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Stanislaus County

**DENTAL PLAN**



GROUP #3001

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# Stanislaus County Dental Plan Description

## INTRODUCTION

This handbook has been developed to provide dental plan highlights and a general understanding of the benefits available to employees (subscribers). After your review, if you have questions or need further information, please contact the CEO-Risk Management Division, Employee Benefits at 525-5717. For contract interpretation, contact the Third Party Administrator, Stanislaus Dental Foundation at 527-2430.

The Stanislaus County Dental Plan is self-funded. This means the County acts in place of an insurance company and determines the covered benefits and the amount of funding necessary to maintain a positive cash balance. Operating costs and claims are paid by the County, and in some cases, by employee co-payments. Actual claim processing and billing are provided by the Third Party Administrator.

## PARTICIPATION

Any County employee who occupies an authorized position with benefits, and works either full time or a percentage that qualifies for coverage, is eligible to enroll in the dental plan. The subscriber's eligible dependents may also be enrolled in the dental plan.

Eligible dependents include:

- \* A lawful spouse (legal separation does not constitute eligibility)
- \* An employee's CA Registered Domestic Partner as defined by California Secretary of State under state law.
- \* Unmarried children under the age of 19.
- \* Unmarried children under the age of 25, if enrolled full-time (12 or more units) at a school, accredited college or university, **OR** under the age of 24 if an I.R.S. dependent. Verification may be required.
- \* Unmarried children over the age of 19, who are incapable of self support due to a physical or mental handicap which occurred prior to age 19 and are more than 50 percent dependent upon you for support and maintenance. Physician verification is required in all cases.

Children include your own child(ren), stepchild(ren), legally adopted or have legal guardianship of child(ren), provided they are primarily dependent upon the subscriber for support and maintenance.

**NOTE:** You may **not** be enrolled both as a subscriber and a dependent in this plan. If you and your spouse are both employed with the County and/or a District, and you have children, only one spouse may enroll them as dependents.

## HOW DOES THE PLAN WORK?

### How Do You Enroll?

The department payroll clerk will provide you with an enrollment form. List your name and names of your dependents, on the enrollment form, should you select dependent coverage.

### Dependent Coverage

If dependent coverage is selected, all eligible dependents must be enrolled and ***their coverage retained for at least three years***, unless you terminate employment with the County earlier. Exceptions are newborn children or a working spouse with his/her own dental coverage.

"Newborn children" may be enrolled ***on or before their fourth birthday***, provided other eligible family members are also enrolled. If a new dependent is acquired in the future (i.e. marriage or adoption), they may be added to the dental plan **within 30 days** by completing a membership change form. Otherwise, dependents **cannot** be added until the next open enrollment period.

***If, after three (3) years, you decide to discontinue dependent dental coverage or you elect to waive you and/or your dependent coverage and elect to receive the excess allowance in cash, you must sign a waiver form to acknowledge that you may never re-enroll in this plan.*** (Unless you have proof of a qualifying event resulting in the loss of other dental coverage submitted to Employee Benefits within 30 days of the event). In cases where there has been a court action (divorce), documents verifying that action must be submitted to the CEO-Risk Management Division.

### When Does Coverage Begin?

Coverage under the dental plan begins on the **first day of month following your date of hire** or the date of a qualifying event date following the submission of necessary paperwork to Employee Benefits within 30 days of the event date.

Coverage for eligible dependents begins at the same time ***provided written application is made for them and submitted to the CEO-Risk Management Division.***

## HOW ARE BENEFITS PAID?

During the first **calendar** year of enrollment in the Plan, covered benefits are paid at 70 percent. Payment increases by 10 percent each subsequent **calendar** year of enrollment, provided a dentist is seen annually. If a dentist is not consulted each year, the benefit level will be reduced by 10 percent per year, down to a minimum of 70 percent. Exceptions are

prosthodontic and dental accident benefits.

The plan pays up to \$1,500 per person per calendar year. A \$10 co-pay is required for each dental visit. Exceptions are any visit for preventative and diagnostic care, as defined below, in which case a co-pay is not applied.

### **WHAT DOES THE PLAN COVER?**

#### **Preventative and Diagnostic Benefits:**

- \* Prophylaxis (cleaning) of teeth shall be provided twice in any twelve (12) month period.
- \* Space maintainers and study models.
- \* Diagnostic oral examinations *twice* every 12 months.
- \* Complete mouth x-rays once every five (5) years, unless a special need is shown.
- \* Bitewing x-rays for *adults* age 18 or over once every twelve (12) months.
- \* Bitewing x-rays for *children* up to age 18 once every six (6) months.

#### **Basic Benefits:**

- \* Extractions and certain other surgical procedures, including pre- and post-operative care.
- \* General anesthesia when provided by a licensed dentist in connection with covered oral surgery services.
- \* Amalgam, synthetic porcelain and plastic restorations (fillings) for treatment of carious lesions (cavities) will be paid as customary and standard treatment. If a more expensive or specialized treatment is chosen, the subscriber will be responsible for the difference in payment plus any required co-payments.
- \* Periodontal treatment of the gums and supporting structure of the teeth and endodontic services (root canal treatment).

#### **Crowns, Jackets and Cast Restoration Benefits:**

- \* When carious lesions (cavities) cannot be restored with amalgam, synthetic porcelain or plastic restorations, the procedure will be covered at the subscribers current percentage rate.
- \* Replacement of crowns, inlays and onlays will be performed, but only if satisfying evidence is presented that ***at least five (5) years have elapsed*** since the date of the insertion of the existing crown, inlay or onlay, ***and only if the existing crown, inlay or onlay is unserviceable and cannot be made serviceable.***

#### **Prosthodontic Benefits are Paid at 50 Percent and Include:**

- \* Complete or partial dentures.
- \* Fixed bridges (including crowns and inlays forming a part of the bridge).
- \* Replacement of an existing denture if it is at least five (5) years old and no longer serviceable.
- \* Implants provided in association with a covered prosthetic appliance. The cost of a standard complete or partial denture is allowed toward the cost of the implants and appliances.

### **Dental Accident Benefits**

Treatment is paid at 100 percent, provided services are:

- \* Plan benefits and meet all plan conditions, exclusions and limitations, including annual maximums.
- \* Commenced within **180 days** of the injury.
- \* Not for conditions caused by an accident before a subscriber was covered for benefits.

### **PREDETERMINATION OF COST**

Whenever your dentist recommends extensive work (eg. bridges, gum surgery, etc., or when a fee of \$500 or more will be charged), the dentist must submit a statement to Stanislaus Dental Foundation (SDF), outlining the proposed treatment and charges.

This procedure allows SDF to determine if the proposed treatment is a covered benefit, the amount that SDF will pay toward the cost and the amount of any co-payments. Based upon this information, the subscriber can decide the course of treatment that best suits his/her needs.

### **CHARGES WHICH ARE NOT COVERED**

**The Dental Plan does not pay for:**

- \* Charges payable under Workers' Compensation, or any Federal or State government agency, except Medi-Cal.
- \* Services with respect to congenital or developmental malformations.
- \* Cosmetic surgery or dentistry, including supplies.

- \* Treatment for flurosis (discoloration of the teeth) and anodontia (congenitally missing teeth).
- \* Restoration and maintenance - Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth, including but not limited to equilibration and periodontal splinting.
- \* Prosthodontic services or any single procedure started prior to the date the subscriber or dependent became eligible for such services under this plan.
- \* Prescribed drugs, pre-medication, or analgesia.
- \* Experimental procedures.
- \* Prophylaxis, if the eligible patient has received two (2) prophylaxes covered by the program in the immediately preceding eleven (11) months.
- \* All hospital costs and any fees charged by a dentist for hospital treatment.
- \* Anesthesia (other than that provided in conjunction with covered oral surgery).
- \* Extra oral grafts (grafting or tissues from outside the mouth to oral tissues.).
- \* Services with respect to treatment of disturbances of temporomandibular joints (jaw joints).
- \* Orthodontic services (treatment of mal-alignment of teeth and/or jaws).

### **CLAIMS PAYMENT**

Upon visiting the dentist, subscribers must provide either the Stanislaus Dental Foundation (SDF) identification card or group number 3001. The subscriber's social security number is the identification number for the employee and the dependents.

To obtain all benefits available, a subscriber must tell the dentist if there is any other dental coverage and may need to sign a SDF claim form which will be provided. The dentist will bill SDF directly for covered services. Subscribers may be required to pay the percentage co-payment or the cost of treatment not covered by the Plan.

If a subscriber goes to a dentist who is not a member of the Stanislaus Dental Foundation, he/she will be required to pay extra out-of-pocket expenses as SDF only reimburses these providers at the Denta-Cal rate. Subscribers may also be required to file their own claim. A list of participating providers is available from the department payroll clerk, the Stanislaus Dental Foundation or the CEO-Risk Management Division. ***Claims submitted 180 days after the date of service will not be paid.***

### **CLAIMS APPEAL**

If a claim is denied, subscribers will receive written notification from the Stanislaus Dental Foundation. Any questioned actions may be appealed to the Foundation for further review.

Appeals must be submitted ***in writing within sixty (60) days of notification of the denial.*** It should be noted that Stanislaus Dental Foundation may request from the subscriber or his/her dentist, additional documentation. In addition, the claim may be referred to a dentist's peer review committee for further review and analysis.

Inquiries or complaints regarding services or the manner in which a claim has been paid or unpaid may be directed to the CEO-Risk Management Division, P.O. Box 1723, Modesto, CA 95354, telephone (209) 525-5717. Subscribers who contact the Stanislaus Dental Foundation should direct correspondence to P.O. Box 576007, Modesto, CA 95357, telephone (209) 527-2430. Group number 3001 and social security numbers must be included in all correspondence with the Stanislaus Dental Foundation.

Disputes, which cannot be resolved by these procedures, are subject to arbitration. Any party to a dispute may initiate arbitration by written notice to the other, outlining the nature of the issue, the amount, if any, involved, and the remedy sought. Subscribers will also need to file two (2) copies of the notice with the American Arbitration Association regional office in San Francisco and pay the fee required by them.

### **COORDINATION OF BENEFITS**

If a subscriber or eligible dependent is covered under two or more dental insurance plans, one is the primary plan and the other plan(s) are secondary.

The primary plan pays its benefits first without regard to the other plan(s). The secondary plan(s) make up the difference to meet all allowable expenses. The benefits are coordinated between insurance's, so subscribers receive a benefit up to, but not over, 100 percent of the dental expenses.

The following rules determine which plan is primary:

- \* The plan covering the subscriber directly, rather than as a dependent.
- \* If the subscriber's and spouse's plans both cover dependent children, the plan of the parent whose birthday (day and month) falls earliest in the calendar year, will be considered primary.
- \* If the other insurance plan does not follow the above rule, the standard gender determination will apply, i.e., the father's plan is primary.
- \* The plan covering a subscriber, or eligible dependent the longest, if neither of the above establishes which plan is primary.

## THIRD PARTY LIABILITY

### **What Is It?**

Third party liability is a provision that allows the dental plan to be reimbursed for services that resulted from an injury caused by another, i.e., automobile accident.

### **How Does It Work?**

When the subscriber's dentist submits a claim for services that appear as though they may have been caused by an accident, the Stanislaus Dental Foundation will contact the subscriber directly. The Foundation needs to know if someone else was responsible for the injury and if the subscriber intends to seek legal action. If legal action is sought, the subscriber is required to reimburse the Plan to the extent of the paid benefits. A set reduction of this amount is generally allowed for attorney fees.

## TERMINATION OF BENEFITS

### **When Does Coverage End?**

A subscriber's insurance under this plan will terminate when:

- \* The plan is discontinued.
- \* The subscriber's employment ends. In this instance, the subscriber's coverage ends at midnight on the last day of month in which employee terminates.
- \* A subscriber is on an unpaid leave of absence and the subscriber does not pay the premiums necessary to continue the dental benefits. Insurance will be reinstated upon a subscriber's return to full-time employment, but ***a new enrollment form must be completed and coverage commences at the 70 percent level.***
- \* Dependent status is lost; coverage will end at midnight on the last day of the month in which status is lost.

## CONTINUATION OF COVERAGE

### **Leave of Absence**

If a subscriber goes on an unpaid leave of absence, their dental insurance will lapse, unless, premiums are paid ***by the subscriber.*** If the subscriber has vacation time or sick

leave available, these hours may be used to remain on the County or District payroll, where applicable. Upon approval by the subscriber's department head for use of any vacation and/or sick time available, insurance premiums would be paid by the County. **Once these hours are exhausted, it is the subscriber's responsibility to pay insurance premiums.**

Contact the department payroll clerk prior to a leave, to calculate when your obligation to pay becomes effective.

If a subscriber chooses not to pay insurance premiums, coverage will be cancelled. Upon return to work, a subscriber will be permitted to re-enroll in the dental plan of choice, but coverage will commence at the 70 percent level.

## **COBRA**

Subscribers and eligible dependents who lose coverage due to resignation, termination of employment, reduction of hours, age or marital status may continue benefits under the provisions of the Consolidated Omnibus Reconciliation Act (COBRA). Effected subscribers and dependents have 60 days from loss of group coverage to enroll in the County's COBRA to continue benefits and will be required to pay monthly premiums. **It is an employee's responsibility to notify the County of changes in status effecting dependent eligibility.**

Subscribers may continue benefits for up to 18 months from loss of coverage. Overage dependents may continue benefits for up to 36 months. Benefits may end sooner if coverage under another plan is elected, if the eligible person fails to make the required premium payment, or upon becoming Medicare eligible.

COBRA forms will be sent automatically from the CEO-Risk Management Division, **but it is important to remember that the COBRA option is only available for sixty (60) days after group coverage ends.**

## **OTHER CONDITIONS**

In the event of a conflict between this handbook and the dental plan document and/or contract, the latter documents will prevail. Copies are available and can be reviewed at the CEO-Risk Management Division.

Stanislaus County reserves the right to change or terminate the plan at any time, subject to collective bargaining agreements.

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