HERRICKS U.F.S.D

SELF-INSURED DENTAL BASIC PLAN

Amended 7/1/2016

RATES FOR DENTAL INSURANCE JANUARY 1, 2011

BASIC FOR ELIGIBLE EMPLOYEES

COVERAGE	EMPLOYEE SHARE	BOARD SHARE	TOTAL
INDIVIDUAL	9.53	9.15	18.68
FAMILY	28.93	30.62	59.55

ENHANCED FOR ELIGIBLE EMPLOYEES

COVERAGE	EMPLOYEE SHARE	BOARD SHARE	TOTAL
INDIVIDUAL	33.44	9.15	42.59
FAMILY	112.74	30.62	143.36

BASIC RATES FOR ELIGIBLE NON-TENURED EMPLOYEES

COVERAGE	EMPLOYEE SHARE	TOTAL
INDIVIDUAL	18.68	18.68
FAMILY	59.55	59.55

ENHANCED FOR ELIGIBLE NON-TENURED EMPLOYEES

COVERAGE	EMPLOYEE SHARE	TOTAL
INDIVIDUAL	42.59	42.59
FAMILY	143.36	143.36

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SCHEDULE OF BENEFITS

PLAN EFFECTIVE DATE: July 1, 2016 **AMENDED: July 1, 2016**

EMPLOYEES' ELIGIBLE: Active Full-Time Employees, Dependents & Eligible Retirees

CONTRIBUTORY BENEFITS FOR ELIGIBLE PERSONNEL AND THEIR DEPENDENTS

MAXIMUM CALENDAR YEAR BENEFIT $1,500.00

For purposes of this plan, a "Calendar Year" is defined as a period of time commencing on January 1 of each year, and ending on December 31 of the same year.

ORTHODONTIC LIFETIME BENEFIT $1,000.00
(Included in the calendar year maximum)
(Adult Ortho is covered)

DENTAL CO-INSURANCE PERCENTAGES (After Satisfying the Deductible)

100% of Reasonable & Customary for Diagnostic & Preventative Services.

50% of Reasonable & Customary for Orthodontic Services.

100% of the Plan Fee Schedule for All Other Covered Services

DENTAL DEDUCTIBLE:

Dental Deductible . . . . . .$ 50.00 per person

Any covered expenses incurred in the last three months of a calendar year, which are used to satisfy that year's cash deductible, will apply toward the cash deductible of the next year.

IN NETWORK PROVIDER OPTION:

Plan provides an option to choose from Two Provider Networks: Stanis Net Plus & Dentemax.

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

DEFINITIONS

COVERED PERSON
An insured person or covered dependent.

INCURRED EXPENSE
An expense is deemed to be incurred on the date a service is rendered or a supply is furnished.

EXCEPTIONS
- Expense for an appliance or modification of a non-orthodontic appliance is deemed to be incurred on the date the master impression is made.
- Expense for a crown, a bridge, or an inlay or onlay restoration is deemed to be incurred on the date the tooth is prepared.
- Expense for root canal therapy is deemed incurred on the date the pulp chamber is opened.

REASONABLE AND CUSTOMARY CHARGE:
A charge which is considered reasonable and customary for a service within the locality where the service is rendered.

NECESSARY SERVICE OR SUPPLY:
A service or supply, which is generally considered by Dentists to be an appropriate dental service or supply for a given dental condition.

The Plan Coordinator (as elected by your employer) reserves the right to determine:
(1) Reasonable and Customary Charges
(2) Necessary Services or Supplies

PLAN COODINATOR
J.J. Stanis and Company, Inc.

EMERGENCY
An urgent, unplanned visit to diagnose or relieve an acute, unexpected dental condition.

DENTIST
A licensed Dentist who is practicing within the scope of his/her license. Dentist shall also mean a licensed physician who provides dental services that are within the scope of his/her license.

DENTAL HYGIENIST
A person who:
- Is licensed to practice dental hygiene.
- Works under the direct control and supervision of a Dentist.

WHEN YOUR COVERAGE BEGINS

BECOMING ELIGIBLE

If your date of employment is prior to January 1, 2011, you will be eligible on the plan effective date shown in the Schedule of Benefits. If your date of employment is on or after January 1, 2011, you will be eligible the first day of the month following your date of employment. 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.

BECOMING COVERED

If you enroll for coverage on or before the day you become eligible, you will be covered on the day you become eligible. If you enroll for coverage more than thirty-one days after the day you become eligible, you will have a 3 month waiting period and coverage will become effective the first of the month after your 3 month waiting period.

WHEN YOUR DEPENDENTS' COVERAGE BEGINS

DEPENDENT

This term means:
(a) Your spouse.
(b) Each of your single children. The term "children" also includes any child who is related to you by blood or marriage; and any other child if that child lives in your household in a parent-child relationship and is dependent on you for support.
Each child must be under age nineteen, or a full-time student under age twenty-five.
If your child is mentally ill, developmentally disabled, mentally retarded or has a physical handicap when coverage would end due to the child's age, coverage may be continued. Ask your Plan Coordinator within thirty-one days of the date your child's coverage ends for details and forms.

BECOMING ELIGIBLE

Each person who is your dependent on the day you become eligible for coverage is eligible on that day. Each other person is eligible on the day that person becomes your dependent.

BECOMING COVERED

A person who is eligible for coverage under this plan as an employee is not also eligible as a dependent. In addition, if both you and your spouse are covered under this plan as employees, your children may not be covered as dependents of both you and your spouse.

Enroll promptly for the coverage of your dependents. Your dependents will be covered on the day they become eligible. Coverage for dependents will begin:
(a) On the day they become eligible, if you enroll for dependent coverage on or before that day.
(b) On the day you enroll them, if you enroll for dependent coverage within thirty-one days after the day they are eligible.

If you enroll your dependents more than thirty-one days after the day you become eligible, they will have a 3-month waiting period and coverage will become effective the first of the month after the 3 month waiting period.

Your dependents will not be covered before the day your coverage begins.

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. 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 submit a 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 and maximums or late enrollment penalties that may apply. If you are a late enrollee you are subject to your plans penalty regardless of any pre-estimate you may receive.

WHAT ARE COVERED DENTAL CHARGES

The Plan Coordinator will determine an amount consistent with the plan provisions, for any covered dental procedure not listed below as a covered service.

(Diagnostic & Preventative Services)

Procedure Code	Description of Service	Maximum Allowance
0110	INITIAL ORAL EVALUATION	*
0120	PERIODIC ORAL EVALUATION	*
0130	EMERGENCY EXAM	*
0140	LIMITED ORAL EVALUATION	*
0150	COMPREHENSIVE ORAL EVALUATION	*
0160	DETAILED ORAL EVALUATION	*
0210	XRAY-COMPLETE SERIES	*
0220	XRAY-SINGLE FILM	*
0230	XRAY-ADDITIONAL FILM	*
0240	XRAY-SINGLE FILM	*
0250	XRAY-SINGLE FILM	*
0260	XRAY-ADDITIONAL FILM	*
0270	BITEWING-XRAY	*
0272	BITEWING-XRAYS	*
0274	BITEWING-XRAYS	*
0290	POSTEROIR/ANTERIOR LATERAL FILM	*
0315	SIALOGRAPHY	*
0320	TMJ ARTHROGRAM FILM	*
0321	OTHER TMJ FILM	*
0330	PANORAMIC FILM	*
0340	CEPHALOMETRIC FILM	*
0415	BACTERIAL CULTURES	*
0425	SUSCEPTIBILITY TEST	*
0460	PULP TESTS	*
0470	DIAGNOSTIC CASTS	*
0471	DIAGNOSTIC PHOTO	*
0501	HISTOPATHOLOGIC EXAM	*
0502	OTHER ORAL PATHOLOGY	*
1110	PROPHYLAXIS (ADULT)	*
1120	PROPHYLAXIS (CHILD)	*
1201	FLUORIDE W/PROPHY CHILD	*
1203	FLUORIDE TREATMENT CHILD	*
1204	FLUORIDE TREATMENT ADULT	*
1205	FLUORIDE W/PROPHY ADULT	*
1351	SEALANT (PER TOOTH)	*
1510	SPACE MAINTAINER UNILATERAL	*

***These charges are paid at 100% of Reasonable & Customary**

(Diagnostic & Preventative Services) Continued

Procedure Code	Description of Service	Maximum Allowance
1515	SPACE MAINTAINER BILATERAL	*
1520	SPACE MAINTAINER UNILATERAL	*
1525	SPACE MAINTAINER BILATERAL	*
1550	RECEMENT SPACE MAINTAINER	*

***These charges are paid at 100% of Reasonable & Customary**

(Restorative Services) [1]

Procedure Code	Description of Service	Maximum Allowance
2140	AMALGAM RESTORATION	16.50
2150	AMALGAM RESTORATION	26.13
2160	AMALGAM RESTORATION	35.75
2161	AMALGAM RESTORATION	44.00
2330	RESIN RESTORATION	23.38
2331	RESIN RESTORATION	31.63
2332	RESIN RESTORATION	42.63
2335	RESIN RESTORATION	37.13
2391	RESIN BASED COMPOSITE ONE SURFACE POSTERIOR	23.38
2392	RESIN BASED COMPOSITE TWO SURFACES POSTERIOR	31.63
2393	RESIN BASED COMPOSITE THREE SURFACES POSTERIOR	42.63
2394	RESIN BASED COMPOSITE FOUR OR MORE SURFACES POSTERIOR	57.75
2410	GOLD FOIL RESTORATION	19.25
2510	INLAY METALLIC	64.63
2520	INLAY METALLIC	134.75
2530	INLAY METALLIC	144.38
2542	PORCELAIN ONLAY TWO SURFACES	19.25
2610	PORCELAIN INLAY	53.63
2643	PORCELAIN ONLAY THREE SURFACES	195.25
2644	PORCELAIN ONLAY FOUR OR MORE SURFACES	342.55
2710	CROWN RESIN LAB	92.13
2720	CROWN RESIN HIGH NOBLE METAL	192.50
2721	CROWN RESIN BASE METAL	192.50
2722	CROWN RESIN NOBL METAL	192.50
2740	PORCELAIN CROWN	182.88
2750	CROWN PORCELAIN HIGH NOBLE METAL	233.75
2751	CROWN PORCELAIN BASE METAL	233.75
2752	CROWN PORCELAIN NOBLE METAL	233.75
2783	CROWN 3/4 PORCELAIN	286.36
2790	CROWN FULL CAST HIGH NOBLE METAL	192.50
2791	CROWN FULL CAST BASE METAL	192.50
2792	CROWN FULL CAST NOBLE METAL	192.50
2910	RECEMENT INLAY	13.75
2915	RECEMENT INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	13.75
2920	RECEMENT CROWN	15.13
2930	STAINLESS STEEL CROWN	56.38
2931	STAINLESS STEEL CROWN	56.38
2932	RESIN CROWN PREFAB	56.38
2940	SEDATIVE FILLING	13.75
2950	CROWN BUILDUP	56.38

[1] Codes removed: 2110, 2120, 2130, 2210, 2380, 2381, 2382, 2385, 2386, 2387, 2540, 2810, 2970

(Restorative Services) Continued

Procedure Code	Description of Service	Maximum Allowance
2951	PIN RETENTION	34.38
2952	CAST POST & CORE	93.50
2954	POST & CORE PREFAB	61.88
2955	POST REMOVAL	63.53
2960	LABIAL VENEER (RESIN LAMINATE) CHAIRSIDE	233.75
2962	LABIAL VENEER (PORCELAIN LAMINATE) LABORATORY	233.75
2980	CROWN REPAIR	63.25
2990	RESIN INFILTRATION	121.96

(Endodontic Services)

Procedure Code	Description of Service	Maximum Allowance
3110	PULP CAP DIRECT	13.75
3120	PULP CAP INDIRECT	13.75
3220	PULPOTOMY THERAPEUTIC	33.00
3221	PULPOTOMY PULPAL DEBRIDMENT	60.50
3310	ROOT CANAL THERAPY	182.88
3320	ROOT CANAL THERAPY	210.38
3330	ROOT CANAL THERAPY	288.75
3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON SURGICAL ACCESS	341.95
3332	INCOMPLETE THERAPY INOPERABLE UNRESTORABLE OR FRACTURED TOOTH	167.99
3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR	182.88
3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID	343.75
3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR	276.00
3410	APICOECTOMY ANTERIOR	99.00
3421	APICOECTOMY	157.37
3425	APICOECTOMY FIRST ROOT	140.25
3426	APICOECTOMY ADDITIONAL ROOT	99.00
3430	RETROGRADE FILLING	71.50
3450	ROOT AMPUTATION	232.38
3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	38.50

(Periodontic Services)[2]

Procedure Code	Description of Service	Maximum Allowance
4210	GINGIVECTOMY	96.25
4211	GINGIVECTOMY	68.75
4231	ANATOMICAL CROWN EXPOSURE - ONE TO TWO TEETH PER QUADRANT	323.40
4240	GINGIVAL FLAP PROCEDURE - FOUR OR MORE PER QUADRANT	181.50
4241	GINGIVAL FLAP PROCEDURE - ONE TO THREE PER QUADRANT	137.50
4249	CROWN LENGTHENING ONE TOOTH	141.63
4260	OSSEOUS SURGERY	254.38
4261	OSSEOUS GRAFT-SINGLE SITE	192.50
4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	136.13
4264	BONE PRELACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT	162.25
4266	GUIDED TISSUE REGENERATION-RESORBABLE BARRIER, PER SITE	223.59

[2] Codes removed: 4220, 4271

(Prosthodontics Removable) Continued

Procedure Code	Description of Service	Maximum Allowance
4267	GUIDED TISSUE REGENERATION - NON RESORABLE BARRIER, PER SITE	203.50
4270	PEDICLE SOFT TISSUE GRAFT	103.13
4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PER TOOTH	524.70
4275	SOFT TISSUE ALLOGRAFT	302.50
4341	PERIO-SCALING PER QUADRANT	46.75
4342	PERIO-SCALING AND ROOT PLANNING - ONE TO THREE TEETH PER QUADRANT	46.75
4355	FULL MOUTH DEBRIDEMENT	24.75
4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS	64.63
4910	PERIO MAINTENANCE	68.75

***This charge is paid at 100% of Reasonable & Customary**

(Prosthodontics Removable)[3]

Procedure Code	Description of Service	Maximum Allowance
5110	COMPLETE DENTURE UPPER	378.13
5120	COMPLETE DENTURE LOWER	350.63
5130	IMMEDIATE DENTURE UPPER	371.25
5140	IMMEDIATE DENTURE LOWER	371.25
5211	UPPER PARTIAL DENTURE/RESIN BASE	412.50
5212	LOWER PARTIAL DENTURE/RESIN BASE	412.50
5213	UPPER PARTIAL DENTURE-CAST METAL	462.00
5214	LOWER PARTIAL DENTURE-CAST METAL	462.00
5225	MAXILLARY PARTIAL DENTURE	790.90
5281	UNILATERAL PARTIAL DENTURE	206.25
5410	ADJUST DENTURE UPPER-COMPLETE	17.88
5411	ADJUST DENTURE LOWER-COMPLETE	17.88
5421	ADJUST DENTURE UPPER-PARTIAL	12.38
5422	ADJUST DENTURE LOWER-PARTIAL	12.38
5510	REPAIR COMPLETE DENTURE	31.63
5520	REPLACE BROKEN OR MISSING TEETH	34.38
5610	REPAIR RESIN BASE	31.63
5620	REPAIR FRAMEWORK	34.38
5630	REPAIR BROKEN CLASP	52.25
5640	REPLACE BROKEN TEETH	27.50
5650	ADD TOOTH TO PARTIAL	48.13
5660	ADD CLASP TO PARTIAL	68.75
5710	REBASE DENTURE UPPER COMPLETE	61.88
5730	RELINE UPPER DENTURE	61.88
5731	RELINE LOWER DENTURE	61.88
5740	RELINE PARTIAL DENTURE	44.00
5741	RELINE PARTIAL DENTURE	44.00
5750	RELINE UPPER DENTURE	103.13
5751	RELINE LOWER DENTURE	103.13
5760	RELINE PARTIAL DENTURE	94.88
5761	RELINE PARTIAL DENTURE	94.88
5820	INTERIM PARTIAL DENTURE (MAXILLARY)	172.17
5850	TISSUE CONDITIONING - UPPER	31.63
5851	TISSUE CONDITIONING-LOWER	31.63
5862	PRECISION ATTACHMENT	144.38

[3] Code removed: 5860

(Prosthodontics Fixed)[4]

Procedure Code	Description of Services	Maximum Allowance
6010	ENDOSSOUS IMPLANT	510.40
6056	PREFABRICATED ABUTMENT	135.30
6057	CUSTOM FABRICATED ABUTMENT - INCLUDES PLACEMENT	275.00
6058	ABUTMENT SUPPORTED PORCELAIN	785.40
6059	ABUTMENT SUPPORTED PORCELAIN FUSED	254.38
6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN	677.60
6062	ABUTMENT SUPPORTED CAST METAL CROWN	420.28
6064	ABUTMENT SUPPORT CAST METAL CROWN	388.59
6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	406.52
6066	IMPLANT SUPPORTED PORC/HI NOBLE CROWN	258.50
6067	IMPLANT SUPPORTED METAL CROWN	243.10
6068	ABUTMENT SUPPORTED RETAINER	426.84
6076	IMPLANT SUPPORTED RETAINER	735.50
6080	IMPLANT MAINTENANCE	51.04
6104	BONE GRAFT AT TIME OF IMPLANT PLACEMENT	283.97
6210	PONTIC HIGH NOBLE METAL	185.63
6211	PONTIC BASE METAL	185.63
6212	PONTIC NOBLE METAL	185.63
6240	PONTIC PORCELAIN HIGH NOBLE METAL	221.38
6241	PONTIC PORCELAIN BASE METAL	221.38
6242	PONTIC PORCELAIN NOBLE METAL	221.38
6250	PONTIC RESIN HIGH NOBLE	176.00
6251	PONTIC RESIN BASE METAL	176.00
6252	PONTIC RESIN NOBLE METAL	176.00
6720	BRIDGE CROWN HIGH NOBLE	198.00
6721	BRIDGE CROWN BASE METAL	198.00
6722	BRIDGE CROWN NOBLE METAL	198.00
6750	BRIDGE CROWN PORCELAIN HIGH NOBLE METAL	240.63
6751	BRIDGE CROWN PORCELAIN BASE METAL	240.63
6752	BRIDGE CROWN PORCELAIN NOBLE METAL	240.63
6780	BRIDGE CROWN 3/4 HIGH NOBLE METAL	188.38
6790	BRIDGE CROWN CAST HIGH NOBLE METAL	198.00
6791	BRIDGE CROWN CAST BASE METAL	247.50
6792	BRIDGE CROWN CAST NOBLE METAL	198.00
6930	RECEMENT BRIDGE	20.63
6950	PRECISION ATTACHMENT	88.00
6980	BRIDGE REPAIR	45.38

(Oral Surgery)[5]

Procedure Code	Description of Services	Maximum Allowance
7111	EXTRACTION CORONAL REMNANTS - DECIDIOUS TOOTH	41.25
7140	EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	20.63
7210	SURGICAL EXTRACTION	28.88
7220	SURGICAL EXTRACTION SOFT TISSUE	49.50
7230	SURGICAL EXTRACTION PARTIAL BONY	79.75
7240	SURGICAL EXTRACTION BONY	121.00
7241	SURGICAL EXTRACTION BONY DIFFICULT	149.88
7250	RESIDUAL ROOT REMOVAL	34.38

[4] Codes removed: 6520, 6530, 6540

[5] Codes removed: 7110, 7120, 7430, 7470

(Oral Surgery) continued

Procedure Code	Description of Services	Maximum Allowance
7280	SURGICAL EXPOSURE	61.88
7295	HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE	98.45
7310	ALVEOPLASTY WITH/EXTRACTION	44.00
7311	ALVEOLOPLASTY IN CONJUNCTIONB WITH EXTRACTIONS 1-3 TEETH PER QUAD	192.50
7320	ALVEOPLASTY NO EXTRACTION	49.50
7350	VESTIBULOPLASTY	59.13
7440	EXCISION/TUMOR > 1.25 CM	79.75
7450	REMOVAL CYST/TUMOR-< 1.25 CM	59.13
7451	REMOVAL CYST/TUMOR > 1.25 CM	123.75
7461	REMOVAL CYST/TUMOR > 1.25 CM	75.63
7465	LESION DESTRUCTION	27.50
7472	REMOVAL OF TORUS PALATINUS	412.50
7510	I & D OF ABSCESS-INTRAORAL	24.75
7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE	88.00
7880	OCCLUSAL ORTHOTIC DEVICE TMJ	154.00
7899	UNSPECIFIED TMJ THERAPY	15.40
7950	OSSEOUS, OSTEOPERIOSTEAL OR CARTILAGE GRAFT OF MADIBLE OR MAXILLA - AUTOGENOUS OR NONAUTOGENOUS, BY REPORT	162.25
7953	BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION - PER SITE	136.13
7960	FRENULECTOMY	75.63
7970	EXCISION OF TISSUE	59.13

(Adjunctive Services)[6]

Procedure Code	Description of Services	Maximum Allowance
9110	PALLIATIVE TREATMENT	12.38
9120	DENTURE SECTIONING	110.00
9210	LOCAL ANESTHESIA	8.25
9215	LOCAL ANESTHESIA	8.25
9230	ANALGESIA	11.00
9310	PROFESSIONAL CONSULTATION	15.13
9430	OFFICE VISIT-REGULAR HOURS	13.75
9630	OTHER DRUGS	13.75
9910	DESENSITIZING MEDICAMENTS	16.50
9940	OCCLUSAL GUARDS	123.75
9951	OCCLUSAL ADJUSTMENT-LIMITED	24.75
9952	OCCLUSAL ADJUSTMENT-COMPLETE	24.75

If the initial placement of a denture or bridge involves the replacement of one or more natural teeth lost or extracted prior to the covered person becoming insured with the Herricks U.F.S.D., there will be no coverage to replace such teeth. This limitation does not apply after you are covered for 60 months.

(ORTHODONTIC SERVICES)

Orthodontic services that include pre-orthodontic care, one appliance, and active treatment monthly maintenance visits per each course of treatment. Fixed & removable appliances to control harmful habits.

All covered orthodontic services will be paid at 50% of Reasonable & Customary.

[6] Codes removed: 9220, 9221, 9241, 9242

COURSE OF ORTHODONTIC TREATMENT

This term means that period which:
(a) Begins when the first orthodontic appliance is installed.
(b) Ends when the last appliance is taken off.

FREQUENCY LIMITATIONS

Oral examinations\evaluations (these services are limited to two in a calendar year)
Prophylaxis (this service is limited to two in a calendar year)
Topical application of stannous fluoride (this service is limited to one in a calendar year and is only covered up to age 15)
Full Mouth and/or Panoramic x-rays are limited to one in three calendar years.
A series of bitewing x-rays four films, (this service is limited to two a calendar year)

PLAN EXCLUSIONS

Covered Dental Charges do not include charges for the following:

(a) Services not ordered by a dentist.
(b) Services due to self-inflicted injury or sickness.
(c) The replacement of lost or stolen dentures, bridges or appliances
(d) Services provided by your spouse, parents, in-laws, children or grandparents
(e) Services provided due to war, if declared or not
(f) For porcelain on molar teeth
(g) For cosmetic reasons
(h) For appliances, restorations or procedures whose purpose is to alter vertical dimension or maintain occlusion.
(i) For inlays or crowns installed as multiple abutments
(j) For prosthetic appliances related to periodontal treatment
(k) For oral hygiene, dietary, plaque control and other educational programs
(l) For replacing tooth structure lost as a result of abrasion or attrition
(m) Coverage for any injury that arises in or out of the course of employment which is compensable under any Workers Compensation or Occupational Disease Act or Law.
(n) For the replacement of any fixed bridge or denture within 5 years of the date of the last placement of such item
(o) For the replacement of congenitally missing teeth
(p) For sealants on teeth other than molars

ALTERNATE PROCEDURE

If there is a less costly alternative to any service or supply which is proposed, furnished or provided and such alternative is within accepted standards of dental practice, then only the Less costly alternative shall be considered as a Covered Expense.

COORDINATION OF BENEFITS (COB)

This COB provision applies to this plan when a Covered Person has dental coverage under more than one Plan. All of the dental expense benefits provided by the policy are subject to this provision.

COORDINATION OF BENEFITS TERMINOLOGY

Plan means any arrangement of coverage written on an expense incurred basis, which provides dental benefits or services by means of:

(1) Group blanket coverage, whether insured or uninsured including coverage provided through:
(a) HMO's and other prepayment group or individual practice plans
(b) Mandatory automobile "no fault" and "fault" insurance, including individual insurance
(2) Governmental programs, except:
(a) Coverage provided under Title XVII (Medicare) and Title XIX (Medicaid) of The Social Security Act of 1965, as amended.
(b) Any plan when by law its benefits are in excess to those of any private insurance plan or non-Governmental plan.
(3) Any coverage under:
(a) Labor-management trusted plans
(b) Union welfare plans
(c) Employer organization plans or employee benefit organization plans

Plan does not mean:
(1) Any type of school accident coverage, including college plans
(2) Individual or family plans or contracts

This plan means the dental expense benefits, which are provided by the policy.
Primary means a plan, which pays Allowable Expense without regard to the existence of any other plans.

Secondary means any plan, which is not considered the Primary Plan. When there are more than two plans covering the same covered person this plan may be primary as to one or more plans and secondary as to a different plan or plans.

EFFECT ON THE BENEFITS OF THIS PLAN

This COB Provision applies when:

(1) A covered person is covered under this plan and one or more other plans.
(2) The covered person incurs Allowable Expense during a Claim Determination Period.
(3) The sum of the benefits payable under all of the plans, in the absence of this or a similar provision, is more than the Allowable Expense. The benefits payable includes those benefits, which a person could have collected but for which they did not apply.

How This Provision is Applied

This plan will pay its benefits without regard to the existence of any other plan when it is primary. When this plan is secondary, it will pay a reduced benefit, which when added to the benefits paid by all other plans will not exceed 100% of the total Allowable Expense.

No plan will pay more than it would have paid in the absence of this provision. When this plan is secondary, any benefits reduced during any Claim Determination Period because of this provision will be reduced proportionately. Only the reduced amount may be charged against any benefit limit of this plan.

ORDER OF BENEFITS DETERMINATION

A plan will always be primary and will pay its benefits first if the plan has no Order of Benefits Determination rules, or it has rules which differ from those set forth here, otherwise the primary and the secondary plan will be determined according to the following rules:

(1) The benefits of a plan, which covers a person as an insured person, are determined before those of a plan which covers a person as a covered dependent.

(2) The benefits of a plan which covers a child as a covered dependent of a parent whose birthday falls earlier in the year are determined before those of a plan of the parent whose birthday falls later in the year. A person's year of birth is not relevant in applying this rule.

If the other plan does not have this rule but instead has a rule based on the gender of a parent, and as a result the plans do not agree on the order of benefits, then the rule in the other plan will determine the order of benefits.

(3) The benefits of a plan that covers a child as a covered dependent of divorced or separated parents are determined in the following order:

(a) The benefits of the plan of the parent with custody of the child are determined first.

(b) The benefits of the plan of the spouse of the parent with custody of the child, the stepparent, are determined next.

(c) The benefits of the plan of the parent not having custody are determined last.

However, if the specific terms of a court decree state that one of the parents is responsible for the dental 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 that actual knowledge.

(4) The benefits of a plan which covers a person as an insured person (or a covered dependent of such insured person) who is not laid off or retired are determined before the benefits of a plan which covers such person (or dependent of such person) as a laid off or retired employee.

If the other plan does not have this rule or their plan does not agree on the order of benefits, this rule is ignored.

(5) If none of the above rules determine an order of benefits, then the benefits of a plan which has covered the person for the longer period of time are determined before those of the plan which has covered the person for the shorter period of time.

Facility of Payment

When another plan makes payments, which should have been made under this plan, the Plan Coordinator reserves the right to decide:

(1) Whether or not to reimburse the organization making the payment

(2) The amount to be paid in order to satisfy the intent of this provision

Any such payment made by the Plan Coordinator will fulfill the responsibility of the amount paid.

Right to Receive and Release Necessary Information
For the purposes of this provision, the Plan Coordinator has the right to give information to or obtain information regarding you or you dependents from:
(1) Any other insurance company
(2) Any organization
(3) Any person
As a claimant under this plan, you must supply the Plan Coordinator with information necessary to enforce this provision.

Right of Recovery
If the Plan Coordinator makes any payment which is more than the amount needed to satisfy the intent of this provision, then the Plan Coordinator will have the right to recover the amount of the excess from one or more of the following:
(1) The person to or for whom such payments were made
(2) Any other insurance company
(3) Any other organization

TERMINATION

1. Termination Date of Coverage - Insured Persons Coverage
Your Benefits will terminate on the earliest of:
(a) The date the policy terminates
(b) The date ending the last period that premiums cease to be paid on your behalf
(c) The last day of the month in which you leave your employ

However, if your employment terminates ask your Employer what rights of continuation, if any, you may have.

2. Termination Date of Coverage - Dependents Coverage
The coverage for your dependent will terminate on the earliest of:
(a) The date on which your coverage terminates
(b) The date on which the dependent no longer meets the definition of a dependent
(c) The last day, for which any required premium contribution is made, if there is failure to make any further required contribution

COBRA (Continuation of Coverage After Termination)
On April 7, 1986, the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 was signed into law. The provisions of the federal law are outlined in (OPTIONAL CONTINUANCE OF DENTAL COVERAGE).

Optional continuance of employee and dependent dental coverage for 18 months
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
(d) Discharge from your job (other than for 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 work hours. J.J. Stanis and Company, Inc. will notify you of your right to continue coverage within 45 days of the termination of your dental coverage.

SPECIAL CONTINUANCE OF DENTAL COVERAGE

If your dependent's coverage ends, he or she may elect to continue for a maximum period of thirty-six months. The dental care coverage under the group plan for him or her, is as follows:

(a) Your dependent spouse may elect to continue coverage on his or her own behalf and that of any dependent children whose coverage would otherwise end, provided that the coverage ends due to:
(1) Your death
(2) Your divorce or legal separation
(3) Your eligibility for Medicare

(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 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) or (b) above. The notice should be given to your Employer as soon as it is 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 WITHIN 60 DAYS OF THE LATER OF (1) THE DATE THE COVERAGE ENDS, OR (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 dependents 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.

SPECIAL CONTINUANCE OF DENTAL COVERAGE (continued)

(d) The date you or your dependent became covered under a group plan, which does not exclude or limit your benefits because of a pre-existing condition.
(e) The date you or your dependent becomes eligible for Medicare
(f) The date your former spouse remarries and thereby becomes covered under another group plan.

CLAIMS SUBMISSION

NOTICE OF CLAIM

Written notice of the event on which claim is based must be given to the Plan Coordinator within 365 days after the loss for which claim is made. Late notice will be accepted only if it is furnished as soon as it 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 (1) the occurrence of the loss, (2) the nature of the loss, and (3) the extent of the loss.

PROOF OF CLAIM

Written proof of claim must be given to the Plan Coordinator within 365 days after the date of loss for which claim is made. Late proof will be accepted only if it is furnished as soon as it 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 a claim less than sixty days after due proof of claim is furnished.

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.

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

All benefit claim inquiries should be directed to

All claims should be mailed to:

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

At the following phone number:

Toll Free (877) 470 – 3715

For additional dental claim forms,
Please visit our website:
www.jjstanisco.com

Mail completed forms to:
J.J. STANIS AND CO MPANY, INC
377 Oak Street, Suite 406 * Garden City, New York 11530
Phone: 516-465-3900 Fax 516-465-3920

Dental Expense Claim

To Be Completed by Employee

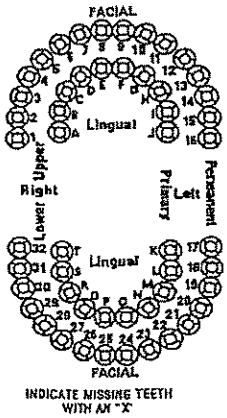
1. Patient First Name / Middle / Last	2. Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	3. Sex ☐ Male ☐ Female	4. Married? ☐ Yes ☐ No	5. Patient Date of Birth Mo. / Day / Year	6. For Office Use
7. If Full-Time Student (Age 19 or Over) School / City / State	8. ID Number	9. If Disabled (Age 19 or Over) ☐ Yes ☐ No		10. Name of Group Dental Program	
11. Employee First Name / Middle / Last	12. Employee Date of Birth	13. Office Phone (Area Code)			
14. Employee Residence Mailing Address	15. City / State / ZIP				
16. Are other Family Members Employed? ☐ Yes ☐ No Name / Social Security / ID Number	17. Date of Birth	18. Name and Address of Employer for item 16			
19. Is Patient Covered by Another Dental Plan? ☐ Yes ☐ No (If Yes, complete the following:) Dental Plan Name / Group No. / Name and Address of Carrier					

20. I Authorize Release of any Information Relating to this Claim.	21. I Certify that the Above Information is Correct.	22. I Authorize Payment Directly to the Below-Named Dentist.
(Signature of Patient or Signature of Authorized Representative If Minor) / Date	Employee Signature / Date	Employee Signature / Date
If Authorized Representative, Relationship to Minor		

To Be Completed by Dentist

23. Dentist Name	24. Mailing Address / City / State / ZIP			
25. Dentist Phone Number	26. Dentist License Number	27. Dentist SSN or T.I.N.	28. Provider Specialty Code	29. NPI (Treating Dentist)
30. NPI (Billing Entity, if different)	31. First Visit Date Current Series	32. Place of Treatment ☐ Office ☐ Hospital ☐ ECF ☐ Other		33. Radiographs or Models Enclosed? ☐ Yes ☐ No How Many?
34. Is Treatment Result of Occupational Illness or Injury? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		35. Is Treatment Result of Auto Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		
36. Other Accident? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		37. Are any Services Covered by Another Plan? ☐ Yes ☐ No (If Yes, Enter Brief Description and Dates)		
38. If Prosthesis, is this Initial Placement? ☐ Yes ☐ No (If No, Reason for Replacement)				39. Date of Prior Replacement
40. Is Treatment for Orthodontics? ☐ Yes ☐ No	If Services Already Commenced, Enter Date Appliance Placed			Months of Treatment Remaining

Dentist's ☐ Pretreatment Estimate ☐ Statement of Actual Services *(Be sure to sign below)**



INDICATE MISSING TEETH WITH AN "X"

41. Examination and Treatment Plan – List In Order From Tooth #1 through Tooth #32 (Use Charting System Shown)

Tooth # or Letter	Surface	Description of Services (Including X-Rays, Prophytaxis, Materials Used, Etc.)	Date Service Performed Mo./ Day /Year	ADA Procedure Number	Fee	For Carrier Use Only

42. I Hereby Certify That The Services Listed Above ☐ Will Be ☐ Have Been Performed.
*Signature of Dentist _____ Date Signed _____ Total Fee Actually Charged

43. Address where treatment was performed
Street _____ City _____ State _____ ZIP _____