SACHEM CENTRAL SCHOOL DISTRICT

TEACHERS/CLERICAL/SSSU

SELF-INSURED

DENTAL PLAN

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This booklet replaces and supersedes any other document, which may have been issued previously.

SCHEDULE OF BENEFITS

PLAN EFFECTIVE DATE: May 1, 2004 (Teachers)
July 1, 2010 (Clerical)
July 1, 2011 (SSSU)

ELIGIBLE CLASSESS: ALL FULL TIME TEACHERS
ALL FULL TIME CLERICAL
ALL FULL TIME SSSU

WAITING PERIOD: 1 year from date of hire (teachers, clerical)

FOR EMPLOYEES AND DEPENDENTS

DENTAL EXPENSE BENEFITS

DENTAL DEDUCTIBLE (Individual)..$50
DENTAL DEDUCTIBLE (Family)..$100
(Covered for Orthodontic Services)

CALENDAR YEAR MAXIMUM BENEFIT..................................$1,200

ORTHODONTIC CARE MAXIMUM
(per calendar year; subject to the Calendar Year Maximum Benefit)..................$500

DATE INCURRED

The charge for a dental service is incurred on:

(a) the date the impression is taken, in the case of dentures for fixed bridges;
(b) the date the preparation of the tooth is begun, in the case of crown work;
(c) the date the work on the tooth is begun, in the case of root canal therapy; and
(d) the date the work is done, in the case of any other work.

SYNOPSIS OF DENTAL BENEFITS

For details of coverage including exclusions and limitations, read the benefit descriptions contained in the following pages of this booklet.

DENTAL CONVERAGE

The coverage evidenced by this booklet provides Dental coverage only

INCREASES AND DECREASES IN AMOUNT OF COVERAGE

Any increase in or addition to the benefits will take effect on the first day of the month following the date of the increase or addition. If you are not actually at work on that date, the

increase or addition will take effect when you return to full-time work. If your covered dependent is hospital confined on that date, the increase or addition will take effect when they are discharged from the hospital. Any decrease in or deletion of benefits will take effect on the first day of the month following the date of the decrease or deletion. Any change applies only to Covered Dental Expenses incurred on or after the effective date of the change.

ELIGIBILITY AND EFFECTIVE DATE

Eligibility

Employees: If on the effective date of the plan you are an active, full-time employee in an eligible class, you will be eligible on that date.

If after the effective date of the plan you become an active, full-time employee in an eligible class, you will be eligible on the day following the completion of any applicable waiting period.

The eligible classes, effective date and waiting period are shown in the pages following.

Dependents: On the date you become eligible for coverage you also become eligible for dependent coverage.

Effective Date of Coverage

Employees: Your coverage is effective:

(a) on the date you become eligible, if you enroll on or before the date you become eligible;
(b) on the date you enroll, if you enroll within 31 days after the date you become eligible;
(c) three months after the date you enroll, if you enroll after 31 days following the date you become eligible;
(d) three months after the date you enroll if you enroll again after having been previously covered under this plan.

If you are not at work on the date you would otherwise become covered, your coverage will be effective on the date you return to active, full-time employment.

ELIGIBILITY AND EFFECTIVE DATE (Cont'd.)

Dependents: Your dependent's coverage is effective:

(a) on the date your dependents become eligible; if you enroll for dependent coverage on or before such date;
(b) on the date you enroll, if you enroll for dependent coverage within 31 days after the date your dependents become eligible;
© three months after the date you enroll, if you enroll for dependent coverage after 31 days following the date your dependents become eligible;
(d) three months after the date you enroll, if you enroll again for dependent coverage after having previously covered such dependents under this plan.

If your dependent is hospital confined on the date they would otherwise become covered, they will become covered on the date they are discharged. This does not apply to a newborn child.

You cannot be covered for dependent coverage unless you are a covered employee.

If your dependent is eligible under this plan for coverage as an employee, they are **not** eligible as a dependent with respect to that coverage. If both you and your spouse (whether married, legally separated or divorced) are covered under this plan as employees, your children may only be enrolled as dependents of you **or** your spouse.

If while covered for dependent coverage you acquire an additional dependent, you will become covered with respect to such dependent on the date they become eligible.

TERMINATION OF COVERAGE

The coverage of any employee will terminate on the date that any of the following events first occurs:

(a) the last day of the month coinciding with or following the date employment or eligibility ends;
(b) the plan terminates; or
© an employee does not make a required contribution.

The coverage on any dependent will terminate on the date that any of the following events first occurs:

(a) the eligibility as a dependent ends;
(b) the employee's coverage ends; or
© the employee does not make a required contribution.

DEFINITIONS

"**Accidental Injury" means** bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.

"**Active, Full-Time Employee" means** an employee of the Plan holder who works: (a) regularly throughout the Plan holder's entire work week; and (b) at least 20 hours per week. Such employee may work at any of the Plan holder's business locations. They may also work at any other location where the plan holder's business requires them to travel. Their main source of earned income must be the earnings received from the Plan older.

"**Covered Dependent**" means a dependent whose coverage is in effect. It does not include a dependent whose coverage has terminated.

"**Covered Employee**" means an active, full-time employee whose coverage is in effect. It does not include an employee whose coverage has terminated.

"**Dentist" means** a person other than a covered employee or covered dependent who is licensed to practice dentistry, and practices with the scope of their license. A physician will be considered a dentist when they perform any dental service within the scope of their license.

"**Dependent**" means: (a) an employee's spouse whether married or legally separated from the employee; and (b) an employee's unmarried child (including any stepchild or legally adopted child) under age 19. If an unmarried child age 19 or over is a full-time student in a school, college or university, they are a dependent until he reaches age 23. "**Dependent**" does not include a person who is an eligible employee, or a member of the armed forces. **Please note that as of 5/1/02 coverage for all students over age 19 under age 23 will be extended for three months after graduation.**

"**Medicare**" means Title XVIII of the Social Security Act of 1965 as then constituted and later amended. In determining benefits payable under Medicare, a covered person will be deemed enrolled and insured for all the Medicare benefits for which such person is entitled, including any benefits for which the covered person must pay.

"Plan Coordinator" This term refers to J. J. Stanis and Company, Inc.

"**Sickness**" means disease or illness including related conditions and recurrent symptoms.

"**Total Disability**" or "**Totally Disabled**" with respect to a covered employee means the complete inability to work at any job because of accidental injury or sickness.

"**Total Disability**" or "**Totally Disabled**" with respect to a covered dependent means the complete inability to do the normal activities of a person of the same age and sex in good health.

DEFINITIONS (Cont'd.)

"**Usual and Customary Charge**" means a charge for a dental service that is the lesser of: (a) the usual charge made by the dentist for that service; or (b) the prevailing charge, as determined by J. J. Stanis and Company, Inc. for that service by most other dentists in the area where the dental services is furnished.

DENTAL BENEFITS

Dental Benefits are payable for Covered Dental Expenses incurred by you or your covered dependents.

Dental Benefits are payable for Covered Dental Expense up to the maximum amount shown in the Schedule of Dental Procedures, less any Dental deductible.

The total amount payable for Covered Dental Expense in a calendar year for dental services, including Orthodontic Care, will not exceed the Calendar Year Maximum Benefit. The Calendar Year Maximum Benefit is shown in the Schedule of Benefits.

The total amount payable for Covered Dental Expenses in a calendar year for Orthodontic Care will not exceed the Orthodontic Care Maximum. The Orthodontic Care Maximum is shown in the Schedule of Benefits.

Covered Dental Expenses:

A Covered Dental Expense is the lesser of: (a) the charges made by a dentist for a dental service or (b) the maximum amount shown in the Schedule of Dental Procedures. Dental service means any of the services listed in the Schedule of Dental Procedures. Such service must be done by or under the direction of a dentist for necessary care of the teeth.

Covered Dental Expenses includes expenses for a dental service that begins while the person is covered by this plan. Covered Dental Expenses will not include expenses for services that begin after Dental Benefits end.

Extended Benefits

Covered Dental Expenses also include expenses for the following dental services that are completed within 3 months* after the date Dental Benefits end if the dental service began before such date. 1. Root Canal Therapy, if the pulp chamber was opened prior to the date coverage ended; 2. A crown bridge of restoration for which a tooth was prepared prior to the date coverage ended; 3. An appliance, if the impression was taken prior to the date coverage ended. * If Dental Benefits end due to termination of the plan or termination of an eligible class, the service must be completed within 1 month after the date Dental Benefits end for the expense to be considered covered.

PRE-TREATMENT ESTIMATE

If covered dental charges for any course of treatment are expected to be more than $300 and you wish to obtain a pre-estimate of any benefits that would be payable, you may submit a pre-treatment plan. This plan is a doctor's written report giving the results of the doctor's exam of the covered person and the suggested treatment.

The estimate is based on dental necessity only and does not take into account any deductibles, maximums or late entrant penalties that may apply. You are subject to your plans' deductibles, maximums & penalties regardless of any pre-estimate you may receive Dental Deductible
The Dental Deductible applies to all dental services except Orthodontic Care. It is a dollar amount of Covered Dental Expense that must be met once each calendar year before benefits are payable for such dental services. Only Covered Dental Expense incurred for dental services, other than Orthodontic Care, may be used to satisfy the Dental Deductible. The Dental Deductible applies to each covered person.

Covered Dental Expenses applied toward the Dental Deductible during the last 3 months of a calendar year may be used toward the Dental Deductible for the next year.

Family Dental Deductible
If the sum of Covered Dental Expenses used toward you and your covered dependent's individual Dental Deductibles in a calendar year equals 2 times the Dental Deductible, the Dental Deductible shall be deemed to be met with respect to Covered Dental Expense incurred by all covered persons in your family for the rest of that calendar year.

PLAN EXCEPTIONS

Dental Expense Benefits will not be payable for the following charges. Such charges will not be considered Covered Dental Expense:

(a) charges on account of accidental injury or sickness that result from war, declared or undeclared, or any act of war;
(b) charges for services that are cosmetic in nature; except benefits are payable for services that are cosmetic when needed as a result of an accidental injury that occurs while covered;
(c) charges for facings on crowns, or pontics, posterior to the second bicuspid and the personalization and characterization of dentures;
(d) charges to the extent that benefits (including any optional benefits) are payable under Medicare;
(e) charges for appliances or restorations; other than full dentures, whose purpose is to alter vertical dimension;
(f) charges for services or supplies for dentures, bridges or for orthodontic diagnosis, evaluation and pre-care, if the charge was incurred within 2 years of the date coverage became effective and;
(g) any charges incurred or treatment rendered unless there is a requirement to pay whether or not there is coverage; or

Plan Exceptions (Cont'd.)

(h) any charges due to accidental injury that arises out of or in the course of employment; or
(i) any charges due to sickness if benefits are payable under a Worker's Compensation Law.
(j) charges for bridges, dentures or orthodontic services for 2 years, if

(1) you enrolled more than 31 days after you first became eligible; or
(2) you enrolled again after having been previously covered under this plan; or

With respect to your dependents coverage

(1) you enrolled for such dependent coverage more than 31 days after your dependent first became eligible; or
(2) you enrolled again for such dependent coverage after such dependent was previously covered under this plan.

COVERED DENTAL PROCEDURES

A Dental Service not listed in the Schedule and not excluded from coverage may be submitted to the Plan Coordinator for consideration. When submitting such expenses the dental service should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature. If accepted by the Company as a Covered Dental Expense, the Covered Dental Expense for such dental service will be an amount determined by the Plan Coordinator and will be consistent with those for listed dental services shown in this document.

Dental services, which do not have uniform professional endorsement, will not be accepted by the Plan Coordinator as Covered Dental Expense. Nor will the Plan Coordinator accept as Covered Dental Expense, expenses incurred for dietary planning for control of dental caries; oral hygiene instruction; training in preventive dental care; or bite registration.

A temporary dental service will be considered a part of the final dental service.

Dental treatment of temporomandibular joint dysfunction (TMJ) is covered as any other dental service. Benefits are payable up to the Allowances shown in the Schedule of Dental procedures.

FREQUENCY LIMITATIONS

DIAGNOSTIC
Oral exams/evaluations (this service is limited to 1 in a 6 month period)

RADIOGRAPHS (these services are limited to 1 in a 6 month period)

PREVENTIVE
Dental Prophylaxis, includes scaling/ polishing (this service is limited to 1 in a 6 month period)
Topical application fluoride, excluding prophylaxis (this service is limited to 1 in a 6 month period)

COVERED DENTAL PROCEDURES

TESTS AND DIAGNOSTIC AIDS, SPACE MAINTAINERS, SEALANTS

RESTORATIVE SERVICES (fillings include bases as necessary).

ENDODONTICS (including radiographs and exclusive of the final restoration).

PERIODONTICS

PROSTHODONTICS (includes adjustments and relines for 6 months following installation. Thereafter, relines and rebases are limited to once every 2 years).

CROWNS AND BRIDGES

ORAL SURGERY

MISCELLANEOUS SERVICES (GENERAL ANESTHESIA)

ORTHODONTIC CARE

Orthodontic diagnosis, evaluation, treatment and appliances - 80% of the Usual and Customary charge

COBRA

The provisions of the COBRA federal law are outlined below.

OPTIONAL CONTINUANCE FOR 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 for gross misconduct).

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, they may elect to continue for a maximum period of thirty six months the Dental coverage under the Group Plan 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 or 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 reasonably possible after the date the event occurred.

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

To continue coverage, you or your dependent must apply in writing to J.J. Stanis 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 the coverage.

You or your dependent must pay the required amount, if any, for the continued coverage. J.J. Stanis will inform you of the monthly amount to be paid. You or your dependent must also pay such amount for any period of continued coverage, which began prior to the election of such continuance. This amount 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 occur:

(a) the Group Plan terminates;
(b) the end of the period allowed for continued coverage;
(c) the end of the period for which contributions were paid;
(d) the date you or your dependent become covered under a group plan;
(e) the date you or your dependent become eligible for Medicare;
(f) the date your former spouse remarries and thereby becomes covered under a group plan.

COORDINATION 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 for that care, if this Plan is the Secondary Plan, may be reduced to the extent that the total benefits paid or provided by all plans during a Claim Determination Period are not more than the total of the Allowable Expenses that the person incurs in that period. 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 by the 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 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 of expense a 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.

This term does not include items of expense for the following coverages: Vision Care, Prescription Drug or Hearing Aid programs.

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.

Claim Determination Period

This term means the time during any one calendar year when a person is covered and incurs charges for one or more items of expense covered under: (i) this Plan; and (ii) 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.

Plan

This term means any plan that provides dental 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 pre-payment, 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 to those of any private insurance plan or other non-governmental plan.

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

"**Plan**" shall not include:

(a) blanket school accident coverage; or
(b) hospital indemnity coverage.

This Plan

This term means that part of this plan, which provides benefits for medical or dental care. This term does not include Vision Care, Prescription Drug or Hearing Aid programs.

Primary Plan

This term means This Plan, or any other Plan, which determines its dental 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 provision 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 will be deemed to have all the coverages for which he or she is so eligible.

No-Fault Motor Vehicle Plan

This term means a motor vehicle plan, which is required by 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) The 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 clause 3 above, date of birth means day and month of birth and not year of birth.

However, if the person is a dependent child of divorced or separated parents, the order will be as follows:

- (i) first, the Plan of the parent with custody of the child;
- (ii) then, the Plan of the spouse of the parent with custody of the child;
- (iii) 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.

(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 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.

Order of Payment (Cont'd)

(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.

CONTINUATION OF COVERAGE ON CERTAIN DEPENDENT CHILDREN

You may continue dental coverage for certain dependent children who reach the age at which coverage would otherwise cease. Due proof must be given that the child is unable to earn their own living for reasons of physical handicap, mental illness or retardation. You must be covered for dependent coverage for the child on the date they reach such age. Proof must be received:

(a) by the Plan Coordinator; and

(b) within 31 days after they reach the age at which the coverage would otherwise cease.

Order of Payment (Cont'd.)

Your child shall continue to be considered a covered dependent so long as:

(a) you submit due proof each year that they remain physically or mentally unable to earn their own living. This must be done within three months before each anniversary of the original date you have proof; and

(b) the amount due is paid.

The Plan Coordinator may have a physician of its choice examine your child during the time his coverage is continued. An exam will not be required more than once a year.

Your coverage for such child will terminate according to the provisions under Termination of Coverage or on the earliest of:

(a) the date the child is able to earn a living on its own;

(b) failure to provide due proof that the child is unable to earn a living on their own; or

(c) failure of the child to submit to an exam by a physician.

GENERAL PROVISIONS

PROOF OF LOSS

Written proof must be given to the Plan Coordinator within 90 days after a covered expense is incurred.

J. J. STANIS AND COMPANY, INC.
100 Jericho Quadrangle, Suite 101
Jericho, NY 11753

Claim forms for filing proof of loss will be available at your benefit's Office

If it is not reasonably possible for the claimant to give proof in the time required, the Plan Coordinator shall not reduce or deny the claim for this reason if the proof is filed as soon as possible.

Examination

The Plan Coordinator has the right to have the claimant examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

Actions at Law

No legal action may be brought to recover on this plan until 60 days after written proof of loss has been given. No such action may be brought after 2 years from the time written proof of loss is required to be given.

Payment of Claims

You may authorize the Plan Coordinator to pay benefits directly to the dentist or other party providing treatment. Any such payments will discharge the Plan Coordinator to the extent of payment made. Unless allowed by law, payments may not be attached or subject to your or your covered dependent's debts.

Facility of Payment

If a claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Plan Coordinator at its option, may make payment to a party who appears to have assumed responsibility for the care of such person. Such payments will be made until a guardian makes a claim.

If a claimant dies while benefits remain unpaid, benefits will be paid, at the Plan Coordinator's option, to:

(a) a person or institution on whose charges claim is based; or
(b) a surviving relative (spouse, parent or child).

Such payment will release the Plan Coordinator of all further liability to the extent of payment.

Modification of Plan

The plan-holder reserves the right to discontinue or modify this Plan at any time.

SCHEDULE OF BENEFITS

DENTAL SERVICE

PROCESS CODE	DESCRIPTION OF SERVICE	MAXIMUM AMOUNT
0120	PERIODIC ORAL EVALUATION	19.26
0140	LMTD ORAL EVALUATION	19.26
0150	COMPR. ORAL EVALUATION	19.26
0160	DETAILED ORAL EVALUATION	19.26
0210	XRAY-COMPLETE SERIES	55.04
0220	XRAY-SINGLE FILM	5.50
0230	XRAY-ADDITIONAL FILM	2.75
0240	XRAY-SINGLE FILM	27.50
0250	XRAY-SINGLE FILM	28.07
0260	XRAY-ADDITIONAL FILM	13.20
0270	BITEWING-XRAY	6.05
0272	BITEWING-XRAYS	9.35
0274	BITEWING-XRAYS	17.06
0290	POST/ANTER LAT FILM	27.50
0310	SIALOGRAPHY	93.00
0320	TMJ ARTHOGRAM FILM	46.78
0321	OTHER TMJ FILM	46.78
0330	PANORAMIC FILM	46.78
0340	CEPHALOMETRIC FILM	93.00
0415	BACTERIAL CULTURES	18.71
0425	SUSCEPTIBILITY TEST	37.42
0460	PULP TESTS	9.35
0470	DIAGNOSTIC CASTS	27.50
0501	HISTOPATHOLOGIC EXAM	41.28
0502	OTHER ORAL PATHOLOGY	41.28
1110	PROPHYLAXIS (ADULT)	27.50
1120	PROPHYLAXIS (CHILD)	22.01
1201	FLUORIDE W/PROPHY CHILD	55.04
1203	FLUORIDE TREATMENT CHILD	16.51
1204	FLUORIDE TREATMENT ADULT	16.51
1205	FLUORIDE W/PROPHY ADULT	55.04
1351	SEALANT (PER TOOTH)	15.41
1510	SPACE MAINTAINER UNILATERAL	165.12
1515	SPACE MAINTAINER BILATERAL	110.08
1520	SPACE MAINTAINER UNILATERAL	132.09
1525	SPACE MAINTAINER BILATERAL	206.50
1550	RECEMENT SPACE MAINTAINER	22.01
2110	AMALGAM RESTORATION 1 SURF	22.01
2120	AMALGAM RESTORATION 2 SURF	33.02

SCHEDULE OF BENEFITS

DENTAL SERVICE

PROCESS CODE	DESCRIPTION OF SERVICE	MAXIMUM AMOUNT
2130	AMALGAM RESTORATION 3 SURF	41.28
2131	AMALGAM RESTORATION	55.04
2140	AMALGAM RESTORATION	22.01
2150	AMALGAM RESTORATION	33.02
2160	AMALGAM RESTORATION	41.28
2161	AMALGAM RESTORATION	55..04
2330	RESIN RESTORATION	45.68
2331	RESIN RESTORATION	55.04
2332	RESIN RESTORATION	91.36
2335	RESIN RESTORATION	63.84
2391	COMPOSITE RESTORATION	45.68
2392	COMPOSITE RESTORATION	55.04
2393	COMPOSITE RESTORATION	91.36
2410	GOLD FOIL RESTORATION	91.36
2420	GOLD FOIL RESTORATION	136.50
2430	GOLD FOIL RESTORATION	164.02
2510	INLAY METALLIC	192.64
2520	INLAY METALLIC	206.40
2530	ONLAY METALLIC	247.68
2542	ONLAY METALLIC 2 SURFACES	27.52
2543	ONLAY METALLIC 3 SURFACES	27.52
2544	ONLAY METALLIC 4 SURF	27.52
2610	PORCELAIN INLAY	136.50
2620	PORCELAIN INLAY	156.86
2630	PORCELAIN INLAY	175.58
2642	ONLAY PORC/2 SURFACE	187.50
2643	ONLAY PORC/3 SURFACES	206.77
2644	ONLAY PORC/ 4 SURFACES	206.77
2650	INLAY COMP/1 SURF	168.24
2651	INLAY COMP/2 SURF.	188.42
2652	INLAY COMP/3 SURF	206.77
2662	ONLAY COMP/RSIN 2 SUR (LAB)	187.50
2663	ONLAY COMP/RSIN 3 SUR (LAB)	206.77
2664	ONLAY-COMP/RSIN 4 SUR	206.77
2710	CROWN RESIN LAB	233.92
2720	CROWN RESIN HIGH NOBLE	344.00
2721	CROWN RESIN BASE METAL	344.00
2722	CROWN RESIN NOBL METAL	344.00
2740	PORCELAIN CROWN	344.00
2750	CROWN PORCELAIN HIGH NOBLE	412.80

SCHEDULE OF BENEFITS

DENTAL SERVICE

PROCESS CODE	DESCRIPTION OF SERVICE	MAXIMUM AMOUNT
2751	CROWN PORCELAIN BASE METAL	412.80
2752	CROWN PORCELAIN NOBLE METAL	412.80
2790	CROWN FULL CAST HIGH NOBLE	330.24
2791	CROWN FULL CAST BASE METAL	227.31
2792	CROWN FULL CAST NOBLE METAL	246.03
2910	RECEMENT INLAY	41.28
2920	RECEMENT CROWN	41.28
2930	STAINLESS STEEL CROWN	82.56
2931	STAINLESS STEEL CROWN	82.56
2932	RESIN CROWN PREFAB	27.50
2940	SEDATIVE FILLING	16.51
2950	CROWN BUILDUP	91.36
2951	PIN RETENTION	9.35
2952	CAST POST & CORE	91.36
2953	CAST POST ADDITIONAL	91.36
2954	POST & CORE PREFAB	91.36
2955	POST REMOVAL NOT ENDO	27.50
2960	LAMINATE	127.69
2961	RESIN LAMINATE	127.69
2962	PORCELAIN LAMINATE	127.69
2970	TEMPORARY CROWN	27.50
2980	CROWN REPAIR	73.20
3110	PULP CAP DIRECT	20.62
3120	PULP CAP INDIRECT	20.62
3220	PULPOTOMY	41.28
3221	PULPAL DEBRIDEMENT	30.27
3230	PULPAL THERAPY ANTERIOR	41.28
3240	PULPAL THERAPY POSTERIOR	82.56
3310	ROOT CANAL THERAPY	151.36
3320	ROOT CANAL THERAPY	344.00
3330	ROOT CANAL THERAPY	412.80
3333	INTERNALL ROOT REPAIR	29.35
3346	RETREAT ROOT CANAL-ANTERIOR	358.28
3347	RETREAT ROOT CANAL-BICUSPID	367.76
3348	RETREAT ROOT CANAL – MOLAR	385.28
3351	APEX/RECALCIFICATION	215.21
3410	APICOECTOMY ANTERIOR	137.60
3411	APICOECTOMY BICUSPID	137.60
3425	APICOECTOMY FIRST ROOT	119.50
3426	APICOECTOMY ADDITIONAL ROOT	51.37
3430	RETROGRADE FILLING	75.40
3440	APICAL CURETTAGE	53.94
3450	ROOT AMPUTATION	150.81
3460	ENDOSSEOUS IMPLANT	234.60
3910	TOOTH ISOLATION	23.70

SCHEDULE OF BENEFITS

DENTAL SERVICE

PROCESS CODE	DESCRIPTION OF SERVICE	MAXIMUM AMOUNT
3920	HEMISECTION	150.81
3940	RECALCIF OF PERF	53.94
3950	CANAL PREP/FIT POST	22.01
4210	GINGIVECTOMY	135.00
4211	GINGIVECTOMY	77.40
4220	GINGIVAL CURETTAGE	22.50
4240	GINGIVAL FLAP PROCEDURE	115.50
4249	CROWN LENGTH 1 TOOTH	50.00
4260	OSSEOUS SURGERY	202.50
4263	BONE GRAFT 1ST SITE IN QUAD	142.80
4264	BONE GRAFT ADDL SITE	214.80
4266	GUIDED TISSUE REGEN	107.10
4267	GUIDED TISSUE NONRESTORABLE	107.10
4270	PEDICLE SOFT TISSUE GRAFT	89.40
4271	FREE SOFT TISSUE GRAFT	107.10
4272	REPOSITIONED FLAP	357.00
4273	CONNECT TISSUE GRAFT	107.10
4274	DISTAL WEDGE	135.00
4320	PROVISIONAL SPLINT-INTRA	59.70
4321	PROVISIONAL SPLINT-EXTR	59.70
4341	PERIO-SCALING/QUAD	59.70
4355	FULL MOUTH DEBRIDEMENT	59.70
4381	LOCAL CHEMO. AGENT	100.00
4910	PERIO MAINTENANCE	30.00
4920	DRESSING CHANGE	12.00
5110	COMPLETE DENTURE UPPER	376.20
5120	COMPLETE DENTURE LOWER	376.20
5130	IMMEDIATE DENTURE UPPER	382.20
5140	IMMEDIATE DENTURE LOWER	382.20
5211	UPPER PARTIAL DENTURE/RESIN BASE	262.50
5212	LOWER PARTIAL DENTURE/RESIN BASE	262.50
5213	UPPER PARTIAL DENTURE-CAST METAL	412.50
5214	LOWER PARTIAL DENTURE-CAST METAL	412.50
5281	UNILATERAL PARTIAL DENTURE	141.60
5410	ADJUST DENTURE UPPER-COMPLETE	7.50
5411	ADJUST DENTURE LOWER-COMPLETE	7.50
5421	ADJUST DENTURE UPPER-PARTIAL	7.50
5422	ADJUST DENTURE LOWER-PARTIAL	7.50
5510	REPAIR COMPLETE DENTURE	37.50

SCHEDULE OF BENEFITS

DENTAL SERVICE

PROCESS CODE	DESCRIPTION OF SERVICE	MAXIMUM AMOUNT
5520	REPLACE BROKEN OR MISSING TEETH	24.00
5610	REPAIR RESIN BASE	37.50
5620	REPAIR FRAMEWORK	24.00
5630	REPAIR BROKEN CLASP	52.50
5640	REPLACE BROKEN TEETH	12.00
5650	ADD TOOTH TO PARTIAL	75.00
5660	ADD CLASP TO PARTIAL	42.60
5710	REBASE DENTURE UPPER-COMPLETE	150.00
5711	REBASE DENTURE LOWER-COMPLETE	150.00
5720	REBASE PARTIAL UPPER-PARTIAL	99.30
5721	REBASE PARTIAL LOWER-PARTIAL	99.30
5730	RELINE UPPER DENTURE	52.50
5731	RELINE LOWER DENTURE	52.50
5740	RELINE PARTIAL DENTURE	52.50
5741	RELINE PARTIAL DENTURE	52.50
5750	RELINE UPPER DENTURE	75.00
5751	RELINE LOWER DENTURE	75.00
5760	RELINE PARTIAL DENTURE	75.00
5761	RELINE PARTIAL DENTURE	75.00
5850	TISSUE CONDITIONING-UPPER	49.80
5860	OVERDENTURE COMPLETE	382.50
5861	OVERDENTURE PARTIAL	353.70
5862	PRECISION ATTACHMENT	62.70
5931	SURGICAL OBTURATOR	353.70
5932	POST SURG OBTURATOR	353.70
5956	OBTURATOR	353.70
5973	SUBPERIOSTEAL IMPLANT	208.20
5974	ENDOSSEOUS IMPLANT	208.20
6010	SURGICAL END IMPLANT	728.37
6057	CUSTOM ABUTMENT	183.47
6066	IMPLANT SUPPORTED PORCELAIN	412.80
6080	IMPLANT MAINTENANCE	27.52
6095	REPAIR IMPLANT ABUTMENT	27.52
6210	PONTIC HIGH NOBLE METAL	275.20
6211	PONTIC BASE METAL	238.87
6212	PONTIC NOBLE METAL	258.14
6240	PONTIC PORCELAIN HIGH NOBLE	412.80
6241	PONTIC PORCELAIN BASE METAL	412.80
6242	PONTIC PORCELAIN NOBLE METAL	412.80
6250	PONTIC RESIN HIGH NOBLE	344.00
6251	PONTIC RESIN BASE METAL	344.00
6252	PONTIC RESIN NOBLE METAL	344.00
6520	INLAY METALLIC TWO SURFACE	247.60
6530	INLAY METALLIC-3 SURFACE	302.70

SCHEDULE OF BENEFITS

DENTAL SERVICES

PROCESS CODE	DESCRIPTION OF SERVICE	MAXIMUM AMOUNT
6543	FIXED PARTIAL/RETAINER ONLAY	591.69
6544	FIXED PARTIAL/ONLAY MOLARS	591.69
6545	CAST METAL RETAINER	105.12
6720	BRIDGE CROWN HIGH NOBLE	344.00
6721	BRIDGE CROWN BASE METAL	344.00
6722	BRIDGE CROWN NOBLE METAL	344.00
6750	BRIDGE CROWN PORC/HIGH NOBLE	412.80
6751	BRIDGE CROWN PORC/BASE METAL	412.80
6752	BRIDGE CROWN PORC/NOBLE METAL	412.80
6780	BRIDGE CROWN 3/4 HIGH NOBLE	275.20
6790	BRIDGE CROWN CAST HIGH NOBLE	330.24
6791	BRIDGE CROWN CAST BASE METAL	238.87
6792	BRIDGE CROWN CAST NOBLE METAL	140.70
6920	CONNECTOR BAR	115.03
6930	RECEMENT BRIDGE	27.52
6940	STRESS BREAKER	38.52
6950	PRECISION ATTACHMENT	124.20
6970	CAST POST & CORE	95.77
6971	CAST POST	95.77
6972	PREFAB POST & CORE	95.77
6975	COPING-METAL	172.46
6980	BRIDGE REPAIR	15.00
7110	EXTRACTION-SINGLE TOOTH	15.00
7120	EACH ADDITIONAL TOOTH	12.00
7130	ROOT REMOVAL EXPOSED ROOTS	18.00
7210	SURGICAL REMOVAL ERUPTED TOOTH	22.50
7220	REMOVAL IMPACT TOOTH SOFT TISSUE	45.00
7230	REMOVAL IMPACT TOOTH PART BONY	60.00
7240	REMOVAL IMPACT TOOTH FULL BONY	105.00
7241	REMOV IMPACT TOOTH FULL BONY DIFF	120.00
7250	SURGICAL REMOVE RESIDUAL TOOTH	45.00
7260	OROLANTRAL FISTULA CLOSURE	150.00
7270	TOOTH REPLANTATION	240.00
7272	TOOTH TRANSPLANTATION	180.00
7280	SURGICAL EXPOSURE	75.00
7281	SURGICAL EXPOSURE	75.00
7285	HARD TISSUE BIOPSY	22.50
7286	SOFT TISSUE BIOPSY	22.50
7290	REPOSITION OF TEETH	75.00
7310	ALVEOPLASTY WITH/EXTRACTION	37.50
7320	ALVEOPLASTY NOT WITH EXTRACTION	45.00
7340	VESTIBULOPLASTY RIDGE EXT	52.50
7350	VESTIBULOPLASTY RIDGE EXT SEE ALS	105.00
7410	EXCISION BENIGN LEGION UP TO 1.2	75.00

7420	RADCL EXC LES >1.25 CM	150.00
7430	EXC BEN TUMOR/LES TO 1.25 CM	112.50
7431	EXCISION/TUMOR>1.25 CM	150.00
7440	EXCISION OF TUMOR	225.00
7441	EXCISION OF TUMOR	300.00
7450	REMOVAL CYST/TUMOR-< 1.25 CM	112.50
7451	REMOVAL CYST/TUMOR > 1.25 CM	120.00
7460	REMOVAL CYST/TUMOR < 1.25 CM	112.50
7510	I & D OF ABSCESS-INTRAORAL	45.00
7520	I & D OF ABSCESS-EXTRAORAL	75.00
7530	REMOVAL OF FRGN BODY	30.00
7540	REMOVAL OF FRGN BODY	75.00
7550	SEQUESTRECTOMY	105.00
7560	SINUSOTOMY	150.00
7610	FRACTURE TREATMENT	300.00
7620	FRACTURE TREATMENT	300.00
7630	FRACTURE TREATMENT	337.50
7640	FRACTURE TREATMENT	337.50
7650	FRACTURE TREATMENT	450.00
7660	FRACTURE TREATMENT	75.00
7670	FRACTURE TREATMENT	224.40
7680	FRACTURE TREATMENT	600.00
7710	FRACTURE TREATMENT	525.00
7720	FRACTURE TREATMENT	525.00
7730	FRACTURE TREATMENT	525.00
7740	FRACTURE TREATMENT	525.00
7750	FRACTURE TREATMENT	450.00
7760	FRACTURE TREATMENT	75.00
7770	FRACTURE TREATMENT	300.00
7780	FRACTURE TREATMENT	750.00
7810	DISLOCATION TREATMENT	600.00
7820	DISLOCATION TREATMENT	75.00
7830	DISLOCATION TREATMENT	60.00
7840	CONDYLECTOMY	750.00
7850	MENISECTOMY	1,125.00
7860	ARTHROTOMY	750.00
7870	ARTHROCENTESIS	30.00
7880	OCCLUSAL ORTHOTIC APPLIANCE	327.30
7910	SUTURE WOUND	30.00
7911	SUTURE WOUND	210.00
7912	SUTURE WOUND	450.00
7920	SKIN GRAFT	150.00
7940	OSTEOPLASTY	1,500.00
7950	OSSEOUS GRAFT/MANDIBLE	675.00
7955	REPAIR MAXILLOFACIAL	750.00
7960	FRENULECTOMY	45.00
7970	EXCISION OF TISSUE	75.00
7971	EXCISION OF GINGIVA	37.50
7980	SIALOLITHOTOMY	45.00

7981	EXC SALIVARY GLSND RPT SEE ALS	300.00
7982	SIALODOCHOPLASTY SEE CODE 4250	525.00
7983	CLOSURE OF SALIVARY FISTULA	600.00
7990	EMERGENCY TRACHEOTOMY	300.00
7995	SYNTHETIC GRAFT	214.80
7996	AUGMENTATION IMPLANT	429.60
9110	PALLIATIVE TREATMENT	9.00
9212	TRIGEMINAL BLOCK	112.50
9220	GENERAL ANESTHESIA 30 MIN	15.00
9221	GENERAL ANESTHESIA 15 MIN	9.00
9241	IV CONSCIOUS SEDATION 1ST 30 MIN	18.00
9242	IV CONSCIOUS SEDATION ADDL 15 MIN	9.00
9310	PROFESSIONAL CONSULTATION	41.28
9410	HOUSE CALL	27.52
9420	HOSPITAL CALL	27.52
9430	OFFICE VISIT – REGULAR HOURS	41.28
9440	OFFICE VISIT – AFTER HOURS	41.28
9610	THERAPEUTIC DRUG INJECTION	22.01
9630	OTHER DRUGS	22.01
9910	DESENSITIZ MEDIC	22.01
9920	BEHAVIOR MANAGEMENT	12.00
9930	COMPLICATIONS	18.00
9940	OCCLUSAL GUARDS	12.00
9950	OCCLUSION ANALYSIS	190.50
9951	OCCLUSAL ADJUSTMENT - LIMITED	22.50
9952	OCCLUSAL ADJUSTMENT - COMPLETE	87.30
9970	ENAMEL ABRASION	22.50
9974	INTERNAL BLEACHING – PER TOOTH	17.70

All Claims should be mailed to:

J. J. Stanis and Company, Inc.
100 Jericho Quadrangle, Suite 101
Jericho, NY 11753

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