A DENTAL PLAN FOR
THE EMPLOYEES OF

THE COUNTY OF NASSAU

Revised Date: January 1, 2022

January 1, 2022

Dear County Employee:

It is our pleasure to provide you with this booklet detailing the benefits and provisions of the dental insurance coverage provided by Nassau County to its eligible employees, their spouses and dependent children up to the end of the month of their 26th birthday.

This flexible program has two coverage options so that you may choose the one that best meets the needs of your family:

Comprehensive Plan

The Comprehensive Plan requires you to choose a Managed Care dentist from a select list of providers in our area. Under this option, most services will be paid for in full, except for osseous surgery and orthodontics, which are subject to a predetermined copayment. There are no reimbursements and no claim forms to complete.

Reimbursement Plan

The Reimbursement Plan permits you to use any dentist. Under this option, payment for services rendered will be up to the amount listed on the reimbursement schedules in this booklet. Reimbursement can be obtained by filing a claim form, and you must assume any costs incurred in excess of the scheduled amounts. In order to lower your out-of-pocket expenses, you may visit the offices of dentists who participate with Healthplex's Preferred Provider Organization (PPO) network. When covered services are received from participating dentists in the Healthplex PPO network in New York and New Jersey, or the Careington PPO network in all other states, you will only be responsible for the copayments shown in this booklet.

Additional information concerning your dental benefits and the filing of claims may be obtained through your **Human Resources** representative. You may also contact the **Healthplex Customer Service Department** at **1-800-468-0600**, or **email** them at **info@healthplex.com**.

Regardless of which option you choose, this coverage is without cost to you, and is one of several excellent programs provided for Nassau County employees to enhance the health of you and your family.

Best regards,

County Comptroller County Executive

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DUAL CHOICE DENTAL PROGRAM GROUP NUMBERS: G022514B, G022514BC, G022514BK, G022514BKC and G022514P

Healthplex, Inc. (as administrator) through its underwriter Dentcare Delivery Systems, Inc. is pleased to present this Dual Choice Dental Program, a program which covers a full range of dental services and allows YOU a choice in selecting one of two dental plans:

The Reimbursement Plan
OR

The Comprehensive Plan

Information about the **REIMBURSEMENT PLAN** begins on **page 9**. This section describes the major provisions of the policy covering enrollees in this option. The Reimbursement Plan permits you to use any dentist of your choice. Payments will be made for covered services received up to the amount provided for in the Reimbursement Plan Schedule of Dental Services. Claims must be filed to obtain reimbursement, and any costs incurred in excess of the scheduled amounts must be assumed by you. If questions arise, the policy will govern.

Enhancements to the Reimbursement Plan effective January 1, 2017 are:

1. Dependent children are now covered up to the end of the month of their 26th birthday

2. Members and/or their dependents who do not reach 50% ($1,250) of their annual maximum in a calendar year can carry over 25% ($625) of their annual maximum into the following calendar year. The maximum rollover can be accrued until an annual maximum of $5,000 is reached.

3. Sealant - Per Tooth are covered at no charge for in-network and there is a $30 reimbursement for out-of-network.

4. Pediatric specialty access with referrals up to age seven (7). (Medical necessity removed)

1. Palatal Expanders (CDT Code D8060- Interceptive Orthodontic treatment with 50% copayment ($375). (This will not apply towards the lifetime orthodontic maximum).

2. Added coverage for one (1) set of retainers (D8680 – orthodontic retention) with 50% co-insurance ($375). This will not apply towards the lifetime orthodontic maximum

3. Implant discounts for surgical placement (approx.40% savings of UCR)

Allowing access to out-of-area dentist for urgent and elective care through any provider in the Careington PPO Network outside of New York/New Jersey area. Members can take advantage of an extensive network of over 95,000 dental access points for care and be responsible for the same copayments as when utilizing local participating dentists. Palliative Urgent Care shall be defined as care for the immediate relief of pain.

Enrollees in this plan have the opportunity to reduce their out-of-pocket expenses

by receiving treatment from dentists in the Healthplex Preferred Provider Organization (PPO) network in New York and New Jersey, or the Careington PPO network in all other states. When covered services are received from participating dentists in the Healthplex or Careington PPO networks, you will only be responsible for the copayments shown in the **Schedule of Dental services** section. Benefits for covered services rendered will automatically be assigned to the provider if you use a PPO dentist.

The **COMPREHENSIVE PLAN** description begins on **page 26**. The Comprehensive Plan requires you to select a participating managed care dentist from the Comprehensive Panel of participating providers. Under this option, most services will be covered in full. In all cases, there are no deductibles, no maximums and no claim forms for you to complete Questions about the benefits, exclusions and limitations and for help finding participating providers in both plans can be answered by contacting a Healthplex **Customer Service Representative** at **800-468-0600**, or by **emailing** us at **info@healthplex.com**.

Enhancements to the Comprehensive Plan effective January 1, 2017 are:

1. Dependent children are now covered up to the end of the month of their 26th birthday.

2. Pediatric specialty access with referrals up to age seven (7). (Medical necessity removed)

3. Composite fillings on posterior teeth will be included with no member out-of-pocket expense.

4. Improved orthodontic benefits to add coverage for Palatal Expanders (CDT code D8060- Interceptive orthodontic treatment of the transitional dentition) with no copayment. (<u>This will not apply</u> towards the lifetime orthodontic maximum.)

5. Added coverage for one set of retainers (D8680 –orthodontic retention) with no copayment. (<u>This will not apply</u> towards the lifetime orthodontic maximum).

6. Access to out-of-area dentists through our national dental network for urgent care. This is an increased urgent care benefit increasing from a $40 one time visit allowance to covered in full when visiting a participating dentist for a medically necessary condition. Members can take advantage of an extensive network of over 95,000 dental access points for urgent care. Palliative Urgent Care shall be defined as care for the immediate relief of pain.

7. Increase access to currently closed practices through provider collaboration. Healthplex will dedicate provider recruitment resources, <u>on a request basis,</u> to work with key practice locations currently not accepting new patients to accommodate Nassau County Members.

EMPLOYEE ELIGIBILITY

ELIGIBLE CLASSES OF EMPLOYEES

All active full-time employees of the County of Nassau and their eligible dependents who are covered by ordinance No. 543-1995, domestic partners of eligible employees or former employees, and the children of domestic partners of eligible employees or former employees, as such terms are defined by Nassau County, former County employees who are now New York State employees in the court system and who were insured by Providers as of December 31, 2007 date or any of the following negotiating units:

a. Civil Service Employees Association (CSEA), Nassau Local 830, AFSCME, Local 1000,AFL-CIO
b. Police Benevolent Association (PBA) of the Nassau County Police Department
c. Detectives Association, Inc. (DAI) of the Nassau County Police Department
d. Superior Officers Association (SOA) of the Nassau County Police Department
e. Corrections Officers Benevolent Association (COBA)
f. Inspectors Police Benevolent Association (IPBA)

APPLICATION FOR COVERAGE

New employees must make application for coverage within sixty (60) days from the first day of the month following their employment. They should file a new enrollment form with the County Comptroller.

DATE EMPLOYEES ARE ELIGIBLE FOR INSURANCE

Each employee in an eligible class on January 1, 2022 will be eligible for insurance on that date.

Each employee who enters an eligible class after January 1, 2022 will be eligible for insurance on the first day of the month coinciding with or next following the date he or she completes two (2) months of full-time work in an eligible class.

REHIRED EMPLOYEES

The County may choose to have insurance for former employees take effect on the date they re-enter an eligible class. This choice may apply to all or some classes of employees. Such former employees must be rehired within twelve (12) months after their insurance ended. The County must notify Dentcare Delivery Systems, Inc. and/or Healthplex, Inc. (administrator) of this choice in writing. If this choice is made, it will apply to all rehired employees in the same class. If it is not made, rehired employees must complete the waiting period shown above.

DATE EMPLOYEE'S INSURANCE TAKES EFFECT

Your insurance will take effect on the date you are eligible.

ACTIVELY AT WORK REQUIREMENT

You must be actively at work in an eligible class on the date your insurance is to take effect. If you are not, such insurance will take effect on the day you resume such work.

EMPLOYEE ELIGIBILITY

The date insurance is to take effect might not be a scheduled workday. If so, you will be considered actively at work on such date if you were actively at work on your last scheduled workday.

DATE EMPLOYEE'S INSURANCE ENDS

Your insurance will end at the earliest of:

1. the date the group policy ends
2. the date insurance ends for your class
3. the end of the period for which the last premium has been paid for you, or
4. the end of the month in which employment ends; except as stated in the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT provision, ceasing full-time work in an eligible class will be considered the end of employment.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

If you cease full-time work, contact the **Human Resources Department** right away for details on continuation of your insurance, if any.

IN ACCORDANCE WITH FEDERAL LAW

PLAN ADMINISTRATOR means that as defined by section 3(6) (A) of the Employee Retirement Income Security Act of 1974 (ERISA).

If your insurance ends because you cease to be in an eligible class under the group policy, which stays in effect, you may elect to continue:

- your dental insurance, and
- your dependents' dental insurance

To do so, you must notify the County within sixty (60) days of the later of:

- the end of the period for which the last premium has been paid by you
- the date a person is eligible for Medicare
- the end of a period of eighteen (18) months
- the date the person is insured under another group insurance plan, or
- the date the group policy ends.

State law may also permit continuation of insurance. Contact the **Human Resources Department** for information.

MAXIMUM PERIOD OF CONTINUATION

You may have your insurance continued under more than one of the continuations described on the previous page. In this case, the maximum period for which insurance may be continued will be equal to the longest single continuation period which applies to you.

EMPLOYEE ELIGIBILITY

At the end of your continuation period, employment will be considered to end and insurance will end. Insurance will not end if, at this time, you resume full-time work in an eligible class.

DEPENDENT ELIGIBILITY

DEFINITION

DEPENDENT means your

1. lawful spouse; and

2. unmarried children whom you support and who are:

   - age 26 (to the end of the month of the dependent's 26th birthday)

"Children" includes stepchildren and adopted children who are supported by you. A child in the process of adoption will be considered a dependent from the day he is supported by you.

A spouse or child who is eligible for insurance under the group policy as an employee will not be considered a dependent.

DATE YOU ARE ELIGIBLE FOR DEPENDENTS' INSURANCE

You will be eligible for dependents' insurance on the later of:

- the date you are eligible for insurance, or

- the date you obtain a dependent.

DATE DEPENDENTS' INSURANCE TAKES EFFECT

1. For dependents you have when you become eligible, dependents' insurance will take effect on the date you are so eligible.

2. Each person who becomes your dependent after you become insured for dependents' insurance will be insured on the date he becomes a dependent.

OUT OF HOSPITAL REQUIREMENT

A dependent might be hospitalized on the date his or her insurance is to take effect. If so, insurance will take effect on the day after he or she is discharged. This requirement will not apply to a newborn child.

DEPENDENT ELIGIBILITY

DATE DEPENDENTS' INSURANCE ENDS

A dependent's insurance will end at the earliest of:

1. the date your insurance ends
2. the date dependents' insurance ends under the group policy
3. the date the person ceases to be a dependent, or
4. the end of the period for which the last premium has been paid for the dependent.

CONTINUATION OF DEPENDENTS' INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a dependent child may be continued past the age limit if he cannot support himself because he is physically or mentally handicapped. Premium payment will be required. Proof of the handicap must be sent to the provider within thirty-one (31) days after the child attains the age limit.

Insurance will continue for as long as such child:

- remains handicapped, and
- meets all the rules for dependents under the plan, except the age limit.

IN ACCORDANCE WITH FEDERAL LAW

PLAN ADMINISTRATOR means that as defined by section 3(6) (A) of the Employee Retirement Income Security Act of 1974 (ERISA).

If dental insurance ends for the dependents listed below, they may elect to continue it. To do so, they must notify the County within sixty (60) days of the later of:

- the date their insurance ends, or
- the date the Plan Administrator gives them notice of their right to elect this continuation.

The dependent will be required to pay the premiums due.

WHO MAY ELECT CONTINUATION

1. a spouse or dependent child whose insurance ends for these reasons:
   - the employee dies
   - the marriage ends by divorce or annulment,
   - or the employee elects Medicare as a primary payer.
2. a dependent child who ceases to be one as defined in the group policy.

CONTINUATION OF DEPENDENTS' INSURANCE WITH PREMIUM PAYMENT

DURATION OF CONTINUATION
Insurance may continue until the earliest of:

- the end of the period for which the last premium has been paid by the dependent
- the date the dependent is eligible for Medicare
- the end of a period of thirty-six (36) months
- the date the dependent is insured under another group insurance plan,
- or the date the group policy ends.

State law may also permit continuation for your spouse. She or he should contact the **Human Resources Department** for information.

Nassau County Retirees GG-473A

Nassau County employees that are retiring are eligible for dental coverage through COBRA for 36 months (contact the County of Nassau Human Resources for COBRA information). When the COBRA plan expires, Nassau County retirees have the option to purchase a Nassau County Retiree plan directly through Healthplex. Retirees may contact the Healthplex marketing department at 1-800-468-0466 to request plan details and an enrollment application for the plan. Dual Option Plans to include;

- Managed Care
  - No annual maximum
  - In network benefits only
  - Select Family Dental Home
  - Referrals for Specialty Services
- PPO Reimbursement
  - $1,500 annual individual maximum $3,000 family maximum
  - In and out of network benefits
  - Select any Provider

THE REIMBURSEMENT PLAN
GROUP NUMBERS: G022514B, G022514BC and G022514P

Under this Option, you and your eligible dependents may employ the services of any dentist you wish. You will be reimbursed for covered dental services rendered up to the maximum amounts shown in the Schedule of Dental Services in this booklet. Claim forms are required in order to be reimbursed, and you must assume any costs incurred in excess of the scheduled amounts. Subject to certain conditions, predeterminations are necessary before the actual dental work is performed.

You may also be treated by dentists who participate in the Healthplex Preferred Provider Organization (PPO) network in New York and New Jersey, or the Careington PPO network in all other states. These dentists have reduced their fees and accept the amounts shown in Healthplex's PPO Schedule of Allowances as payment in full. When covered services are received from participating dentists in the Healthplex PPO Plan, you will only be responsible for the copayments shown in this booklet.

To find a participating PPO dentist, log onto **www.healthplex.com** and click on "**Our Dentists**". Under the "**Members**" section on the right-hand side, enter your group number and then select the plan you are interested in. You can search for either general dentists or specialists (endodontist, periodontist, etc.)

SCHEDULE OF BENEFITS

DENTAL BENEFITS FOR ALL INSURED PERSONS
Dental benefits to be paid during each calendar year:

For Orthodontics: the lesser of:

- 100% of the dentist's fee, or
- 100% of the amounts in the fee schedule

These benefits are subject to an overall lifetime maximum dental benefit of $1,650 for each person while insured.

For other services listed in the Schedule of Dental Services:

- 100% of the amounts in the fee schedule

These benefits are subject to an overall yearly maximum dental benefit of $2,500 for each person while insured.

NASSAU COUNTY BUY-UP PLAN OPTION GG-705P01

In addition to the Reimbursement plan information and the Reimbursement Plan Schedule of Dental Services as indicated in this brochure, for those members who have elected to purchase the Buy-Up Plan Option (available January 1, 2022), additional PPO benefit enhancements are as follows;

- No Charge for covered orthodontic services, which include palate expanders with a patient copayment of $375.00
- Surgical placement of implants
- Cosmetic services such as bleaching and veneers
- Alternate Benefit clause has been removed for this plan which means that there is coverage for tooth colored (composite) fillings and porcelain crowns on molar teeth

Please note that only active members are eligible for this Buy-Up plan. Also, note that if your dependent child is undergoing orthodontic treatment, you will not be able to switch to the Buy-Up plan until the next annual open enrollment period provided that your child's orthodontic treatment has been completed, including retention treatment.

THE REIMBURSEMENT PLAN

DEFINITIONS

ACTIVE WORK or **ACTIVELY AT WORK** means that you perform each duty of your job for full pay. This must be done at the County's place of business or any place to which such business requires you to travel.

FULL-TIME means active work on the County's regular work schedule for the class of employees to which you belong. The work schedule must be at least twenty (20) hours a week.

INSURED PERSON means an insured member or insured dependent. Each will be insured only for the benefits for which he becomes and remains insured by the group policy.

MEDICARE means Parts A and B of the medical care benefits provided by Title XVIII of the Social Security Act of 1965.

COUNTY means the County of Nassau.

DENTAL BENEFITS

If you or one of your dependents, while insured, incurs the covered charges described, Dentcare Delivery Systems, Inc. will pay these benefits.

DEFINITIONS

DENTIST means a person licensed to:

- render dental services
- perform dental surgery, or
- administer anesthetics (or fluids and blood incident to the anesthesia) for dental surgery.

Such person must act within the scope of his or her license.

PREFERRED PROVIDER ORGANIZATION (PPO) means a network of licensed dentists who have contractually agreed to accept the PPO Schedule of Allowances as payment in full for all covered services.

REASONABLE AND CUSTOMARY CHARGE means a charge not more than the usual charge for a dental service in the locality where it is received. The person's sex, age and state of health will be taken into account.

COURSE OF TREATMENT means all treatments that result from an exam by a dentist. The treatment must be recommended by such dentist. A course of treatment will be considered to start on the date of the exam. It will end on the date all recommended services have been rendered.

COVERED CHARGES

Covered charges are charges for dental services which are:

- rendered by a dentist, and
- shown in the Schedule of Dental Services

Any amount of such charges which exceeds reasonable and customary charges will not be covered.

Benefits for such charges will be equal to the fees charged, up to:

1. the amount shown in the Schedule of Dental Services, and
2. the maximum amount for all dental services during each calendar year for Orthodontia. This maximum is shown in the Schedule of Benefits.

Dentcare Delivery Systems, Inc. has made an agreement with Healthplex, Inc. to serve as Claims Administrator for the Reimbursement Option.

DENTAL INFORMATION REQUIRED

As part of proof of a claim, Dentcare Delivery Systems, Inc., through its administrator Healthplex, can require proof of the condition or treatment of the teeth or mouth. Such proof may include:

- a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim
- the dentist's or hospital's itemized bills
- X-rays, lab or hospital reports
- casts, molds or study models

TREATMENT PLAN NOTICE

If a dental plan reveals the need for:

- a dental service for which the estimated cost exceeds $250
- orthodontia, or
- fixed bridgework

a notice must be sent to Healthplex within twenty (20) days of such exam. The notice must be on a standard predetermination form, should describe the dental services recommended, and give the estimated cost of providing such services.

Healthplex has the right to require such notice in any other instance that it thinks necessary. If Healthplex makes such a request, the notice must be sent within twenty (20) days after the day the claim is received. No benefits will be paid under this benefit section for a dental service which is not begun within ninety (90) days after a predetermination was sent to Healthplex.

HOW TO FILE YOUR CLAIM

Your group insurance program is designed to help process your claim as quickly as possible. Therefore, your claim will be administered by Healthplex, Inc.

Once dental work has been completed for you or a family member, benefit payment will be paid to you unless you have indicated on the claim form that you wish Healthplex to pay the dentist directly. Please note benefit payments are automatically assigned to participating PPO providers. Your promptness in submitting the required claim form (which should be fully completed by you and your dentist) will result in speedy payment of your claim.

PLEASE FOLLOW THESE STEPS:

1. Your dentist may submit any standard claim for dental services. You may obtain a claim form from your **Human Resources Department,** or through our website at **www.healthplex.com.** A separate claim form must be used for each member of your family.

2. Complete the member section of the form. Please print legibly or type. A complete and accurate claim form will speed payment.

3. Sign and date the "Authorization to Release Information".

4. If you wish to have your benefits paid directly to the dentist, sign and date the "Authorization to Pay Benefits to Dentist." If you wish payment directly to you, do not sign this portion. Benefits will automatically be assigned to participating PPO dentists.

5. Bring your claim form with you to the dentist.

6. Ask the dentist to complete and sign the Attending Dentist's Statement.

7. The completed claim form and supporting materials should be sent to:

Healthplex, Inc.
Attn: Claims Department
PO Box 211672
Eagan, MN 55121

THE REIMBURSEMENT PLAN SCHEDULE OF DENTAL SERVICES*

GROUP NUMBERS: G022514B, G022514BC, and G022514P

A.D.A. SERVICE NUMBER	Dental Services	Maximum Amount of Out-of-Network Benefit	In-Network PPO Copayment
	Diagnostic		
	Clinical Oral Exam (one per 6 month period)		
120	Periodic	$25.00	No Charge
140	Limited	25.00	No Charge
150	Comprehensive	25.00	No Charge
	Radiographs		
210	Intraoral complete series (including bitewings) (*one per 36 month period)*	56.00	No Charge
220	Intraoral, single, first film	10.52	No Charge
230	Intraoral, each additional film	10.52	No Charge
240	Intraoral, occlusal, single, first film	19.00	No Charge
250	Extraoral, single, first film	20.00	No Charge
260	Extraoral, each additional film	15.00	No Charge
270	Bitewing, single, first film	10.00	No Charge
272	Bitewing, 2 films	14.00	No Charge
274	Bitewing, 4 films (*one per 6 month period)*	24.20	No Charge
330	Panoramic, Maxilla and Mandible, single film (*one per 36 month period)*	50.00	No Charge
340	Cephalometric Film *(one per 36 month period)*	50.00	No Charge
	Others		
470	Diagnostic casts	37.00	No Charge
	Preventive		
	Dental Prophylaxis (four per calendar year)		
1110	Adult	44.00	No Charge
1120	Child	30.00	No Charge
	Fluoride Treatment (one per 12 month period)		
1206	Topical Application of Fluoride, varnish	31.00	No Charge
1208	Topical Application of Fluoride	31.00	No Charge
1351	Sealants – Unrestored permanent teeth	30.00	**No Charge**
	Space Maintainers (one per lifetime < age 14)		
1510	Fixed, Unilateral band type	156.00	No Charge
1515	Fixed, Bilateral	220.00	No Charge
1520	Removable, Unilateral	188.00	No Charge
1525	Removable, Bilateral	188.00	No Charge

**This is an abbreviated ADA code list, contact your HR representative for the complete schedule of ADA codes covered under the Reimbursement Plan*

THE REIMBURSEMENT PLAN

SCHEDULE OF DENTAL SERVICES

A.D.A. SERVICE NUMBER	Dental Services	Maximum Amount of Out-of-Network Benefit	In-Network PPO Copayment
	Restorative		
	Amalgam Restorations		
2140	One surface	$30.00	$15.00
2150	Two surfaces	42.00	18.00
2160	Three surfaces	54.00	21.00
2161	Four or more surfaces	54.00	31.00
2951	Pin retained	20.00	5.00
	Composite Restorations		
2330	Composite Resin, Anterior, one surface	27.50	22.50
2331	Composite Resin, Anterior, two surfaces	50.00	20.00
2332	Composite Resin, Anterior, three surfaces	70.00	18.00
2335	Composite Resin, Anterior, involving incisal angle	70.00	25.00
2391	Composite Resin, Posterior, one surface	27.50	22.50
2392	Composite Resin, Posterior, two surface	42.00	28.00
2393	Composite Resin, Posterior, three surface	54.00	34.00
2394	Composite Resin, Posterior, four or more surfaces	54.00	41.00
	Metallic Restorations (one per five (5) year period)		
2410	Gold Foil, one surface	31.55	133.45
2510	Inlay, one surface	135.00	115.00
2520	Inlay, two surfaces	210.00	90.00
2530	Inlay, three surfaces	260.00	100.00
2542	Onlay, two surfaces	210.00	90.00
	Porcelain Restoration (one per five (5) year period)		
2610	Inlay, one surface	175.00	45.00
2620	Inlay, two surfaces	175.00	45.00
2630	Inlay, three surfaces	175.00	45.00
	Crowns – Single Restorations Only (one per five (5) year period)		
2710	Resin	215.00	No Charge
2720	Resin, High Noble Metal	250.00	275.00
2740	Porcelain Ceramic	240.00	185.00
2750	Porcelain, High Noble Metal	285.00	310.00
2780	¾ Cast, High Noble Metal	143.73	281.27

THE REIMBURSEMENT PLAN

SCHEDULE OF DENTAL SERVICES

A.D.A. SERVICE NUMBER	Dental Services	Maximum Amount of Out-of-Network Benefit	In-Network PPO Copayment
	Restorative		
2790	Full Cast, High Noble Metal	$215.00	$310.00
2930	Stainless Steel	95.35	14.65
2952	Cast Post and Core	85.00	80.00
2954	Prefabricated Post and Core	70.00	35.00
	Other Restorative Services		
2910	Recement Inlay	26.00	10.00
2915	Recement Post	25.00	5.00
2920	Recement Crown	14.72	23.28
	Endontics		
3110	Direct Pulp Cap (one per 24 month period)	17.50	7.50
3220	Therapeutic Pulpotomy (one per tooth per lifetime)	40.00	25.00
	Root Canal Therapy (one per tooth per lifetime)		
3310	Anterior	240.00	110.00
3320	Bicuspid	290.00	135.00
3330	Molar	320.00	180.00
3410	Apicoectomy, Anterior	120.00	90.00
3421	Apicoectomy, Bicuspid	120.00	90.00
3425	Apicoectomy, Molar	135.00	100.00
3426	Apicoectomy, each additional root	91.77	33.23
3430	Retrograde Filling, per root	45.00	10.00
	Periodontics		
	one per sixty (60) months/one per six (6) months*		
4210	Gingivectomy, per quadrant*	150.00	30.00
4211	Gingivectomy, 1-3 teeth*	22.00	20.50
4260	Osseous Surgery, per quad*	275.00	185.00
4261	Osseous Surgery, 1-3 teeth*	100.00	75.00
4263	Bone Replacement Graft*	100.00	75.00
4270	Pedicle Soft Tissue Graft*	100.00	30.00
4271	Free Soft Tissue Graft*	100.00	175.00
4341	Scaling and Root Planing, per quad**	55.00	35.00
4342	Scaling and Root Planing, 1-3 teeth**	40.00	5.00
4910	Periodontal Maintenance**	50.00	22.50

THE REIMBURSEMENT PLAN

SCHEDULE OF DENTAL SERVICES

A.D.A. SERVICE NUMBER	Dental Services	Maximum Amount of Out-of-Network Benefit	In-Network PPO Copayment
	Prosthodontics - Removable		
	Complete Dentures (one per arch per five (5) years)		
5110	Complete Upper	$356.86	$293.14
5120	Complete Lower	356.86	293.14
5130	Immediate Upper	356.86	318.14
5140	Immediate Lower	356.86	318.14
	Partial Dentures (one per arch per five (5) years)		
5211	Partial Upper, Acrylic Base	404.53	45.47
5212	Partial Lower, Acrylic Base	404.53	45.47
5213	Partial Upper, Cast Base	404.53	290.47
5214	Partial Lower, Cast Base	404.53	290.47
5281	Removable unilateral, partial	325.00	190.00
	Adjustments to Dentures (included within six (6) months of denture insertion)		
5410/11	Complete Denture	24.54	.46
5421/22	Partial Denture	24.54	4.91
	Repairs to Dentures (included within six (6) months of denture insertion)		
5510	Repair Broken Denture	30.00	35.00
5520	Replace Tooth	24.54	30.46
5610	Repair Resin Denture Base	30.00	35.00
5620	Repair Cast Framework	60.00	40.00
5630	Repair/Replace Clasp	72.21	17.79
5640	Replace Broken Tooth on Partial	24.54	30.46
5650	Adding Tooth to Partial	60.29	No Charge
5660	Adding Clasp to partial	72.21	17.79
	Denture Duplication and Relining (such service must be rendered one (1) year or more after insertion and is limited to one such service in two (2) years)		
5710/11	Rebase Complete Denture	140.00	110.00
5730/31	Reline Complete Denture (Office)	75.00	60.00

THE REIMBURSEMENT PLAN

SCHEDULE OF DENTAL SERVICES

A.D.A. SERVICE NUMBER	Dental Services	Maximum Amount of Out-of-Network Benefit	In-Network PPO Copayment
	Prosthodontics – Removable (Continued)		
5740/41	Relining Partial Denture (Office)	$60.29/$80.00	$29.71/$55.00
5750/51	Relining Complete Denture (Lab)	83.43/105.00	66.57/95.00
5760/61	Relining Partial Denture (Lab)	83.43	61.57/96.57
5850	Tissue Conditioning	29.45	32.55
	Implant Services (once per five (5) years)		
6058	Implant / Abutment Supported Porcelain/ Ceramic Crown	215.00	635.00
6059	Abutment Supported by Porcelain Fused to Ceramic High Noble Metal Crown	215.00	785.00
6060	Abutment Supported Porcelain Fused to Metal Crown	215.00	685.00
6061	Abutment Supported by Porcelain Fused to Noble Metal Crown	215.00	785.00
6065	Implant Supported by Porcelain/Ceramic Crown	215.00	985.00
6066	Implant Supported Porcelain Fused to Metal Crown	215.00	785.00
6067	Implant Supported Metal Crown	215.00	285.00
6068/77	Implant/Abutment Supported	Not Covered	Not Covered
	Prosthodontics – Fixed (once per five (5) years)		
	*Bridge, Pontics***		
6210	Pontic, High Noble Metal	215.00	310.00
6240	Pontic, Porcelain High Noble Metal	265.00	330.00
6250	Pontic, Resin High Noble Metal	250.00	275.00
	Retainers		
6545	Retainer, Cast Metal	135.00	90.00
6602	Inlay, one surface High Noble	175.00	135.00
6603	Inlay, three or more surfaces High Noble	225.00	145.00
6611	Onlay, three or more surfaces High Noble	250.00	275.00
	Bridge, Crowns		
6720	Plastic, High Noble Metal	250.00	275.00
6740	Porcelain	240.00	185.00
6750	Porcelain, High Noble Metal	285.00	310.00
6780	¾ cast, High Noble Metal	165.00	145.00
6790	Full Cast High Noble Metal	215.00	310.00

**see page 32(d) for additional information

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THE REIMBURSEMENT PLAN

SCHEDULE OF DENTAL SERVICES

A.D.A. SERVICE NUMBER	Dental Services	Maximum Amount of Out-of-Network Benefit	In-Network PPO Copayment
	Prosthodontics – Fixed (Continued)		
	Other Prosthetic Services		
6930	Recement Fixed Partial Denture	$38.00	$24.00
6970	Cast Post and Core	85.00	80.00
6972	Prefabricated Post and Core	70.00	35.00
	Oral Surgery		
	Extractions (once per tooth per lifetime)		
7111	Coronal Remnants, Deciduous	44.00	22.00
7140	Erupted Tooth or Exposed Root	44.00	22.00
7210	Surgical Extraction, Erupted Tooth	70.00	40.00
7220	Extraction of Tooth, Soft Tissue Impaction	105.00	50.00
7230	Extraction of Tooth, Partial Bony Impaction	125.00	63.00
7240	Extraction of Tooth, Complete Bony Impaction	155.00	85.00
7250	Surgical Removal of Residual Root	55.00	35.00
7280	Surgical Exposure of Unerupted Tooth	125.00	100.00
7285	Biopsy of Hard Tissue	70.00	20.00
7286	Biopsy of Soft Tissue	55.00	20.00
	Alveoplasty (one per twelve (12) month period)		
7310	In Conjunction with Extractions, per quad	27.50	34.50
7320	Not in Conjunction with Extractions, per quad	85.00	40.00
	Surgical Excision		
7450	Removal of Odontogenic Cyst or Tumor, up to 1.25 cm	125.00	55.00
7451	Removal of Odontogenic Cyst or Tumor, over 1.25 cm	210.00	90.00
7471	Removal of Exostosis, Maxilla or Mandible	275.00	105.00
7510	Incision and Drainage of Abscess, Intraoral	48.00	17.00
7960	Frenulectomy (Frenectomy or Frenotomy)	135.00	55.00
7970	Excision of Hyperplastic Tissue, per arch	95.00	125.00
8060	Palatal Expanders with 50% coinsurance- (does not apply towards orthodontic maximum)		$375.00
D8680	1 set of retainers (Orthodontic retention) with 50% coinsurance		

THE REIMBURSEMENT PLAN

SCHEDULE OF DENTAL SERVICES

A.D.A. SERVICE NUMBER	Dental Services	Maximum Amount of Out-of-Network Benefit	In-Network PPO Copayment
	General Services		
9110	Palliative (Emergency) Treatment of Dental Pain	$20.00	$10.00
9220	General Anesthesia, first 30 min.	55.00	60.00
9221	General Anesthesia, additional 15 min.	Not Covered	55.00
9951	Occlusal Adjustment, Limited	35.00	20.00
9952	Occlusal Adjustment, Complete	70.00	80.00

Where procedures have time limitations, such procedures will be considered "by report" of the attending dentist where extenuating circumstances may exist.

Dentcare Delivery Systems, Inc., through its administrator Healthplex, will determine the amount of benefit (if any), for services not shown above. Such amounts will be consistent with the amounts shown.

DENTAL SERVICE

Orthodontia (including diagnosis, preventive treatment, orthodontic treatment and orthodontic appliances).

AMOUNT OF BENEFITS

the lesser of:

- 100% of the dentist's fee, or
- 100% of the fee schedule

not to exceed the overall maximum dental benefit shown in the Schedule of Benefits on page 7.

SPECIAL PROVISIONS FOR GROUPS TAKEN OVER FROM A PRIOR PLAN

These special provisions apply only to those persons who:

- were insured by a given benefit section of a prior plan, and
- become insured by a similar benefit section of the group policy on the date such section takes effect.

PRIOR PLAN means the County's group insurance plan in effect on the day before a given benefit section of the group policy takes effect.

For services rendered as part of a course of treatment begun before a person becomes insured:

Benefits will be paid up to the lesser of:

- the benefits this plan would pay, or
- the benefits the prior plan would have paid had it stayed in force.

COORDINATION OF BENEFITS PROCESSING

This Addendum to the Agreement is for the purpose of delineating the terms and conditions under which the Contractor will provide specific administration services for the County regarding the processing of Dental claims where the Coordination of Benefits ("COB") is requested by an eligible fund participant in accordance with the terms of the Agreement, and the standards set forth by the National Association of Insurance Commissioners ("NAIC"), and this Addendum.

I. When the Contractor's PPO Plan is primary:

In the event Primary payer status is determined based upon criteria defined by the NAIC, benefits will be calculated in accordance with the terms of the agreement, just as if the member had no other dental coverage under any other plan.

II. When the Contractor's PPO Plan is determined to be secondary coverage:

Upon receipt of a request for a COB the Contractor will determine if the claim is eligible to be coordinated as per this Addendum. The only time the Contractor will pay as a secondary coverage is when it is determined that eligible fund participant for whom the coordination claim is submitted has an absolute residual out of pocket cost that he/she is personally liable.

Secondary plan payment will not be determined until after the primary plan has rendered a payment determination. In the event that there are any outstanding procedure codes within a given COB claim request that have not been fully adjudicated by the primary plan due to insufficient documentation, the Contractor shall not process the outstanding procedure codes until full adjudication by the primary plan has taken place. When coordinating benefits, the Contractor shall pay towards any remaining eligible participant responsible expenses for each service up to the Contractor's plan schedule allowance. COB is limited to services that are covered under the Contractor's PPO Plan.

In order to coordinate benefits, the Contractor requires a legible copy of the primary plan's determination and explanation of benefits with service level detail itemizing payment and participant out-of-pocket expense. The participant's out-of-pocket expense shall be used to determine secondary plan payment for each service.

If the participant's out-of-pocket expense *is not indicated* on the primary plan's payment determination, the Contractor shall make an assumption that the participant has no out-of-pocket expense. Upon submission of documentation substantiating participant payment of an out-of-pocket expense, the Contractor may process the claim under the standards detailed above

Once a participant's out-of-pocket expense has been appropriately identified, the Contractor shall coordinate benefits for each service as follows:

- **The participant has no out-of-pocket expense:**
  - No payment from the Contractor is due.
- **The participant has an out-of-pocket expense:**

- The Contractor shall reimburse the participant's out-of-pocket expense up to the schedule allowance.
  - Note: The Contractor may reduce payment by any amount so that the total benefit paid between both insurance plans does not exceed the total allowable expense.
  - In the absence of a contractual agreement with the primary plan, the Contractor reserves the right to pend processing of the secondary claim to request proof of participant payment.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For this section to work, Dentcare Delivery Systems, Inc. and/or Healthplex, Inc. must exchange information with other plans. To do so, Dentcare Delivery Systems, Inc. and/or Healthplex, Inc. may give to or get from any source all such information it thinks necessary. This will be done without the consent of or notice to any person. Any person claiming benefits under this plan must give to Healthplex, Inc. (administrator) the information it requires.

FACILITY OF PAYMENT

Another plan may pay a benefit that should be paid by Dentcare Delivery Systems, Inc. by the terms of this section. If this happens, Dentcare Delivery Systems, Inc. may pay to such payor the amount required for it to satisfy the intent of this section. This will be done at the discretion of Dentcare Delivery Systems, Inc. Any amount so paid will be considered a benefit paid under this plan. Dentcare Delivery Systems, Inc. will not be liable for such payment after it is made.

RIGHT TO RECOVER OVERPAYMENTS

Dentcare Delivery Systems, Inc. may pay benefits in excess of those required by this section. If this happens, Dentcare Delivery Systems, Inc. has the right to recover such excess from:

- any person to or for whom such payments were made
- any other insurer, or
- any other organization.

As Policyholder, the County of Nassau offers enrollees a managed care dental plan from Dentcare Delivery Systems, Inc. The following provisions apply:

THE REIMBURSEMENT PLAN

EFFECT OF INTERATION WITH

THE COMPREHENSIVE PLAN
(MANAGED CARE)

IF YOU ELECT THE DENTCARE COMPREHENSIVE OPTION, insurance provided under the Reimbursement policy for you and your dependents will end on the date you enroll in the Comprehensive Plan and are covered by that policy.

When you become a Comprehensive Plan enrollee, the Benefits After Insurance Ends provisions of the Reimbursement group policy will not apply to you and your dependents.

IF YOU ELECT THE REIMBURSEMENT PLAN

DATE TRANSFER TO SUCH INSURANCE TAKES EFFECT

If you are a Comprehensive Plan enrollee you may transfer to such insurance by written request. If you elect to do so, any dependents who are Comprehensive Plan members must also be included in such request. The date you and your dependents are to be insured depends on when and why the transfer request is made.

REQUEST MADE DURING AN OPEN ENROLLMENT PERIOD

Dentcare Delivery Systems, Inc. and the County will agree when this period, which will occur annually, will be. If you request insurance during this period, you and your dependents will be insured on the date such period ends.

Request Made Because:

- Dentcare ends its operations
- you move outside Dentcare's participating providers' service area

If you request insurance because membership ends for these reasons, the date you and your dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, you will be insured on the date such membership ends
- the date membership ends, you will be insured on the date the request is made.

THE REIMBURSEMENT PLAN

EFFECT OF INTERACTION WITH THE COMPREHENSIVE PLAN (MANAGED CARE)

OTHER PROVISIONS AFFECTED BY A TRANSFER

If a person makes a transfer, the following provisions, if required by the group policy for such insurance, will not apply on the transfer date:

- any actively at work requirement
- any waiting period, or
- course of treatment exclusion.

CHARGES NOT COVERED

Charges incurred before a person becomes insured will not be considered covered charges.

MAXIMUM BENEFIT

The total amount of benefits to be paid for each person will be any maximum benefit specified in the group policy, regardless of any interruption in such person's insurance under the group policy.

THE COMPREHENSIVE PLAN

GROUP NUMBERS G022514BK and G022514BKC

Under the Comprehensive Plan, members of the group select a dentist from Dentcare's panel of managed care participating dentists. The dentist provides all necessary care referring to a wide range of specialists should it become necessary. It is important to note that under this option, care provided by a non-participating dentist is NOT covered unless arranged for by Dentcare.

For those employees selecting the Comprehensive Plan, general dental care is only available from the participating managed care dentists. All family members must select the same general dentist. If children prefer to be treated by pediatric dentists, the employee and his/her family may best be served by the Reimbursement Plan which allows coverage at any dental office.

THE PARTICIPATING DENTIST:

The dentists participating in this program are selected from private neighborhood practices and must meet rigid criteria to be chosen as a member of the dental panel. In order to be selected, a dentist must not only meet professional standards as set forth by the American Dental Association, but must also provide an adequate and qualified staff, a comfortable hygienic environment and modern equipment.

In addition, the participating dentists are credentialed by Healthplex, a Credentials Verification Organization, to ensure that they are properly licensed and qualified to provide dental care. Any dentist who does not meet the high standards of this program is subject to removal from the panel.

ADVANTAGES AND SPECIAL FEATURES

- For most dental services including x-rays, cleanings, fillings, root canals, periodontal care, extractions and prosthetics, there is no charge to the patient. For services that are excluded or limited by the plan, or for services that are upgraded, there may be predetermined charges.
- 24 Hour Hotline to assist you in obtaining care at night or on the weekend.
- Referrals to participating endodontists, oral surgeons, periodontists and orthodontists, if necessary, are handled by your participating managed care general dentist, at no additional charge to you.
- NO CLAIM FORMS TO COMPLETE.

THE COMPREHENSIVE PLAN

Please note that under this option, only care provided by your participating managed care dentist is covered. Services rendered by any other dentist will not be covered unless arranged for by your plan dentist.

For emergency services, a maximum of two visits per calendar year per insured are covered for services rendered by a participating dentist. If you currently are undergoing treatment or have had regular checkups, however, there is no limitation.

If the emergency is out-of-area or you are unable to obtain the services of your plan dentist, you will be reimbursed up to a maximum of $25 per family member per calendar year upon presentation of a bill for emergency care rendered by a non-participating dentist. If the emergency is outside of the New York and New Jersey area, members have access to the Careington PPO Network for urgent care.

EMERGENCY SERVICE

24 HOUR REFERRAL

In the event you are unable to reach your own participating dentist - a 24 Hour Emergency telephone number is provided to obtain immediate care from another plan dentist:

800-468-0600

THE COMPREHENSIVE PLAN SCHEDULE OF DENTAL SERVICES

GROUP NUMBERS G022514BK and G022514BKC

These are the most you will have to pay to your Participating Dentist for the services listed.

Deductible	**None**
Maximum Benefits Payable Per Calendar Year	**Unlimited**

Diagnostic and Preventive Services	**Charge to the Patient**
Oral Exam	
Full Mouth X-Rays	
Bitewing Series	
Single Films	NO CHARGE
Prophylaxis	
Fluoride Treatment	
Sealants (unrestored permanent tooth)	
Emergency Treatment	
Restorative	
Amalgam, One Surface	NO CHARGE
Amalgam, Two Surfaces	
Amalgam, Three Surfaces or More	
	NO CHARGE
Composite Filling, One Surface (Anterior & Posterior)	
Composite Filling, Two Surfaces (Anterior & Posterior)	
Composite Filling, Three Surfaces or More (Anterior & Posterior)	
Oral Surgery	
Routine Extraction	
Surgical Extraction	
Soft Tissue Impaction	NO CHARGE
Full Bony Impaction	
Alveolectomy, Per Quad	
General Anesthesia for Surgical Extractions	
Root Canal Therapy	
Pulp Capping, Direct	
Root Canal Therapy, Anterior	NO CHARGE
Root Canal Therapy, Bicuspid	
Root Canal Therapy, Molar	

THE COMPREHENSIVE PLAN

Periodontics	**Charge to Patient**
Scaling of Teeth, Per Quad	
Gingivectomy, Per Quad	NO CHARGE
Osseous Surgery, Per Quad	
Prosthetics - Crowns	
Acrylic with Metal Crown	
Porcelain Crown	
Porcelain with Metal Crown	
Stainless Steel Crown	
Cast Post	NO CHARGE
Recementation, Per Crown	
Acrylic with Metal Crown/Pontic	
Porcelain with Metal Crown/Pontic	
Recementation, Bridge	
Prosthetics - Removable	
Full Upper Denture, Including Adjustments	
Full Lower Denture, Including Adjustments	
Partial Upper Denture, Cast Chrome Base	NO CHARGE
Partial Lower Denture, Cast Chrome Base	
Partial Unilateral Denture, Cast Chrome Base	
Prosthetics - Repairs	
Denture Adjustments Complete	
Broken Body of Denture	NO CHARGE
Replacement of Broken/Missing Teeth	
Orthodontia	NO CHARGE FOR COVERED SERVICES
Insertion (placement of brackets)	
Up to 24 months of active treatment	
Palatal Expander	**NO CHARGE**

There may be patient responsibility for uncovered appliances or treatment exceeding 24 months.

DUAL CHOICE DENTAL PLAN

EXCLUSIONS AND LIMITATIONS

GROUP NUMBERS: G022514B, G022514BC, G022514BK, G022514BKC

and G022514P

Benefits shall not be provided for:

(a) Services rendered for injuries or conditions which are compensable under Worker's Compensation or Employer's Liability Laws; services which are provided by any Federal or State or local government agency, or are provided without cost to the Covered Person, by any municipality, County or other political subdivision or community agency.

(b) Services rendered or items furnished for any conditions, disease, ailment or injury occurring while the Covered Person is on active duty during military service, or for services or items provided under the laws of the United States of America, or of any state of the United States, or of any foreign country, or of any political subdivision of any of the foregoing.

(c) Surgical procedures to correct congenital or developmental malformations, and procedures, appliances or restorations for cosmetic purposes or to increase vertical dimension, treat temporomandibular joint dysfunction, restore occlusion or restore tooth structure lost by attrition.

(d) Dental services rendered prior to the date the person became eligible for such services under this plan, or after the date on which coverage ends.

(e) Analgesics (such as nitrous oxide) or other euphoric or prescription drugs.

(f) Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting, including multiple abutments.

(g) Procedures primarily for the purpose of plaque control (except prophylaxis), oral hygiene or dietary instructions.

(h) Bases or procedures of an experimental nature. Crowns on implants are not covered (Managed Care Plan).

(i) General anesthesia, except when rendered in conjunction with covered oral surgery by a licensed practitioner other than the treating dentist.

(j) Replacement of lost or stolen appliances.

(k) All other services not specifically included in this contract.

DUAL CHOICE DENTAL PLAN

EXCLUSIONS AND LIMITATIONS

(l) Any services or items which are determined by the plan's Dental Director not to be a necessary service or item in connection with the condition, disease or injury for which the Covered Person is being treated.

(m) Services or items rendered by a family member, or treatment covered or provided under terms of a benefit plan issued by another insurance company, benefit plan or dental facility.

(n) Broken appointments. For appointments not canceled 24 hours in advance, there is a $30.00 charge to the member (Managed Care Plan).

(o) Services, procedures, or appliances necessary to treat missing teeth, which teeth are already missing on the Effective Date of this Contract, provided, however, that if a Covered Person is eligible for full dentures hereunder, such eligibility shall not be affected by the fact that any tooth or teeth were missing prior to the Effective Date.

(p) Any service not rendered by a participating general dentist, unless a referral is made and authorized by the company to a participating specialist. Patients who are unmanageable by the general dentist, or who desire to be treated under general anesthesia, have no coverage under the plan (Managed Care Plan).

2. Coverage is subject to the following limitations:

(a) Diagnostic and palliative

(i) Examinations will be provided only once in a six (6) month period. Complete mouth radiograph series will be provided only once in a five (5) year period, unless special need is shown. Supplementary bitewing radiographs are provided upon request, but no more than once every six (6) months.

(ii) Palliative treatment is not covered when rendered on the same day as other treatment.

(b) Preventive and periodontal

(i) Prophylaxis will be provided up to four (4) times in a calendar year.

(ii) Periodontal scaling and root planing will be provided once in a six (6) month period and will not be payable on the same date of service as prophylaxis

(iii) Topical application of fluoride will be provided to cover Dependents with a primary or mixed dentition.

DUAL CHOICE DENTAL PLAN

EXCLUSIONS AND LIMITATIONS

(c) Restorative and Prosthetic

(i) Benefits are allowed for one restoration per tooth, regardless of the number of restoration combinations actually placed.

(ii) Reconstruction: Replacement of inlays, onlays, crowns and bridges will be made only after five (5) years have elapsed following insertion under this or any other prior program.

(iii) Replacement will be made of an existing denture only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances satisfactory will be provided in accordance with the Contract. Prosthodontic appliances including abutment crowns will be replaced only after five (5) years have elapsed following any prior provision of such appliances under any prior dental plan.

(iv) If, in the provision of Prosthodontic Services, the Covered Person and the Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the plan will cover only the standard procedure and the Covered Person is responsible for any difference in cost.

(d) In the event that there are alternate methods of treating a condition (e.g., varying techniques, substances and appliances) which methods carry different fees, any other provisions of the Contract notwithstanding, the plan shall cover the procedure with the lesser fee, unless a method carrying the greater fee is the only adequate treatment. In the event the Covered Person elects treatment beyond that determined to be adequate by the Plan, he shall remain responsible for that portion of the Dentist's fee not paid by the plan. Typical limitations in this category are fixed bridges (when partial denture can be used to replace more than one missing tooth in an arch), and single crowns (when the tooth can be restored with an amalgam or composite restoration).

(e) In the event that a Covered Person transfers from the care of one Dentist to that of another Dentist during a course of treatment, or if more than one Dentist renders services for the same dental procedure, the Plan shall not be liable for more than the amount it would have been liable for had but one Dentist rendered all the services during each course of treatment, nor shall the Plan be liable for duplication of services rendered.

Exclusions and Limitations

(f) Orthodontics

(i) Coverage is for dependent children only (Managed Care Plan) and must be preauthorized by the company. Only those cases involving Class II or Class III malocclusions will be considered for coverage. Such cases must have either a unilateral crossbite, an overjet in excess of 4 mm, or an overbite that impinges on the palatal gingival. Coverage is limited to twenty-four (24) months of treatment.

3. In cases of Dental Emergency, Dentcare will reimburse a Member a maximum per contract year of $25.00 for services rendered by a General Dentist upon a presentation of bills. This benefit will only be paid if the patient is unable to obtain care from a plan dentist. Members have access to the Careington PPO network outside of New York and New Jersey area for urgent care (Managed Care Plan).

Plan administered by:

The Reimbursement Option

&

The Comprehensive Plan is underwritten by

Healthplex, Inc.

333 Earle Ovington Blvd., Suite 300

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