City of Del Rio

Schedule of Dental Benefits

Effective 10/01/2020

Note: This plan does not have a late entrant clause.

The City of Del Rio has added access to the providers associated with the Dental Network of America (DNoA) to their dental plan. Website: dnoa.com Plan name: DNoA PRO

Description of Services

Benefit Maximums

Preventive, Basic and Major Dental Expense Benefit ---------- $1,500 per calendar year

Orthodontic Benefit

Limited to Dependent Children under the age of nineteen (19) ---------- $1,500 per lifetime

	Deductible	**Benefit Percentage**
Preventive Dental	None	100% of Reasonable & Customary
Basic and Major Dental ***Implants are classified as a Major Service and require pre-determination***	$50 calendar year per individual combined ($150 calendar year per family)	Basic 80% of Reasonable & Customary Major 50% of Reasonable & Customary
Orthodontic ***Implants are classified as a Major Service and require pre-determination***	None	50%

Description of Dental Benefits

Subject to the terms and conditions of the Plan, TML Health will not pay benefits in excess of usual, reasonable and customary charges, which are incurred for necessary services, which are rendered by a licensed dentist.

Deductible

Before benefits are paid, you must meet the appropriate deductible shown in the Schedule of Dental Benefits. The scheduled deductibles shall apply individually to each covered individual, unless the family deductible has been satisfied. The family deductible is accumulative. The deductibles for the Basic Dental Expense Benefit and for the Major Dental Expense Benefit are combined and only a single

deductible applies to these two (2) benefits in any calendar year. The Orthodontic Services Expense Benefit does not have a deductible.

Benefit Percentage

After the deductible, if any, has been satisfied, TML Health will pay the appropriate percentage of eligible dental expenses that is shown in the Schedule of Dental Benefits.

Maximum Benefit

TML Health will not pay more than the maximum benefit shown in the Schedule of Dental Benefits for each covered individual.

Benefits

The Plan benefits are divided into the following sections:

- Preventive Dental Expense Benefit
- Basic Dental Expense Benefit
- Major Dental Expense Benefit
- Orthodontic Services Expense Benefit - for Covered Dependent Children under the age of nineteen (19)

Dental Claims from Foreign Providers

Claims for dental charges incurred as a result of travel outside of the United States or its territories specifically to receive dental treatment are covered unless otherwise specifically excluded under this Plan. The claims must be submitted in English and will be processed according to the same guidelines and limitations as claims submitted by providers inside the United States. In addition, the plan will not assign benefits to foreign providers and payment will not exceed the allowable that would have been eligible is services were rendered in the United States.

List of Eligible Dental Services

It is important to note that when there is more than one way to properly treat a particular dental condition, benefits will be payable not to exceed the benefit for the least expensive course of treatment. To help you identify your out-of-pocket costs, you may request a predetermination for plan benefits from TML Health.

Preventive Care 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 nineteen (19) and two (2) treatments in a calendar year.
4. Sealants - for children under the age of thirteen (13) not to exceed $100 per calendar year
5. X-rays
    a. Bitewings - limited to two (2) sets in a calendar year
    b. Full mouth (complete series including bitewings) – limited to one (1) in a thirty-six (36) month period.
    c. Panoramic with/without bitewings - is also a full mouth limited to one (1) in a thirty-six (36) month period.

Basic Care Services

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 basic care services and supplies covered by the Plan.

Subject to Deductible

1. Emergency oral exams, palliative treatments.
2. X-rays (periapicals) (non-preventive).
3. Space Maintainers - initial appliance only for children under age nineteen (19) to replace primary teeth.
4. Diagnostic casts.
5. 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)).
6. Stainless steel crowns - primary/permanent tooth.
7. Pin retention.
8. 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.
9. Anesthesia - general, in conjunction with surgical procedures only; analgesia; intravenous sedation.
10. Endodontics treatment - (root canal treatment and pulp capping when not provided on the same day as a permanent restorative service)
11. 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 a calendar year.
12. Oral surgery.
13. Occlusal adjustment if in active periodontal treatment.
14. Repair or recementing of crowns, inlays and onlays and bridges.
15. 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.
    c. The existing denture is an immediate temporary denture replacing one or more teeth, and replacement by a permanent denture is required,
16. The following information must be provided:
    a. Initial placement – provide which teeth are being replaced and the date of each extraction (if available).

b. Replacements – provide which teeth are being replaced and the Date of the prior placement and reason for this replacement.

17. Reline and adjustments of partial and complete dentures after six (6) months.

Major Care Services

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 services and supplies listed in this section. This list is intended to give you a general description of major care services and supplies covered by the Plan.

Subject to Deductible

1. Removable mouth guard or appliance to alleviate thumb sucking and bruxism.
2. Onlays/Inlays.
3. Crown Build-ups.
4. 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.

   b. Reason for replacing crown.
5. Bridges-Partial Dentures - Full Dentures - Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments).
6. Gold restorations.
7. Dental implants – Benefits are available when the services have been pre-determined by the Plan.
8. If it is determined that an alternate benefit is payable under the Plan, the alternate benefit is applicable only to the prosthesis over the implant(s) rather than towards the implant placement.

Orthodontic Care Services

The Orthodontic Care benefit is only available to covered dependent children who are less than nineteen (19) years of age. This benefit ends on the child's nineteenth (19^{th}) 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 Maximum

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 TML Health by the dentist and returned to the dentist showing estimated benefits before dental work starts. The following information must be included:

1. Classification the malocclusion;
2. Description 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 50% 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.

Additional Provisions for Orthodontic Care Services

Benefits for orthodontic services utilizing fixed appliances will not be available for more than twenty-four (24) consecutive months, or less than eighteen (18) months for a full course of treatment.