 or more in charges must be submitted to the Claims Administration Office for prior authorization of benefits **before** treatment begins.

Dental Benefits

Deductible

Each covered individual must pay the first $75 in Covered Dental Expenses each Calendar Year before the Plan will pay any Covered Dental Expenses.

Coinsurance and Calendar Year Maximum

If an Eligible Individual incurs a necessary Covered Dental Expense, the Plan will pay 70% of the amount specified for the procedure in the Fee Schedules, but in no event more than the Usual, Customary and Reasonable Charge, up to a maximum benefit of $3,000 per Eligible Individual per Calendar Year.

Orthodontic Benefits

If an Eligible Individual receives necessary orthodontic treatment, the Plan will pay 50% of the Usual, Customary and Reasonable Charges incurred up to a lifetime maximum benefit of $1,500 per Eligible Individual.

Schedule of Services

Subject to the Limitations and Exclusions set forth below, the Schedule of Services are covered when rendered by a Dentist, or a dental hygienist under the supervision of a Dentist, and when determined to be an Allowed Charge.

A) Necessary procedures to assist the Dentist in ***evaluating the existing conditions*** to determine the required dental treatment.

- Full mouth x-rays are limited to one set every 36 consecutive months;
- Bitewing x-rays are limited to one set every six consecutive months

B) ***Preventive Care***: Necessary procedures to prevent the occurrence of oral disease. These services include:

- Prophylaxis, not to exceed three per calendar year;
- Topical application of fluoride solutions;
- Initial Exam – once every 12 months and periodic exam once every six months.
- Sealants on molars without restorations up to age 14;
- Space maintainers (not related to orthodontic treatment).

C) ***Oral Surgery:*** Necessary procedures for extractions and oral dental surgery including pre- and post-operative care.

D) ***Restorative Dentistry:*** Necessary procedures for amalgam, synthetic porcelain and plastic restorations. Gold restorations, crowns and jackets shall be provided when teeth cannot be restored with the above materials.

E) ***Endodontics:*** Necessary pulpal therapy and root canal filling (treatment of non-vital teeth).

F) ***Periodontics:*** Necessary procedures for treatment of the tissues supporting the teeth.

G) ***Prosthodontics:*** Necessary procedures for construction of bridges, partial and complete dentures. Replacement will be allowed every five (5) years if deemed necessary. This applies to the existing crowns and prosthetics. This benefit also includes implants (new and/or pre-existing and all related and attendant services).

H) ***Orthodontics:*** Necessary procedures and appliances for the interception and treatment of malocclusion of the teeth and their supporting structures. Benefits will be paid in equal monthly installments for the duration of the treatment plan submitted by the attending Orthodontist. The provider must submit a bill monthly.

Limitations and Exclusions.

A) Services for injuries or conditions which are compensable under Worker's Compensation or Employer's Liability Laws, services provided by any Federal or State Government Agency, (service related), or provided without cost by any municipality, county or other political subdivision are not covered services.

B) Services with respect to congenital malformations or cosmetic surgery or dentistry for purely cosmetic reasons are not covered services.

C) Crowns placed on molars shall receive the allowance of full cast crowns, as porcelain crowns are considered cosmetic in this area. (Build-up under a crown shall be included in the cost of the crown.)

D) Oral hygiene instruction, plaque control, nutritional and tobacco counseling, periocharting and fee for completion of claim form are not covered services. Please note that nutritional and tobacco counseling benefits are available under the preventive care benefits of the medical plan.

E) Prosthetics and crowns which were paid for by this Plan are limited to replacement once every five years and only if deemed necessary.

F) Procedures, appliances or restorations solely for aesthetic purposes are not covered benefits.

G) Procedures, appliances or restorations that the Dental Consultant deems unnecessary may be disallowed.

H) Periodontal root planing is limited to four (4) quadrants in 24 months.

I) Elective or optional procedures may be disallowed by the Dental Consultant.

J) Posterior composite restorations will not be allowed. Allowance will be made for amalgam restorations on posterior teeth.

K) Space maintainers for primary teeth are subject to approval by the Dental Consultant.

L) Crown build-up and/or gingival surgery, and construction of temporaries are to be included in the fee for the crown.

M) Temporomandibular Joint Syndrome (TMJ) associated procedures are not covered benefits.

N) Expenses incurred for appliances or restorations necessary to increase vertical dimension or restore occlusion or for the purpose of splinting are not covered.

O) Any dental treatment rendered out of the United States and its territories shall be limited to emergency treatment and reviewed by the Trust Funds' Dental Consultant and will be denied if not consistent with California standards.

P) If an Eligible Individual selects a more expensive program of treatment than is customarily provided, or specialized techniques rather than standard procedures, benefits shall be payable for the least expensive plan of treatment, provided the treatment is professionally acceptable.

Q) Any experimental dental procedure. A procedure is considered as experimental when there is no consensus in the professional dental community on the safety or effectiveness of the procedure, there is insufficient evidence to determine its appropriateness, or if use of the procedure for the given indication in the specified patient population is confined largely to research protocols.

Extended Dental Benefits.

If a dental procedure is initiated prior to an Eligible Individual's termination of eligibility, dental benefits for that procedure shall be provided until the earliest of the following dates:

A) the end of two calendar months from the date eligibility was terminated: or

B) the date of completion of the specific course of dental treatment.