WEST HEMPSTEAD EDUCATION ASSOCIATION

SELF-INSURED DENTAL PLAN

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SCHEDULE OF BENEFITS

PLAN EFFECTIVE DATE: July 1, 1998/ Amended 9/1/12

EMPLOYEES' ELIGIBLE: All Active Full-Time Members Of The West Hempstead Teachers Association Who Work At Least 20 Hours Per Week.

CONTRIBUTORY BENEFITS FOR ELIGIBLE PERSONNEL AND THEIR DEPENDENTS

MAXIMUM CALENDAR YEAR BENEFIT……………………………….$2,000.00

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

ORTHODONTIC LIFETIME BENEFIT…………………………………..$1,500.00
(Included in the calendar year maximum)

DENTAL CO-INSURANCE PERCENTAGES (After Satisfying the Deductible)

In Network: 100% of Stanis Net Plus Fee Schedule for Diagnostic & Preventative Services.
Out of Network: 100% of Reasonable & Customary for Diagnostic & Preventative Services.

In Network: 50% of Stanis Net Plus Fee Schedule for Orthodontic Services
Out of Network: 50% of Reasonable & Customary for Orthodontic Services.

In Network/Out of Network:
100% of the Stanis Net Plus Fee Schedule For All Other Covered Services

DENTAL DEDUCTIBLES:

Individual Dental Deductible..$ 50.00

Family Dental Deductible..$150.00

(The Deductible does not apply to Diagnostic, Preventative & Orthodontic Services)

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 calendar year.

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 both 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 July 1, 1998, you will be eligible on the plan effective date shown in the Schedule of Benefits. If your date of employment is on or after July 1, 1998, 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 within thirty-one days after the day you become eligible, you will be covered on the day you enroll. **You should enroll promptly. If you enroll more than thirty-one days after the day you become eligible; you will only be entitled to $100 in benefits for the first 24 months.**

WHEN YOUR DEPENDENTS' COVERAGE BEGINS

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 covered until the end of the month of their nineteenth (19) birthday or a full-time student until the end of the month of their twenty-fifth (25) birthday.

PROOF OF FULL TIME STUDENT STATUS

Written proof of full time student status will be required for dependent children between the 19-25 years of age. Proof for the Spring semester will cover the period of January 1 thru August 31. Proof of the Fall semester will cover the period from September 1 thru December 31.

If your child is mentally ill, developmentally disabled, 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 they become eligible; they will be entitled to receive only $100 in benefits for the first 24 months.

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 on pages 13-21 as a covered service.

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)
A series of bitewing x-rays consist of four films, (this service is limited to two in a calendar year)
Full Mouth and/or Panoramic x-rays are limited to one in three calendar years.
Topical application of stannous fluoride (this service is limited to one in a calendar year and is only covered for persons under age 15)

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) For prosthetic appliances related to periodontal treatment;
(e) Services provided due to war, if declared or not;
(f) For porcelain on molar teeth;
(g) For oral hygiene, dietary, plaque control and other educational programs;
(h) For cosmetic reasons;
(i) For appliances, restorations or procedures whose purpose is to alter vertical dimension or maintain occlusion;
(j) 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;
(k) For replacing tooth structure lost as a result of abrasion or attrition;
(l) For the replacement of any fixed bridge, or denture within 5 years of the date of the last placement of such item;
(m) For the replacement of congenitally missing teeth;
(n) For inlays or crowns installed as multiple abutments.

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 West Hempstead Education Association, there will be no coverage for such device. This limitation no longer applies after 60 consecutive months of coverage.

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.

COORDINATION OF BENEFITS TERMINOLOGY (Continued)

(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.

EFFECT ON THE BENEFITS OF THIS PLAN (Continued)

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 charge against any benefit limit of this plan.

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.

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.

ORDER OF BENEFITS DETERMINATION (Continued)

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 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 that ends the last period for which premiums are paid on your behalf;
(c) The date you are no longer a member of a class eligible for this coverage.
However, if your employment terminates ask your Employer what rights of continuation, if any, you may have.

TERMINATION (Continued)

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 you are no longer eligible for dependents coverage;
   (c) The date on which the dependent no longer meets the definition of a dependent;
   (d) The last day, for which any required premium contribution is made, if there is failure to make any further required contribution.

3. **Family Continuance Benefit (Dependent Dental Benefits After Your Death)**
   If, however, your benefits end because you die, then items (2a) and (2d) above will not apply. Coverage for your surviving dependents will continue until the earliest of these dates:

   (a) If your surviving spouse is a covered dependent the date such spouse remarries;
   (b) The date on which a dependent ceases to meet the policy's definition of dependent;
   (c) The end of a one year period which begins on the date of your death;
   (d) The date on which the policy terminates.

For information on the cost of dependent survivor coverage, contact the Plan Coordinator.

If your surviving spouse dies, your other eligible dependents may continue their coverage as dependent survivors until they no longer meet the eligibility requirements as dependents.

If your survivor is eligible for dependent survivor coverage but chooses not to participate or fails to make the required payments, coverage will be terminated permanently. Your survivor may not re-enroll.

Any extension of benefits after coverage ends under COBRA, as defined on next page, will also apply to dependents when coverage provided by the Family Continuance Benefits ends.

However, the time period for which coverage was continued under the Family Continuance Benefit will be deducted from the 36 months available under COBRA

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. The Plan Coordinator 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, The Plan Coordinator 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.

SPECIAL CONTINUANCE OF DENTAL COVERAGE (Continued)

You or your dependent must pay the required amount if any, for the continued coverage. The Plan Coordinator 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;
(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.

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	MAXIMUM ALLOWANCE
0120	PERIODIC ORAL EVALUATION	*
0140	LIMITED ORAL EVALUATION	*
0150	COMPREHENSIVE ORAL EVALUATION	*
0160	DETAILED ORAL EVALUATION	*
0170	LIMITED RE-EVALUATION	*
0210	XRAY – COMPLETE SERIES	*
0220	XRAY – SINGLE FILM- PERIAPICAL	*
0230	XRAY – ADDITIONAL FILM- PERIAPICAL	*
0240	XRAY – SINGLE FILM- INTRAORAL	*
0250	XRAY – SINGLE FILM- EXTRAORAL	*
0260	XRAY – ADDITIONAL FILM- EXTRAORAL	*
0270	BITEWING – XRAY- 1	*
0272	BITEWING – XRAYS- 2	*
0274	BITEWING – XRAYS- 4	*
0290	POSTERIOR/ANTERIOR LATERAL FILM	*
0310	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	*
0501	HISTOPATHOLOGIC EXAM	*
1110	PROPHYLAXIS (ADULT)	*
1120	PROPHYLAXIS (CHILD)	*
1201	FLUORIDE TREATMENT WITH PROPHY CHILD	*
1203	FLUORIDE TREATMENT CHILD	*
1204	FLUORIDE TREATMENT ADULT	*
1205	FLUORIDE TREATMENT WITH PROPHY ADULT	*
1351	SEALANT (PER TOOTH)	*
1510	SPACE MAINTAINER UNILATERAL	*
1515	SPACE MAINTAINER BILATERAL	*
1520	SPACE MAINTAINER UNILATERAL	*
1525	SPACE MAINTAINER BILATERAL	*
1550	RECEMENT SPACE MAINTAINER	*

*** These services are payable at 100% of Reasonable and Customary**

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	MAXIMUM ALLOWANCE
8080	APPLIANCE FEE	**
8210	HARMFUL HABIT APPLIANCE	**
8220	HARMFUL HABIT APPLIANCE	**
8660	PRE ORTHODONTIC CARE (Out of Network only)	**
8670	ORTHODONTIC MONTHLY MAINTENANCE	**

**** These services are payable at 50% of Reasonable and Customary**

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	CURRENT SCHEDULE
2140	AMALGAM RESTORATION-1 SUR. PERMANENT	$ 64
2150	AMALGAM RESTORATION-2 SUR.PERMANENT	$ 69
2160	AMALGAM RESTORATION-3 SUR.PERMANENT	$ 90
2161	AMALGAM RESTORATION-4+ SUR.PERMANENT	$ 102
2330	RESIN RESTORATION- 1 SUR. ANTERIOR	$ 64
2331	RESIN RESTORATION-2 SUR. ANTERIOR	$ 87
2332	RESIN RESTORATION-3 SUR. ANTERIOR	$ 107
2335	RESIN RESTORATION-4+ SUR. ANTERIOR	$ 130
2336	RESIN COMPOSITE CROWN - PRIMARY	$ 138
2337	RESIN COMPOSITE CROWN – ANTERIOR PERM	$ 146
2390	RESIN COMPOSITE CROWN - ANTERIOR	$ 150
2391	COMPOSITE RESTORATION-1 SUR POST. PERM	$ 67
2392	COMPOSITE RESTORATION-2 SUR POST.PERM.	$ 96
2393	COMPOSITE RESTORATION-3 SUR POST.PERM.	$ 121
2394	COMPOSITE RESTORATION-4+ SUR.POST.PERM.	$ 143
2410	GOLD FOIL RESTORATION-1 SUR.	$ 244
2420	GOLD FOIL RESTORATION-2 SUR.	$ 279
2430	GOLD FOIL RESTORATION-3 SUR.	$ 428
2510	INLAY METALLIC-1 SUR.	$ 257
2520	INLAY METALLIC-2 SUR.	$ 293
2530	INLAY METALLIC-3 SUR.	$ 460
2542	ONLAY METALLIC-1 SUR.	$ 368
2543	ONLAY METALLIC -2 SUR.	$ 403
2544	ONLAY METALLIC-3 SUR.	$ 439
2610	PORCELAIN INLAY-1 SUR.	$ 242
2620	PORCELAIN INLAY-2 SUR.	$ 317
2630	PORCELAIN INLAY-3+ SUR.	$ 467
2642	ONLAY PORCELAIN-2 SUR.	$ 527
2643	ONLAY PORCELAIN-3 SUR.	$ 556
2644	ONLAY PORCELAIN-4+ SUR.	$ 573
2650	INLAY COMPOSITE-1 SUR.	$ 121
2651	INLAY COMPOSITE-2 SUR.	$ 242
2652	INLAY COMPOSITE-3+ SUR.	$ 401
2662	ONLAY COMPOSITE RESIN (LAB)-2 SUR.	$ 236
2663	ONLAY COMPOSITE RESIN (LAB)-3 SUR.	$ 345
2664	ONLAY-COMPOSITE RESIN (LAB)- 4+ SUR.	$ 494
2710	CROWN RESIN (LAB)	$ 204
2720	CROWN RESIN HIGH NOBLE METAL	$ 595
2721	CROWN RESIN BASE METAL	$ 550
2722	CROWN RESIN NOBLE METAL	$ 575
2740	PORCELAIN CROWN	$ 600

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	CURRENT SCHEDULE
2750	CROWN PORCELAIN HIGH NOBLE METAL	$ 615
2751	CROWN PORCELAIN BASE METAL	$ 560
2752	CROWN PORCELAIN NOBLE METAL	$ 575
2780	CROWN 3/4 CAST HIGH NOBLE	$ 466
2781	CROWN 3/4 CAST BASE METAL	$ 438
2782	CROWN 3/4 CAST NOBLE METAL	$ 453
2783	CROWN 3/4 PORCELAIN	$ 479
2790	CROWN FULL CAST HIGH NOBLE	$ 580
2791	CROWN FULL CAST BASE METAL	$ 560
2792	CROWN FULL CAST NOBLE METAL	$ 565
2799	PROVISIONAL CROWN	$ 195
2910	RECEMENT INLAY	$ 50
2920	RECEMENT CROWN	$ 44
2930	STAINLESS STEEL CROWN	$ 130
2931	STAINLESS STEEL CROWN	$ 144
2932	PREFABRICATED RESIN CROWN	$ 130
2940	SEDATIVE FILLING	$ 50
2950	CROWN BUILDUP	$ 144
2951	PIN RETENTION	$ 35
2952	CAST POST & CORE	$ 207
2953	ADDITIONAL CAST POST	$ 98
2954	POST & CORE PREFABRICATED	$ 184
2955	POST REMOVAL	$ 102
2957	ADDITIONAL PREFABRICATED POST	$ 81
2960	LAMINATE	$ 260
2961	RESIN LAMINATE	$ 389
2962	PORCELAIN LAMINATE	$ 418
2970	TEMPORARY CROWN	$ 115
2980	CROWN REPAIR	$ 113
3110	PULP CAP DIRECT	$ 38
3120	PULP CAP INDIRECT	$ 28
3220	PULPOTOMY	$ 87
3221	GROSS PULPAL DEBRIDEMENT – PRIMARY	$ 84
3230	PULPAL THERAPY – ANTERIOR – PRIMARY	$ 90
3240	PULPAL THERAPY – POST – PRIMARY	$ 90
3310	ROOT CANAL THERAPY- ANTERIOR	$ 360
3320	ROOT CANAL THERAPY- 2 CANALS	$ 440
3330	ROOT CANAL THERAPY-3 CANALS	$ 572
3331	ROOT CANAL THERAPY	$ 109
3332	INCOMPLETE ENDODONTIC THERAPY	$ 281
3333	INTERNAL ROOT REPAIR	$ 94
3346	RETREAT ROOT CANAL – ANTERIOR	$ 480
3347	RETREAT ROOT CANAL – BICUSPID	$ 575
3348	RETREAT ROOT CANAL- MOLAR	$ 690
3351	APEXIFICATION INITIAL	$ 200

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	CURRENT SCHEDULE
3352	APEXIFICATION/RECALCIFICATION – INTERIM	$ 90
3353	APEXIFICATION/RECALCIFICATION – FINAL	$ 272
3410	APICOECTOMY ANTERIOR	$ 400
3421	APICOECTOMY-PERIRADICULAR – BICUSPID	$ 450
3425	APICOECTOMY-PERIRADICULAR – MOLOR	$ 500
3426	APICOECTOMY-PERIRADICULAR – ADD'L ROOT	$ 170
3430	RETROGRADE FILLING	$ 125
3450	ROOT AMPUTATION	$ 255
3470	INTENTIONAL REPLANTATION	$ 546
3910	SURGICAL PROC-ISOLATION TOOTH	$ 35
3920	HEMISECTION	$ 202
3950	CANAL PREPARATION OF DOWEL OR POST	$ 85
4210	GINGIVECTOMY-QUADRANT	$ 330
4211	GINGIVECTOMY-1-3 TEETH	$ 140
4240	GINGIVAL FLAP PROCEDURE	$ 485
4245	APICALLY POSIT FLAP	$ 266
4249	CROWN LENGTH BY TOOTH	$ 390
4260	OSSEOUS SURGERY-QUADRANT	$ 625
4261	OSSEOUS SURGERY- 1-3 TEETH	$ 300
4263	BONE GRAFT 1ST SITE IN QUADRANT	$ 240
4264	BONE REPLACEMENT GRAFT IN QUADRANT	$ 173
4266	GUIDED TISSUE REGENERATION	$ 374
4267	GUIDED TISSUE NON RESTORABLE	$ 370
4270	PEDICLE SOFT TISSUE GRAFT	$ 480
4271	FREE SOFT TISSUE GRAFT	$ 432
4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT	$ 515
4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$ 288
4275	SOFT TISSUE ALLOGRAFT	$ 275
4320	PROVISIONAL SPLINT INTRACORONAL	$ 230
4321	PROVISIONAL SPLINT EXTRCORONAL	$ 200
4341	PERIODONTAL SCALING QUADRANT	$ 125
4342	PERIODONTAL SCALING 1-3 TEETH	$ 70
4355	FULL MOUTH DEBRIDEMENT	$ 121
4381	LOCAL CHEMOTHERAPEUTIC AGENT	$ 102
4910	PERIODONTAL MAINTENANCE	$ 75
5110	COMPLETE DENTURE UPPER	$ 690
5120	COMPLETE DENTURE LOWER	$ 633
5130	IMMEDIATE DENTURE UPPER	$ 719
5140	IMMEDIATE DENTUE LOWER	$ 690
5211	UPPER PARTIAL DENTURE/RESIN BASE	$ 619
5212	LOWER PARTIAL DENTURE/RESIN BASE	$ 619

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	CURRENT SCHEDULE
5213	UPPER PARTIAL DENTURE-CAST METAL	$ 719
5214	LOWER PARTIAL DENTURE-CAST METAL	$ 690
5225	MAXILLARY PARTIAL DENTURE FLEXIBLE	$ 719
5226	MANDIBULAR PARTIAL DENTURE FLEXIBLE	$ 525
5281	UNILATERAL PARTIAL	$ 294
5410	ADJUST DENTURE UPPER COMPLETE	$ 29
5411	ADJUST DENTURE LOWER COMPLETE	$ 52
5421	ADJUST DENTURE UPPER PARTIAL	$ 44
5422	ADJUST DENTURE LOWER PARTIAL	$ 35
5510	REPAIR BROKEN COMPLETE DENTURE BASE	$ 97
5520	REPLACE MISSING/BROKEN TEETH-DENTURE	$ 97
5610	REPAIR RESIN BASE	$ 87
5620	REPAIR FRAMEWORK	$ 102
5630	REPAIR BROKEN CLASP	$ 104
5640	REPLACE BROKEN TEETH	$ 87
5650	ADD TOOTH TO PARTIAL	$ 104
5660	ADD CLASP TO PARTIAL	$ 138
5710	REBASE COMPLETE MAXILLARY DENTURE	$ 126
5711	REBASE COMPLETE MANDIBULAR DENTURE	$ 126
5720	REBASE MAXILLARY PARTIAL DENTURE	$ 74
5721	REBASE MANDIBULAR PARTIAL DENTURE	$ 74
5730	RELINE UPPER DENTURE- CHAIRSIDE	$ 175
5731	RELINE LOWER DENTURE-CHAIRSIDE	$ 175
5740	RELINE PARTIAL DENTURE-CHAIRSIDE	$ 102
5741	RELINE PARTIAL DENTURE-CHAIRSIDE	$ 161
5750	RELINE UPPER DENTURE-LAB	$ 173
5751	RELINE LOWER DENTURE-LAB	$ 173
5760	RELINE PARTIAL DENTURE-LAB	$ 202
5761	RELINE PARTIAL DENTURE-LAB	$ 202
5820	INTERIM PARTIAL DENTURE – MAXILLARY	$ 288
5821	INTERIM PARTIAL DENTURE – MANDIBULAR	$ 288
5850	TISSUE CONDITIONING UPPER	$ 130
5851	TISSUE CONDITIONING LOWER	$ 130
5860	OVERDENTURE COMPLETE	$ 543
5861	OVERDENTURE PARTIAL	$ 610
5862	PRECISION ATTACHMENT	$ 288
5982	SURGICAL STENT	$ 199
6010	SURGICAL ENDOSTEAL IMPLANT	$ 978
6020	ABUTMENT PLACEMENT	$ 489
6057	CUSTOM ABUTMENT	$ 821
6058	ABUTMENT SUPPORTED PORCELAIN CROWN	$ 714
6059	ABUTMENT SUPPORT PORCELAIN METAL CROWN	$ 705
6060	ABUTMENT SUPPORT PORCELAIN METAL CROWN	$ 582
6061	ABUTMENT SUPPORT PORCELAIN NOBLE METAL	$ 616
6062	ABUTMENT SUPPORT CAST HIGH NOBLE METAL	$ 703

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	CURRENT SCHEDULE
6063	ABUTMENT SUPPORT CAST METAL CROWN	$ 705
6064	ABUTMENT SUPPORT CAST METAL CROWN	$ 666
6065	IMPLANT SUPPORTED PORCELAIN	$ 680
6066	IMPLANT SUPPORTED PORCELAIN FUSED	$ 685
6067	IMPLANT SUPPORTED METAL CROWN	$ 664
6068	ABUTMENT SUPPORTED RETAINER – PORCELAIN	$ 714
6069	ABUTMENT SUPPORTED RETAINER – FUSED METAL	$ 705
6070	ABUTMENT SUPPORTED RETAINER – FUSED METAL	$ 666
6071	ABUTMENT SUPPORTED RETAINER – FUSED METAL	$ 680
6072	ABUTMENT SUPPORTED RETAINER – CAST METAL	$ 694
6073	ABUTMENT SUPPORTED RETAINER – CAST METAL	$ 628
6074	ABUTMENT SUPPORTED RETAINER – CAST METAL	$ 677
6075	IMPLANT SUPPORTED RETAINER – CERAMIC	$ 706
6076	IMPLANT SUPPORTED RETAINER – PORCELAIN	$ 685
6077	IMPLANT SUPPORTED RETAINER – CAST METAL	$ 664
6080	IMPLANT MAINTENANCE PROCEDURE-REMOVAL	$ 87
6210	PONTIC HIGH NOBLE METAL	$ 540
6211	PONTIC BASE METAL	$ 500
6212	PONTIC NOBLE METAL	$ 525
6240	PONTIC PORCELAIN HIGH NOBLE	$ 540
6241	PONTIC PORCELAIN BASE METAL	$ 500
6242	PONTIC PORCELAIN NOBLE METAL	$ 525
6245	PONTIC PORCELAIN – CERAMIC	$ 530
6250	PONTIC RESIN HIGH NOBLE	$ 530
6251	PONTIC RESIN BASE METAL	$ 490
6252	PONTIC RESIN NOBLE METAL	$ 500
6519	INLAY/ONLAY PORCELAIN/CERAMIC	$ 425
6520	INLAY METALLIC	$ 293
6530	INLAY METALLIC	$ 363
6545	CAST METAL RETAINER	$ 230
6548	RETAINER – PORCELAIN/CERAMIC – RESIN BOND	$ 210
6720	BRIDGE CROWN HIGH NOBLE	$ 600
6721	BRIDGE CROWN BASE METAL	$ 565
6722	BRIDGE CROWN NOBLE METAL	$ 580
6740	CROWN PORCELAIN – CERAMIC	$ 580
6750	BRIDGE CROWN PORCELAIN HIGH NOBLE	$ 600
6751	BRIDGE CROWN PORCELAIN BASE METAL	$ 540
6752	BRIDGE CROWN PORCELAIN NOBLE METAL	$ 570
6780	BRIDGE CROWN 3/4 HIGH NOBLE	$ 570
6781	BRIDGE CROWN 3/4 PREDOMINANTLY BASE METAL	$ 580
6782	BRIDGE CROWN 3/4 CAST NOBLE METAL	$ 570
6783	BRIDGE CROWN 3/4 PORCELAIN-CERAMIC	$ 575
6790	BRIDGE CROWN CAST HIGH NOBLE	$ 590
6791	BRIDGE CROWN CAST BASE METAL	$ 560
6792	BRIDGE CROWN CAST NOBLE METAL	$ 570
6930	RECEMENT BRIDGE	$ 56
6940	STRESS BREAKER	$ 202

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	CURRENT SCHEDULE
6950	PRECISION ATTACHMENT	$ 239
6970	CAST POST & CORE – PARTIAL DENTURE	$ 207
6971	CAST POST – PARTIAL DENTURE	$ 190
6972	PREFABRICATED POST & CORE	$ 184
6973	CORE BUILD UP – RETAINER	$ 144
6975	COPING METAL	$ 250
6976	CAST POST – ADDITIONAL – SAME TOOTH	$ 80
6977	PREFABRICATED POST – ADDITIONAL SAME TOOTH	$ 82
6980	PARTIAL DENTURE REPAIR	$ 107
7140	EXTRACTION	$ 110
7210	SURGICAL EXTRACTION	$ 140
7220	SURGICAL EXTRACTION SOFT TISSUE	$ 175
7230	SURGICAL EXTRACTION PARTIAL BONY	$ 235
7240	SURGICAL EXTRACTION BONY	$ 275
7241	REMOVAL IMPACTED TOOTH – COMPLETE BONY	$ 350
7250	RESIDUAL ROOT REMOVAL	$ 145
7260	ORAL ANTRAL FISTULA	$ 294
7270	TOOTH REPLANTATION	$ 295
7272	TOOTH TRANSPLANT – REIMPLANT & SPLINT	$ 300
7280	SURGICAL EXPOSURE	$ 335
7281	SURGICAL EXPOSURE	$ 317
7285	HARD TISSUE BIOPSY	$ 245
7286	SOFT TISSUE BIOSPY	$ 170
7290	REPOSITION OF TEETH	$ 275
7310	ALVEOPLASTY WITH EXTRACTION	$ 130
7320	ALVEOPLASTY WITH NO EXTRACTION	$ 245
7340	VESTIBULOPLASTY	$ 395
7350	VESTIBULOPLASTY	$ 395
7410	EXCISION/LESION<1.25 CM	$ 185
7420	EXCISION/LESION>1.25 CM	$ 126
7430	EXCISION/TUMOR<1.25 CM	$ 240
7431	EXCISION/TUMOR>1.25 CM	$ 295
7450	REMOVAL CYST/TUMOR<1.25 CM	$ 245
7451	REMOVAL CYST/TUMOR>1.25CM	$ 295
7460	REMOVAL CYST/TUMOR<1.25 CM	$ 265
7461	REMOVAL CYST/TUMOR>1.25 CM	$ 295
7471	REMOVAL OF EXOTOSIS	$ 202
7510	I & D ABCESS – INTRAORAL	$ 155
7520	I & D ABSCESS – EXTRAORAL	$ 245
7530	REMOVAL FOREIGN BODY/SKIN/ALVEOLAR TISSUE	$ 95
7550	SEQUESTRECTOMY FOR OSTEOMYELITIS	$ 61
7880	OCCLUSAL ORTHOTIC DEVICE	$ 420
7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	$ 58
7911	COMPLICATED SUTURE UP TO 5 CM	$ 12
7912	COMPLICATED SUTURE > 5 CM	$ 18
7950	OSSEOUS/PERIO/CARTILAGE GRAFT-MANDIBULAR	$ 255
7960	FRENULECTOMY	$ 345

PLAN FEE SCHEDULE

ADA CODE	DESCRIPTION OF SERVICE	CURRENT SCHEDULE
7970	EXCISION OF TISSUE	$ 345
7971	EXCISION PERIOCORONAL GINGIVA	$ 122
9110	PALLIATIVE TREATMENT	$ 50
9210	LOCAL ANESTHESIA	$ 12
9220	GENERAL ANESTHESIA (30 MINUTE)	$ 130
9221	GENERAL ANESTHESIA (15 MINUTE)	$ 58
9230	ANALGESIA-ANXIOLYSIS INHALATION NITROUS	$ 38
9241	IV CONSCIOUS SEDATION-1ST 30 MINUTES	$ 144
9242	IV CONSCIOUS SEDATION- ADD'L 15 MINUTES	$ 72
9310	PROFESSIONAL CONSULTATION	$ 52
9410	HOUSE/EXTENDED CARE FACILITY CALL	$ 46
9420	HOSPITAL CALL	$ 46
9430	OFFICE VISIT – REGULAR HOURS	$ 41
9440	OFFICE VISIT – AFTER REGULAR HOURS	$ 58
9610	THERAPEUTIC DRUG – INJECTION	$ 29
9630	OTHER DRUGS &/OR MEDICAMENT	$ 23
9910	APPLICATION DESENSITIZING MEDICAMENT	$ 46
9911	APPLICATION DESENSITIZING RESIN	$ 35
9940	OCCLUSAL GUARDS	$ 245
9950	OCCLUSION ANALYSIS - MOUNTED CASE	$ 130
9951	OCCLUSAL ADJUSTMENT LIMITED	$ 73
9952	OCCLUSAL ADJUSTMENT COMPLETE	$ 202
9970	ENAMEL MICROABRASION	$ 29

All Claims should be mailed to
J.J. STANIS AND COMPANY, inc. at the following address:

J.J. STANIS AND COMPANY, INC.
377 Oak Street
Suite 406
Garden City, NY 11530

All Benefit and Claim inquiries should be directed to
J.J. STANIS AND COMPANY, INC.
At the following phone number:

Toll Free: (877) 470-3715