DUTCHESS COMMUNITY COLLEGE

SELF-INSURED

DENTAL BENEFITS

Revised: June 2015

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SCHEDULE OF BENEFITS

PLAN EFFECTIVE DATE September 1, 1997

EMPLOYEES' ELIGIBLE: All Full-Time Employees in a Covered Class

DEPENDENTS ELIGIBLE: All Dependents as defined

NON-CONTRIBUTORY DENTAL BENEFITS FOR YOU AND YOUR DEPENDENTS:

Dental Co-Insurance Rate

100% - of the Plan Schedule for All Covered Services.

Maximum Dental Benefit Per Calendar Year... **$2160**

Maximum Orthodontic Lifetime Benefit Per Covered Individual……….…… **$2,322**
(This is subject to the Maximum Dental Benefit.)

Dental Deductible………………………………………………………………. **NONE**

(Your Benefit Year: Begins on January 1 and ends December 31.)

For more details consult your Plan Coordinator, J.J. Stanis and Company, Inc.

This booklet supercedes any document previously issued concerning your dental benefits.

WHEN YOUR COVERAGE BEGINS

BECOMING ELIGIBLE

You are eligible for Employee Coverage while:
(a) You are a full-time Employee; and/or
(b) You are in a Covered Class; and
(c) You have completed the Employment Waiting Period.

EMPLOYMENT WAITING PERIOD

For Employees who are full-time and in a Covered Class on 9/1/92 – No waiting period.

For All Other Employees - The period extending to the first day of the month, following the start of full-time employment.

You are full-time if you regularly work at least the number of hours per week required for your Employment class. This cannot be less than 30 hours per week.

BECOMING COVERED

Your Employee Coverage will begin the first day on which:
(a) You are eligible for Employee Coverage; and
(b) You are in a Covered Class; and
(c) Your coverage is not being delayed since you are not actively at work; and
(d) That Coverage is part of the Group Contract.

If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to active work.

WHEN YOUR DEPENDENTS' COVERAGE BEGINS

BECOMING ELIGIBLE

You are eligible for Dependents Coverage while:
(a) You are eligible for Employee Coverage; and
(b) You have a Qualified Dependent.

QUALIFIED DEPENDENTS

The following are people who may obtain Dependent Coverage:
(a) Your spouse.
(b) Your unmarried children less than 19 years old.

Your children include your legally adopted children and each of your stepchildren and foster children who depends on you for support and maintenance.

WHEN YOUR DEPENDENTS COVERAGE BEGINS (CONTINUED)

EXCEPTIONS

The age 19 limit does not apply to a child who:

(a) Entirely depends on you for support and maintenance;
(b) Is enrolled as a full-time student in a school; and
(c) Is less than the Student Age Limit of 25.

Your spouse or children are not your Qualified Dependents while on active duty in the armed forces of any country.

BECOMING COVERED

Your Dependents Coverage will begin the first day on which:

(a) The person is your Qualified Dependent; and
(b) You are in a Covered Class; and
(c) You are covered for the Employee Coverage.

CHANGE IN FAMILY STATUS

It is important that you inform your Employer promptly when:

(a) You first acquire a Qualified Dependent; or
(b) A new Qualified Dependent becomes eligible; or
(c) A Qualified Dependent becomes ineligible.

DENTAL BENEFITS

WHAT IS COVERED

Benefits are payable for Covered Dental Charges incurred while the person is covered for these benefits. These charges must be due to a disease, defect or accidental injury to teeth covered by these benefits.

MAXIMUM AMOUNT PAYABLE

The maximum amount payable for each covered procedure can be found in the List of Covered Dental Expenses.

ELIGIBLE CHARGES

A charge is considered eligible if all of the following conditions are met:

(a) It is made for a Dental Service furnished to you or your Covered Dependent.
(b) The Service is in the List of Covered Dental Services.
(c) The person is covered by this plan when the charge is incurred.

A charge is considered incurred as follows:

(a) For an appliance or the alteration of one: On the date the impression is taken.
(b) For a crown, bridge or gold restoration: On the date the tooth is prepared.
(c) For root canal therapy: On the date the pulp chamber is opened.
(d) For all other Dental Services: On the date the service is provided.

ELIGIBLE CHARGES (CONTINUED)

A charge for a Dental Service is not an Eligible Charge if it is excluded to the extent that it:
(1) Falls outside the Charge Limit for that service; or
(2) Is described in the Plan Exclusions.

PAYMENT GUIDELINES

This plan will not pay benefits in excess of any charge submitted regardless if this plan is primary or secondary. This plan will not pay for Medical services nor will it coordinate benefits with any plan that provides Medical benefits.

If Covered Dental Charges for any course of treatment are expected to be more than $300 and you wish an estimate of any benefits that would be payable, you may give the Plan Coordinator a treatment plan. This plan is a doctor's written report giving the results of the doctor's exam of the covered person, the suggested treatment and proposed charge. **The estimate is based on dental necessity only and does not take into account any maximums that apply.**

PLAN EXCLUSIONS

The following expenses or services are not covered by this plan.

(1) Charges for services that are not either necessary or customarily performed to maintain or improve the dental health of a covered person's mouth.
(2) Charges for a service not furnished by a Dentist. This does not apply if the service:
  (a) is performed by a licensed dental hygienist under the direction of a Dentist; or (b) is an x-ray ordered by a Dentist.
(3) Charges for services:
  (a) furnished by or for the United States government or any other government, unless payment of the charge is required by law; or
  (b) to the extent that the service, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are in excess to those of any private insurance program or other non-governmental program.
(4) Charges for the replacement or modification of partial or full removable dentures, removable bridges or fixed bridgework, or for the addition of teeth to any of these, or for the replacement or modification of crowns or gold restorations, within 5 years after the device was installed.
(5) Charges for partial or full removable dentures, removable bridges, or fixed bridgework if it includes replacement of one or more natural teeth missing before the person became a Covered Person by this Plan. This does not apply if the denture, bridge or bridgework also includes replacement of a natural tooth that:
  (a) Is removed while the person is Covered by this plan; and
  (b) Was not an abutment to a partial denture, removable bridge or fixed bridge installed during the prior 5 years.

PLAN EXCLUSIONS (CONTINUED)

(6) Charges for any of the following services:
   (a) Appliances, or the modification of one, if an impression was made before the person was covered by this plan.
   (b) Crowns, bridges or gold restorations, if a tooth was prepared before the person was covered by this plan.
   (c) Root Canal Therapy, if the pulp chamber was opened before the person became a Covered Person.

(7) Charges in connection with services furnished for cosmetic purposes. Facings on crowns, or pontics, that are behind the second bicuspid will always be considered cosmetic. This does not apply if the service is needed as a result of accidental injuries sustained while a person is a Covered Person.

(8) Charges in connection with:
   (a) Orthodontic services or procedures that are not listed as covered expenses.
   (b) The Replacement of lost or stolen appliances; or
   (c) Appliances, restorations or procedures needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion.

(9) Charges in connection with:
   (a) Injuries arising out of, or in the course of, any work for wage or profit.
   (b) Diseases covered, by any workers' compensation law, occupational disease law or similar law.

(10) Charges for services that exceed the usual charge made by the provider for the service when there is no coverage.

(11) Charges for services to the extent that it is above the prevailing charge in the area for dental care of a comparable nature. A charge is above the prevailing charge to the extent that it is above the range of charges generally made in the area for dental care of a comparable nature. The area and that range are determined by the Plan Coordinator.

(12) Oral Hygiene instruction.

(13) Fissure sealants.

EXTENSION OF COVERAGE

A person's coverage will be extended for charges incurred in the 30 days after the date the person ceases to be covered. This extension applies to the services in the List of Dental Services only. There is no extension for other services.

During an extension this Coverage will apply to charges for the Dental Services listed in the "Extension of Benefits" on page 17. This extension will apply only if the persons' new dental coverage is not provided through Dutchess Community College.

LIST OF COVERED DENTAL SERVICES

The following is a complete List of Dental Services that are covered by this plan. If a Dental Service is not listed below it is not covered unless:

(1) A charge is made for a service furnished for the dental care of a specific condition; and
(2) The list includes one or more services, which under standard practices are separately suitable for the dental care of that condition.

In that case, the charge will be considered as a service on the list that would have produced a professionally acceptable result as determined by the Plan Coordinator. Two or more services in the list may be suitable for the dental care of a specific condition, under standard dental practice. Pre-operative x-rays or other diagnostic records may be requested by the Plan Coordinator to assist in this determination.

(Note: The amounts in the list below show the maximum payable for each eligible charge)

Code	Service	MAXIMUM BENEFIT
Diagnostic & Preventative Services		
D0120	Periodic Oral Evaluation- established patient (limited to two each calendar year)	$34.00
D0140	Limited Oral Evaluation- problem focused	$34.00
D0150	Comprehensive Oral Evaluation- new or established patient	$34.00
D0160	Detailed and extensive oral evaluation- problem focused, by report	$34.00
D0170	Re-evaluation- limited, problem focused (established patient; not post operative visit)	$34.00
D0180	Comprehensive periodontal evaluation- new or established patient	$34.00
D9110	Emergency Palliative Treatment	$33.00
D1120	Prophylaxis for children under age 14 (This service is limited to two each calendar year)	$32.00
D1110	Prophylaxis for individuals age 14 or over, include scaling and polishing (This service is limited to two each calendar year)	$48.00
D1203	Topical application of fluoride	$16.00
D1204	Topical application of fluoride	$16.00
D1208	Topical application of fluoride (This service is limited to one treatment per calendar year and is only covered for dependents under age 18)	$16.00
D0470	Study models	$19.00
D0460	Pulp test	$7.00
Bitewing x-rays: A series of bitewing x-rays consist of four films (This service is limited to two in a calendar year)		
D0270	One film	$8.00
D0272	Two films	$16.00
D0274	Four films	$32.00
D0210	Full Mouth and/or Panoramic x-rays are limited to one in three years	$58.00
D0330	Full Mouth and/or Panoramic x-rays are limited to one in three years	$58.00
D0220	Periapical Single film	$8.00
D0240	Intraoral, occlusal film	$14.00
D0250	Extraoral, one film	$17.00
D0260	Extraoral, two films	$17.00
D0290	Anterior film	$18.00
D0340	Cephalometric film	$24.00
D1510	Space Maintainers fixed unilateral	$72.00
D1515	Space Maintainers fixed bilateral	$150.00
D1520	Space Maintainers removable unilateral	$90.00
D1525	Space Maintainers removable bilateral	$155.00

LIST OF COVERED DENTAL SERVICES (CONTINUED)
BASIC SERVICES

	MAXIMUM BENEFIT
Oral Surgery Includes local anesthetics and routine postoperative care.	
Extractions	
D7140 Uncomplicated (single)	$46.00
D7140 Each additional tooth	$46.00
Surgical Extractions	
D7210 Surgical removal of erupted tooth	$70.00
D7220 Soft tissue impaction	$96.00
D7230 Partial bony impaction	$130.00
D7240 Complete bony impaction	$158.00
D7250 Root recovery	$70.00
D7282 Surgical exposure (for orthodontia)	$77.00
D7280 Surgical exposure (to aid eruption)	$64.00
D7285 Biopsy of oral tissue- hard	$75.00
D7286 Biopsy of oral tissue – soft	$75.00
Alveoplasty	
D7310 4 or more, Alveoplasty (per quadrant, in conjunction with extractions)	$58.00
D7311 1-3 teeth, Alveoplasty (per quadrant, in conjunction with extractions)	$58.00
D7320 4 or more, Alveoplasty (per quadrant, not in conjunction with extractions)	$92.00
D7321 1-3 teeth, Alveoplasty (per quadrant, not in conjunction with extractions)	$92.00
Surgical Incision	
D7510 Incision and drainage of abscess, intraoral	$49.00
D7520 Incision and drainage of abscess, extraoral	$66.00
Other Repair Procedures	
D7960 Frenectomy	$140.00
D7340 Vestibuloplasty ridge extension (secondary epithelialization)	$274.00
D7350 Vestibuloplasty- ridge extension (including soft tissue grafts, muscle reattachment, Revision of soft tissue attachment and management of hypertrophied/hyperplastic)	$274.00
Anesthetics	
D9220 General anesthesia, only when in conjunction with a surgical procedure	$60.00
Periodontics	
Subgingival curettage (per quadrant) limited to four quadrants per year	$54.00
D4341 Scaling & root planing (4 or more teeth per quadrant)	$21.25
D4342 Scaling & root planing (1-3 teeth per quadrant)	$21.25
D9951 Correction of occlusion (limited)	$35.00
D9952 Correction of occlusion (complete)	$140.00
D4210 Gingivectomy (including post-surgical visits)4 or more contiguous teeth per quadrant	$240.00
D4211 Gingivectomy (including post-surgical visits)1-3 contiguous teeth per quadrant	$240.00
D4212 Gingivectomy, treatment per tooth	$25.00
D4260 Osseous surgery (including post-surgical visits) 4 or more per quadrant	$360.00
D4261 Osseous surgery (including post-surgical visits) 1-3 teeth per quadrant	$360.00
D4270 Pedicle soft tissue graft	$140.00
D4277 Free soft tissue graft(including donor site surgery)first tooth or edentulous tooth	$104.00
D4278 Free soft tissue graft(including donor site surgery)each add'l tooth or edentulous tooth	$104.00
Endodontics Unless otherwise indicated, the limit shown is for one tooth.	
D3110 Pulp capping (direct)	$18.00
D3120 Pulp capping (indirect)	$18.00
D3320 Vital pulpotomy	$36.00

LIST OF COVERED DENTAL SERVICES (CONTINUED)

	MAXIMUM BENEFIT
Root Canals (permanent teeth only), including X-rays but excluding final restoration.	
D3310 Single root	$225.00
D3320 Bi-rooted	$275.00
D3330 Tri-rooted	$365.00
D3346 Retreat Root Canal Anterior	$166.00
D3347 Retreat Root Canal Bicuspid	$194.00
D3348 Retreat Root Canal Molar	$232.00
Periapical Services	
D3410 Apicoectomy/periradicular surgery - anterior	$170.00
D3421 Apicoectomy/periradicular surgery – bicuspid (first root)	$170.00
D3425 Apicoectomy/periradicular surgery – molar (first root)	$170.00
D3426 Apicoectomy/periradicular surgery – each add'l root)	$170.00
Restorative Services	
(Multiple restorations in one surface will be considered as a single restoration)	
Amalgam Restorations - primary teeth	
D2140 One surface	$36.00
D2150 Two surfaces	$45.00
D2160 Three surfaces	$60.00
D2161 Four or more surfaces	$65.00
Amalgam Restorations - permanent teeth	
D2140 One surface	$40.00
D2150 Two surfaces	$53.00
D2160 Three surfaces	$70.00
D2161 Four or more surfaces	$75.00
Pins	
D2951 Pin Retention	$26.00
Synthetic Restorations	
Silicate cement filling	$46.00
D2330 Composite one surface, anterior	$38.00
D2391 Composite one surface, posterior	$38.00
D2331 Composite two surfaces, anterior	$62.00
D2392 Composite two surfaces, posterior	$62.00
D2332 Composite three surfaces, anterior	$94.00
D2393 Composite three surfaces, posterior	$94.00
D2335 Composite (4 or more involving incisal angle), anterior	$100.00
MAJOR SERVICES	
Crowns	
D2930 Stainless steel (when tooth cannot be restored with a filling material), primary tooth	$56.00
D2931 Stainless steel (when tooth cannot be restored with a filling material), permanent tooth	$56.00
D2740 Porcelain	$320.00
D2750 Porcelain fused to high nobel metal	$350.00
D2751 Porcelain fused to predominantly base metal	$350.00
D2752 Porcelain fused to nobel metal	$350.00
D2790 Full Cast high noble metal	$330.00
D2791 Full Cast predominantly base metal	$330.00
D2792 Full Cast noble metal	$330.00
D2710 Resin based composite (indirect)	$310.00

LIST OF COVERED DENTAL SERVICES (CONTINUED)

	MAXIMUM BENEFIT
D2712 Resin ¾ resin based composite (indirect)	$310.00
D2720 Resin with high noble metal	$310.00
D2721 Resin with predominantly base metal	$310.00
D2722 Resin with noble metal	$310.00
Resin (laboratory)	$200.00
D2780 3/4 cast high noble metal	$310.00
D2781 3/4 cast predominantly base metal	$310.00
D2782 3/4 cast noble metal	$310.00
D2954 Post & core	$110.00
D2950 Crown buildup	$56.00
D2960 Labial veneer (resin laminate), chairside	$78.00
D2961 Labial veneer (resin laminate), laboratory	$78.00
D2962 Labial veneer (porcelain laminate, laboratory	$78.00
Recementing	
D2910 Inlay	$14.00
D2920 Crown	$36.00
D6930 Bridge	$48.00
Inlays	
D2510 One surface gold	$200.00
D2520 Two surfaces gold	$320.00
D2530 Three or more surfaces gold	$340.00
D2610 Porcelain- inlay – one surface	$288.00
D2620 Porcelain- inlay – two surfaces	$288.00
D2630 Porcelain- inlay – three or more surfaces	$288.00

Prosthodontics, Removable

(Fees for dentures, partial dentures and relining include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)

Full Dentures	
D5110 Complete upper or lower denture, maxillary	$475.00
D5120 Complete upper or lower denture, mandibular	$475.00
D5130 Immediate upper or lower denture, maxillary	$475.00
D5140 Immediate upper or lower denture, mandibular	$475.00
Partial Dentures	
D5211 Partial upper or lower with acrylic base, maxillary	$340.00
D5212 Partial upper or lower with acrylic base, mandibular	$340.00
D5225 Partial upper or lower with acrylic base, flexible base, maxillary	$340.00
D5226 Partial upper or lower with acrylic base, flexible base, mandibular	$340.00
D5213 Partial upper or lower with metal base, maxillary	$500.00
D5214 Partial upper or lower with metal base, mandibular	$500.00
D5281 Unilateral partial, one piece cast metal	$240.00
Adjustments To Dentures	
D5410 Adjustment to denture more than six months after installation, complete-maxillary	$14.00
D5411 Adjustment to denture more than six months after installation, complete-mandibular	$14.00
D5421 Adjustment to denture more than six months after installation, partial-maxillary	$14.00
D5422 Adjustment to denture more than six months after installation, partial-mandibular	$14.00

LIST OF COVERED DENTAL SERVICES (CONTINUED)

	MAXIMUM BENEFIT
Repairs To Dentures	
D5510 Repair broken complete denture base no teeth involved	$48.00
D5610 Repair resin denture base no teeth involved	$48.00
D5620 Repair cast framework, no teeth involved	$48.00
D5630 Repair or replace clasp	$85.00
D5660 Add clasp to existing partial denture	$85.00
D5520 Replacing missing or broken teeth, each tooth, complete denture	$52.00
D5640 Replacing missing or broken teeth, each tooth	$52.00
D5670 Replacing all teeth and acrylic on cast metal framework (maxillary)	$52.00
D5671 Replacing all teeth and acrylic on cast metal framework (mandibular)	$52.00
Add Tooth To Partial To Replace Extracted Natural Teeth	
D5650 Per tooth	$85.00
Denture Relining	
D5730 Full/Partial (office), complete denture, maxillary	$90.00
D5731 Full/Partial (office), complete denture, mandibular	$90.00
D5740 Full/Partial (office), partial denture, maxillary	$90.00
D5741 Full/Partial (office), partial denture, mandibular	$90.00
D5750 Full/Partial (lab), complete, maxillary	$150.00
D5751 Full/Partial (lab), complete, mandibular	$150.00
D5760 Full/Partial (lab), partial, maxillary	$150.00
D5761 Full/Partial (lab), partial, mandibular	$150.00
Other Prosthetic Services	
D5931 Obturator prosthesis, surgical	$100.00
D5932 Obturator prosthesis, definitive	$100.00
D5933 Obturator prosthesis, modification	$100.00
D5850 Tissue conditioning, maxillary	$52.00
D5851 Tissue conditioning, mandibular	$52.00
D5860 Overdenture complete, by report	$420.00
D5861 Overdenture partial, by report	$420.00
D5710 Rebase full denture, maxillary	$130.00
D5711 Rebase full denture, mandibular	$130.00
Prosthodontics, Fixed	
Pontics	
D6210 Cast, high noble metal	$186.00
D6211 Cast, predominantly base metal	$186.00
D6212 Cast, noble metal	$186.00
D6214 Cast, titanium	$186.00
D6240 Porcelain, fused to high noble metal	$310.00
D6241 Porcelain, fused to predominantly base metal	$310.00
D6242 Porcelain, fused to noble metal	$310.00
D6245 Porcelain, and ceramic	$310.00
D6205 Resin, indirect based composite	$275.00
D6250 Resin, with high noble metal	$275.00
D6251 Resin, with predominantly base metal	$275.00
D6252 Resin, with noble metal	$275.00
Retainers	
D6600 Two surfaces, porcelain/ceramic	$320.00
D6602 Two surfaces, high noble metal	$320.00
D6604 Two surfaces, predominantly base metal	$320.00

LIST OF COVERED DENTAL SERVICES (CONTINUED)

		MAXIMUM BENEFIT
D6606	Two surfaces, noble metal	$320.00
D6601	Three or more surfaces, porcelain/ceramic	$340.00
D6603	Three or more surfaces, high noble metal	$340.00
D6605	Three or more surfaces, predominantly base metal	$340.00
D6607	Three or more surfaces, noble metal	$340.00
D6608	Onlay, in addition to inlay allowance, porcelain/ceramic, two surfaces	$95.00
D6609	Onlay, in addition to inlay allowance, porcelain/ceramic, three or more surfaces	$95.00
D6610	Onlay, in addition to inlay allowance, cast high noble metal, two surfaces	$95.00
D6611	Onlay, in addition to inlay allowance, cast high noble metal, three or more surfaces	$95.00
D6612	Onlay, in addition to inlay allowance, cast predominantly base metal, two surfaces	$95.00
D6613	Onlay, in addition to inlay allowance, cast predominantly base metal, three or more	$95.00
D6614	Onlay, in addition to inlay allowance, cast noble metal, two surfaces	$95.00
D6615	Onlay, in addition to inlay allowance, cast noble metal, three or more surfaces	$95.00
D6634	Onlay, in addition to inlay allowance, titanium	$95.00
D6545	Cast metal retainer	$165.00
D6624	Cast porcelain/ceramic retainer	$165.00
Repairs To Bridges		
D6980	Repair	$35.00
Bridge Crowns		
D6710	Resin, indirect	$310.00
D6720	Resin, with high noble	$310.00
D6722	Resin, with noble metal	$310.00
D6740	Porcelain/ceramic	$350.00
D6750	Porcelain, fused to high noble metal	$350.00
D6751	Porcelain, fused to predominantly base metal	$350.00
D6752	Porcelain, fused to noble metal	$350.00
D6780	3/4 Cast, noble metal	$310.00
D6781	3/4 Cast, predominantly base metal	$310.00
D6782	3/4 Cast, noble metal	$310.00
D6790	Cast, high noble metal	$330.00
D6791	Cast, predominantly base metal	$330.00
D6792	Cast, noble metal	$330.00
D6794	Cast, titanium	$330.00

LIST OF COVERED DENTAL SERVICES (CONTINUED)

Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.

A. ORTHODONTIC BENEFITS

Benefits for the charges incurred in connection with the Orthodontic Procedures performed on a covered person are described below. There is a maximum amount payable under this plan for orthodontic services. This maximum is listed in the Schedule of Benefits on page 1.

B. ELIGIBLE CHARGES

An orthodontic charge is eligible for payment if the following condition is met:

- An active appliance for that Orthodontic Procedure is inserted while the person is covered for these benefits.

Exclusions

(1) Charges for Orthodontic Procedures if the active appliance for that Procedure has been installed before the person became covered by this plan.
(2) Retention appliances or visits.

ORTHODONTIC SERVICES

The only services eligible for orthodontic coverage are listed below. There is no benefit extension for orthodontic services incurred after the date a person ceases to be a covered for benefits by this plan.

Covered Orthodontic Procedures

Orthodontic Services

D8080 Comprehensive Dental Treatment visit - Adolescent
D8090 Comprehensive Dental Treatment visit - Adult
D8210 Orthodontic Removable Appliance Therapy
D8220 Fixed Appliance Therapy
D8660 Pre-Orthodontic Treatment Visit
D8670 Periodic Orthodontic Treatment Visit
D8680 Orthodontic Appliance (removal of appliances, construction and placement of retainer (s))

Pre-Orthodontic Work-up

This can include cephalometric x-rays, study models and a Professional Consultation.

Active Treatment Appliance

The use of an active appliance to move teeth and to correct:

(1) faulty position of teeth (malposition); or
(2) abnormal bite (malocclusion).
(3) vertical or horizontal overlap of upper teeth over lower arches with each other.
(4) faulty alignment of the upper and lower arches with each other.
(5) cross-bite.

Monthly Maintenance Visits
You are allowed one visit per month to maintain and or adjust an Orthodontic Appliance.

Orthodontic Treatment Plan

Your Dentist should submit an orthodontic treatment plan on a claim form approved by the Plan Coordinator. The treatment plan should:
(1) state the class of malocclusion or malposition;
(2) recommend and describe the needed treatment;
(3) estimate the duration of the treatment;
(4) estimate the total charge for the treatment;
(5) include cephalometric x-rays, study models and any other supporting evidence that the Plan Coordinator may require.

GENERAL INFORMATION

DEFINITIONS

Active Work/Actively at Work

This term means the performance of all duties that pertain to your work at the place where it is normally accomplished, or where it is required to be accomplished by your Employer.

DOCTOR

For purposes of Dental Benefits, the term "Doctor" means a dentist or physician. The term:

(a) "dentist" means a Doctor of Dental Surgery or a Doctor of Medical Dentistry;

(b) "physician" means legally licensed to practice medicine and surgery.

CHARGES/FEES/EXPENSES

The terms "charges," "fees," or "expenses," as they relate to dental care, will not include any amount:

(a) for a service or supply, which is not medically necessary, even if ordered by a doctor. Medically Necessary. This term means services or supplies which, as determined by the Plan Coordinator are: (i) provided for the diagnosis or treatment of a medical condition; (ii) proper for the symptoms, diagnosis or treatment of a medical condition; (iii) done in the proper setting or manner required for a medical condition; and (iv) within the standards of generally accepted dental care practice.

(b) for a service or supply which is provided only as a convenience, even if ordered by a doctor.

(c) for repeated tests which are not needed, even if ordered by a doctor.

(d) more than what is reasonable and customary in the locale where incurred, as determined by the Plan Coordinator and as elected by your Employer.

These amounts will be determined by the Plan Coordinator.

PLAN COORDINATOR

Refers to J.J. Stanis and Company, Inc.

CLAIM DETERMINATION PERIOD

This term means the time during any one plan year when a person is covered and incurs charges for one or more items of expense covered under this Plan; and at least one other plan. As each claim is submitted, each Plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later allowable Expenses are incurred in the same Claim Determination Period.

NON-DUPLICATION OF BENEFITS

If a covered person is entitled to benefits for dental care under this Plan and at least one other plan, the amount of benefits provided by this Plan, if this Plan is the Secondary, may be reduced to the extent that the total benefits paid do not exceed the covered or submitted charge whichever is less. The amount by which the Secondary Plan's benefits have been reduced shall be used by the Secondary Plan to pay the stated percentage of Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period on behalf of the covered person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligations to pay for the stated percentage of Allowable Expenses based on all the claims which were submitted up to that point in time during the Claim Determination Period. This will be done as set forth in Order of Payment

ALLOWABLE EXPENSES

This term means any necessary, reasonable and customary item, expense or part of the cost of which is covered by (a) this Plan, or (b) one of the other plans, except Medicare or a "no-fault" motor vehicle plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

PLAN

This term means any plan that provides medical or dental care coverage written on an expense incurred basis with which coordination is allowed.

"Plan" may include:

(a) any group insurance, or any other method of coverage for persons in a group.

(b) an insured arrangement of group coverage.

(c) group coverage through HMOs and other prepayment group practice and individual practice plans.

(d) any governmental plan, but not including a state plan under Medicaid.

(e) any plan required by law, but shall not include a law or plan when, by law, its benefits are in excess of any private insurance plan or other non-governmental plan.

(f) the medical benefits coverage group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.

"Plan" shall not include:

Blanket school accident coverage; or hospital indemnity coverage.

THIS PLAN

This term means that part of the Group Plan which provides benefits for dental care.

PRIMARY PLAN

This term means This Plan, or any other Plan, which determines its medical or dental care benefits for a covered person without taking into account any other Plan. A Plan is Primary if either:

(i) the Plan does not have a Non-Duplication of Benefits provisions like This Plan; or

(ii) the Plan, in accord with Order of Payment, would determine its benefits first.

SECONDARY PLAN

This term means any plan, which is not a Primary Plan.

MEDICARE

This term means TITLE XVIII of the Federal Social Security Act, as it now is, or as it may be changed. A person who is eligible for Medicare is deemed to have all the coverages for which they are eligible.

NO-FAULT MOTOR VEHICLE PLAN

This term means motor vehicle plan, which is required by the law and provides medical or dental care payments, which are made, in whole or in part, without regard to fault. A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

ORDER OF PAYMENT

When a person is covered under two or more plans, the rules that follow will decide the order in which the plans will pay benefits:

1. A plan, which does not have a provision like this Non-Duplication of Benefits, will pay before this plan.
2. A plan, which covers a person other than as a dependent, will pay before a plan which covers a person as a dependent.
3. A plan which covers a person as a dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers the person as a dependent of a person whose date of birth occurs later in a calendar year provided that:
   - (i) if said dates of birth are the same, the plan, which has covered a person for the longest time, will pay first.
   - (ii) if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefit.

In item 3 above, date of birth means day and month of birth. It does not mean year of birth. However, if the person is a dependent child of divorced or separated parents, the order will be as follows:

(a) first, the plan of the parent with custody of the child;
(b) then, the Plan of the spouse of the parent with custody of the child;
(c) finally, the Plan of the parent not having custody of the child.

However, if there is a court decree which sets forth a financial duty for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has the actual knowledge.

NON-DUPLICATION OF BENEFITS (CONTINUED)

4. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that person's dependent) are determined before those of a plan which covers such a person as a laid-off or retired employee (or as that person's dependent).
5. If these four rules do not decide which plan will pay its benefits first, the plan which has covered the person for the longest time will pay first. The length of time a person has been covered under a Plan is determined by the following:
   (a) Two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
   (b) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, then it is measured from the date the claimant first became a member of the group.

To administer claims, the Plan Coordinator, without the consent of any person, will have the right:
(a) to give or to get any data needed to determine benefits under this provision; and each person claiming benefits under a Plan must give the Plan Coordinator any data needed to pay the claim.
(b) to pay an organization for the payment made under its Plan, which should have been paid by the Plan Coordinator. Amounts so paid will be deemed benefits paid under this Plan; and to the extent so paid there will be no more liability under this Plan. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.
(c) to recover any excess if the amount paid is more than it should have paid under this provision from one or more of:
   (i) The persons it has paid or for whom it has paid;
   (ii) Insurance companies; or
   (iii) Other organizations.

A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, to the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided by the Primary Plan. Nothing in this provision shall be interpreted to require a Plan to reimburse a covered person in cash for the value of services provided by a Plan, which provides benefits in the form of services.

WHEN YOUR COVERAGE ENDS

EMPLOYEE AND DEPENDENTS COVERAGE

Your Employee Coverage or your Dependents' Coverage will end when the first of these occurs:
(a) You are no longer in the Covered Classes because your employment ends (see below) or because your class changes.
(b) Your class is removed from the Covered Classes.
(c) The part of the Group Contract providing coverage ends.
(d) The coverage is Dependents' Coverage and your Employee Coverage under that Coverage ends.

Your Dependents' Coverage will end when they cease to be a Qualified Dependent under this plan.

WHEN YOUR COVERAGE ENDS (CONTINUED)

End of Employment: For coverage purposes, your employment will end when you are no longer a full-time Employee actively at work for the Employer. But, under the terms of the Group Plan the Plan Holder may consider you as still employed in the Covered Classes during certain types of absences from full-time work. This is subject to any time limits or other conditions in the Group Plan.

If you stop active full-time work for any reason, you should contact the Plan Coordinator at once to determine what arrangements, if any, have been made to continue any of your coverage.

Continued Coverage for an Incapacitated Child

This applies only to the Dependent Coverage you have for a child under this coverage. The coverage for the child will not end on the date the age limit in the definition of Qualified Dependent is reached if both of these are true:

(1) The child is then mentally or physically incapable of earning a living. The Plan Coordinator must receive proof of this within the next 31 days.

(2) The child otherwise meets the definition of Qualified Dependent.

If these conditions are met, the age limit will not cause the child to stop being a Qualified Dependent under that Coverage. This will apply as long as the child remains so incapacitated.

COBRA

On April 7, 1986, the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 was signed into law. The provisions of the federal law are outlined below (OPTIONAL CONTINUANCE OF DENTAL INSURANCE).

OPTIONAL CONTINUANCE OF DENTAL COVERAGE

Special Continuance of Employee and Dependent Coverage

If your coverage ends, you may elect to continue for a maximum period of eighteen months the Dental Coverage under the Group Plan for you and your dependents, provided that the coverage ends due to:

(a) lay-off;

(b) a reduction in the scheduled work hours per week;

(c) voluntary termination of employment with your Employer; or

(d) discharge from your Employer's employ (other than gross misconduct).

Please Note: The 18 month period may be extended to 29 months, if you are determined by the Social Security Administration to have been disabled at the time of such termination of employment or reduction in schedule work hours.

J.J. Stanis and Company, Inc. will notify you of your right to continue coverage within 45 days of the occurrence of an above event.

SPECIAL CONTINUANCE OF DEPENDENT COVERAGE

If your dependent's coverage ends, he or she may elect to continue for a maximum period of thirty-six months the Dental coverage under the Group Plan for him or her, as follows:

(a) Your dependent spouse may elect to continue coverage on his or her own behalf and on that of any dependent children whose coverage would otherwise end, provided that the coverage ends due to:
 (i) your death; or
 (ii) your divorce or legal separation.

(b) Your dependent child, whose coverage would otherwise end, may elect to continue coverage on his or her own behalf provided that the coverage ends due to the death of the employee when there is no surviving parent, or the child's marriage or attainment of the age limit.

You and your dependent must notify your Employer of the occurrence of the events shown in (a)(ii) or (b) above. The notice should be given to your Employer as soon as is reasonably possible after the date the event occurred.

Within 45 days of receipt of notice that an event ending in a dependent's coverage has occurred, J.J. Stanis and Company, Inc. shall send notice to your dependent of the right to continue coverage.

To continue coverage, you or your dependent must apply in writing to J.J. Stanis and Company, Inc. within 60 days of the later of (1) the date the coverage ends; and (2) the date you or your dependent receive notice of the right to continue coverage.

You or your dependent must pay the required amount if any, for the continued coverage. J.J. Stanis and Company, Inc. will inform you of the monthly premium to be paid. You or your dependent must also pay such premium for any period of continued coverage, which began prior to the election of such continuance. This premium must be paid within 45 days after the date the continued coverage is elected.

The continued coverage will begin on the date after the date coverage would have ended. It will end when the first of the following events occurs:
(a) the Group Plan terminates;
(b) the end of the period allowed for continued coverage or for which premiums were paid;
(c) the date you or your dependent become covered under a group plan, which does not exclude or limit your benefits because of a pre-existing condition;
(d) the date you or your dependent becomes eligible for Medicare;
(e) the date your former spouse remarries and thereby becomes covered under a group plan.

CLAIMS INFORMATION

On receipt of due proof of claim, Dental benefits are payable to you. You may make an assignment of your group dental benefits.

NOTICE OF CLAIM

Written notice of the event on which a claim is based must be given to the Plan Coordinator within 20 days after the loss for which a claim is made. Late notice will be accepted only if it is furnished as soon as is reasonably possible.

On receipt of such notice, you will be given forms for filing proof of claim. If you have not been given such forms within fifteen days after the receipt of notice, you can fulfill the terms of the Plan as to proof of claim by giving written proof of (i) the occurrence of the loss; (ii) the nature of the loss; and (iii) the extent of the loss. Such proof must be given within the time stated in "Proof of Claim" below.

PROOF OF CLAIM

Written proof of claim must be given to the Plan Coordinator within 90 days after the date of loss for which claim is made. Late proof will be accepted only if it is furnished as soon as is reasonably possible. Itemized bills may be required as part of proof of claim.

EXAMINATIONS

The Plan Coordinator, at its own expense, has the right to have a doctor examine any person when it deems it reasonably necessary while there is a claim pending under the Plan.

LEGAL ACTIONS

No one may sue for payment of claim less than sixty days after due proof of claim is furnished or more than 2 years after the date proof of claim is required by the Plan. The coverage evidenced by this document provides Dental Coverage only.

EXTENSION OF BENEFITS

No payment will be made under this benefit for dental services or supplies furnished on or after the date of termination of a Covered Person's insurance, except under the following specified circumstances:

1. In the case of appliances or modifications of appliances, if the master impression was taken while dental insurance was in force, benefits will be payable if the appliance was delivered or installed within 30 days after the termination of insurance;

2. In the case of a crown, bridge, inlay or onlay restorations, if the tooth or teeth were prepared while dental insurance was in force, benefits will be payable if such crown, bridge or cast restoration was installed within 30 days after the termination of insurance;

3. In the case of root canal therapy, if the pulp chamber was opened while dental insurance was in force, benefits will be payable if such root canal therapy is completed within 30 days after the termination of insurance.

All Claims should be mailed to
J.J. Stanis and Company, Inc. at the following address:

J.J. Stanis and Company, Inc.
377 Oak Street, Suite 406
Garden City, NY 11530

All Benefit and Claim inquiries should be directed to
J.J. Stanis and Company, Inc.
At the following phone number:

Toll Free: (877) 470-3715