

**SSMC Employee Dental Benefit Plan
Notice of Summary of Material Modification
Dental Expense Benefits Revised**

Date of Notice : April 1, 2004

Applicability Date: June 1, 2003

To: Plan Participants in the SSMC Employee Dental Benefit Plan and COBRA participants.

The Benefit Schedule of Plan has been modified for compliance with the Electronic Data Interchange (EDI) provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To comply with federal HIPAA regulations, the Plan has been amended to modify covered procedures in accordance with the procedures listed in the “CDT 4 - Current Terminology” handbook published by the American Dental Association. Modifications include name changes, addition of new procedures and deletion of coverage for procedures that are no longer listed or are considered part of another major procedure based on the CDT 4 handbook.

The following revised schedule is applicable to Covered Expenses incurred on and after June 1, 2003. All other Plan provisions, limitations or exclusions remain the same.

E. Benefit Schedule

The following is a list of covered dental services and the maximum allowance payable for each. The allowance or scheduled allowance for unlisted covered services will be determined by the Claims Administrator and shall be consistent with the other items listed in this benefit schedule. The Plan Administrator may, at its option, change the Schedule of Allowances from time to time. Please refer to **Section IV-Plan Exclusions** for additional Plan limitations and exclusions.

To comply with the Electronic Data Interchange (EDI) provisions of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan Covered Services must be listed in the “CDT 4 –Current Terminology handbook published by the American Dental Association. If the CDT 4 - Current Terminology handbook is updated, this Plan must modify its covered services for compliance under HIPAA. This could mean addition of new procedures and deletion of previously covered procedures.

Please Note

You are responsible for payments of charges more than the applicable UCR allowance or scheduled amount.

1. Preventive Services

| <i>Plan pays 100% of the Usual Customary and Reasonable (UCR) allowance for covered preventive expenses. Preventive care is limited to the following procedures services.</i> | | |
|---|-----------|--|
| Covered Preventive Procedures | Allowance | Special Limits |
| Prophylaxis (scaling/cleaning with or without inflamed gums) and related routine oral examinations. | UCR | Coverage is limited to twice per Calendar Year. |
| Fluoride Topical Application (limited to children under age 14) | UCR | Maximum once per Calendar Year for any combination of treatment. They must apply topical fluoride separately from the paste or substance used for prophylaxis. Coverage ends on child’s 14th birthday. Separate Plan payment will be made for Prophylaxis done at the same time. |

| Covered Preventive Procedures | Allowance | Special Limits |
|---|-----------|---|
| Sealants | UCR | Limited to molars and once per tooth in any 36 consecutive months. Not a benefit for Covered Persons age 16 or older. |
| Space Maintainer Fixed or Removable , unilateral or bilateral | UCR | |

2. Diagnostic Services

Diagnostic Services are limited to those shown below. Unlisted procedures are not covered. Occasionally, diagnostic services will be considered part of a major procedure allowance or part of a case fee allowance. In these instances, the Plan will not make a separate Plan payment. The Plan pays 100% of the UCR allowance for the listed procedures.

| Covered Diagnostic Procedures | Allowance | Special Limits |
|--|-----------|---|
| Clinical Oral Evaluations Comprehensive/Periodic | UCR | Limited to twice per Calendar Year |
| Limited (Dental Emergencies) Palliative treatment (emergency pain relief) | UCR | Must not be at the same time as another service except x-rays. X-rays are allowed separately. Benefits are not payable for emergency exams done on the same day as palliative treatment. Palliative treatment includes sedative fillings. If the service is the start of treatment for root canal therapy or other procedure, separate charges will not be covered. |
| X-rays Intraoral complete series with or without bitewings; Panoramic maxillary or mandibular, single film. | UCR | Coverage limited to once for either complete series or panoramic x-rays, not both in any 36-consecutive months. |
| Bitewings One film Two films same day 7-8 vertical films same day | UCR | Coverage limited to twice per Calendar Year and to no more than 8 films for any combination of standard and/or vertical bitewings each Calendar Year. |
| Other X-rays, including but not limited to periapical and occlusal | UCR | When needed to diagnose a covered dental condition. Cephalometric x-rays are not covered. |
| Tests and Laboratory Diagnostic Casts for Comprehensive Cases | UCR | When needed for comprehensive diagnosis of covered dental condition. |

3. Composite Restorations (Also, see *Other Restorations*)

The Plan pays 100% of the UCR allowance for the listed procedure.

| | | |
|------------------------------|-----|---|
| Resin Based Composite | UCR | Benefits based on surfaces filled per tooth |
|------------------------------|-----|---|

4. Endodontics (Also see *Other Endodontics*)

| <i>The Plan pays 100% of UCR allowance for the listed procedure.</i> | | |
|--|-----------|--|
| Covered Endodontic Therapy | Allowance | Special Limits |
| Vital Pulpotomy | UCR | Deciduous teeth only |
| Root Canals | UCR | Allowance includes related services such as treatment plan, pulp tests, pulpotomy, x-rays, clinical procedures, and follow up care (separate charges for these procedures will not be covered). Apicoectomy and final restoration expenses are covered separately. |

5. Other Restorations

| <i>The Plan covers the following services for restoration of tooth damage due to illness or Injury only. Services must be considered appropriate and usual for the dental conditions. Benefits are not payable for services considered cosmetic or esthetic. Allowance includes local anesthetic and usual care before and after restorative procedure. Multiple surfaces restored on one tooth during the same visit are considered one restoration. Each surface filled on the same tooth during one treatment is not considered a separate tooth.</i> | | |
|--|---|--|
| Covered Other Restoration Procedures | Maximum Allowance | Special Limits |
| Amalgam Restorations Primary/Permanent Teeth One surface Two surfaces Three or more surfaces Four or more surfaces | 9.00 13.00 16.00 20.00 | Allowance based on the total number of surfaces filled per tooth. |
| Sedative Filling | 10.00 | |
| Pin retention | 3.00 | Allowance is per pin. Maximum two pins per tooth. Amalgam restoration considered separate service. |
| Inlay (Metallic; Porcelain/Ceramic; Resin) One Surface Two surfaces Three or more surfaces Reccement | 53.00 67.00 74.00 10.00 | Allowance based on total number of surfaces restored per tooth. |
| Onlay (Metallic; Porcelain/Ceramic; Resin) | \$ 10.00 | Allowance per tooth in addition to inlay. |

6. Crown Restorations

| Crown Restoration Procedures | Maximum Allowance | Special Limits |
|--|-------------------|----------------|
| <p>Allowance is per tooth. Crowns must be considered dentally necessary for restoration. Benefits are not payable if considered cosmetic or aesthetic. Benefits are not payable for porcelain crowns on second and/or third molars. If porcelain crown used, benefits will be limited to the alternate covered crown considered adequate for the restoration. <i>Replacement of crown following additional treatment of natural teeth is covered. Otherwise, crown replacement is only covered if previous crown placement is 5 years old and unserviceable.</i> Temporary crown is not covered.</p> | | |
| Resin Crowns | | |
| Resin-based composite, anterior | \$ 30.00 | |
| Resin- Indirect | 16.00 | |
| Resin with high noble metal | 93.00 | |
| Resin with base metal; noble metal | 83.00 | |
| Porcelain Crowns | | |
| Porcelain/Ceramic substrate | 95.00 | |
| Porcelain with high noble metal | 97.00 | |
| Porcelain with base metal; noble metal | 88.00 | |
| Full Cast | | |
| high noble metal | 91.00 | |
| base metal; noble metal | 82.00 | |
| ¾ cast | | |
| high noble metal; noble metal; base metal; | 86.00 | |
| porcelain/ceramic | 86.00 | |
| Stainless steel | 17.00 | |
| Cast post & core in addition to crown | 24.00 | |
| Prefabricated post & core in addition to crown | 31.00 | |
| Recement Crown | 10.00 | |
| Crown Repair | \$ 12.32 | |

7. Other Endodontics

Treatment for diseases of pulp cavities inside the root of a tooth and surrounding tissues. The Plan covers services and supplies for the following procedures when not considered part of another procedure. Local anesthetic such as Novocain is considered part of a dental procedure. Separate benefits are not available for local anesthetic. Allowances include usual initial and follow up care.

| Covered Other Endodontic Procedures | Allowance | Special Limits |
|-------------------------------------|-----------|---|
| Apicoectomy | \$ 54.00 | No benefit if considered part of any other procedure. |
| Hemisection | \$ 41.00 | |

8. Periodontics

*Treatment of the gums and tissues of the mouth, including gingivitis. The Plan covers services and supplies for the following procedures when **not considered** part of another procedure. Allowances include local anesthetic and usual follow up care. All periodontal care is subject to the Claim Administrator's dental consultant review for approval of Plan Benefits.*

| Covered Periodontic Procedures | Maximum Allowance | Special Limits |
|---|-------------------------|---|
| Gingivectomy/gingivoplasty 1-3 teeth per quadrant 4 or more teeth per quadrant | \$ 33.50 67.00 | If more than one periodontal service done, allowance will be limited to the most inclusive covered procedure. |
| Gingival Flap including root planning 1-3 teeth per quadrant 4 or more teeth per quadrant | \$ 33.50 67.00 | |
| Crown Lengthening | 41.56 | |
| Osseous surgery, with or without graft (includes flap entry and closure). 1-3 teeth per quadrant 4 or more teeth per quadrant | 63.00 126.00 | |
| Full Mouth Debridement | 35.00 | To enable comprehensive evaluation and diagnosis. |
| Scaling and Root Planing 1-3 teeth per quadrant 4 or more teeth per quadrant | 15.00 30.00 | Limited to one service per quadrant, up to four quads per Calendar Year. |
| Grafting Surgical graft Soft tissue graft Pedicle soft tissue graft | 65.00 70.00 63.00 | |
| Tissue Regeneration - Guide | 32.00 | |
| Occlusal Adjustments Complete Limited | 43.00 \$ 11.00 | |

9. Prosthodontics (Dentures and Bridges)

*The Plan covers services and supplies for the following dentures and bridges. Allowances include related services such as diagnostic procedures, impressions, denture materials, adjustments, clasps, rests, false teeth, crowns, and usual post-delivery care. Coverage for Prosthodontics replacement is limited to circumstances shown previously in this section under **Coverage Limitations, Bridgework and Dentures**.*

| Covered Prosthodontics Procedures | Maximum Allowance | Special Limits |
|---|--------------------|----------------|
| Complete Dentures Complete upper or lower Immediate upper or lower | \$144.00 144.00 | |

| Covered Prosthodontics Procedures | Maximum Allowance | Special Limits |
|---|--|--|
| Partial Dentures Maxillary or mandibular partial denture- Resin base (including any conventional clasps, rests and teeth) Maxillary or mandibular partial denture- Cast metal framework with resin denture base (including any conventional clasps, rests and teeth) | 169.00 169.00 | |
| Removable Unilateral one piece cast metal | 169.00 | Not covered if considered temporary |
| Denture Repairs Repair broken denture base; cast framework Replace broken tooth Repair or replace broken clasp Addition tooth/claspto Partial Denture (for additionally extracted or lost tooth) Per tooth Per clasp | 15.00 7.00 7.00 19.00 6.00 | |
| Adjustments to Dentures Complete maxillary or mandibular denture Partial Maxillary or mandibular denture | 8.00 8.00 | Not covered if done within six months after denture placement |
| Rebase Complete or partial denture Reline Complete denture Partial denture | 54.00 33.00 30.00 | Not covered if done within six months after denture placement |
| Tissue Conditioning , upper or lower | 17.00 | |
| Fixed Bridge-Pontics Cast high noble metal Cast base metal; noble metal Porcelain fused to high noble metal Porcelain fused to base metal; noble metal Porcelain/ceramic Resin with high noble metal Resin with base metal; noble metal | 92.00 83.00 110.00 99.00 87.00 97.00 87.00 | Allowances are per pontic. Plan payment will be limited to 50% of allowance if related to replacement of natural teeth all of which were missing before the person became covered under the Plan. Exception: Person covered or eligible for 24 consecutive months shown previously in this section under Coverage Limitations, Bridgework and Dentures . |
| Fixed Partial Inlays/Onlays (Porcelain/ceramic; cast high noble, base or noble metal) Inlays Two surfaces Three or more surfaces Onlays (In addition to inlay) Two or more surfaces Fixed Partial Retainer Cast metal or porcelain ceramic | 67.00 74.00 10.00 34.00 | |

| Covered Prosthodontics Procedures | Maximum Allowance | Special Limits |
|--|--|--|
| Fixed Bridge Abutments (crowns) Resin with high noble metal Resin with base metal; noble metal Porcelain/ceramic Porcelain fused to high noble metal Porcelain fused to base metal; noble metal 3/4 cast high noble metal 3/4 cast base metal; noble metal; ¾ cast porcelain/ceramic noble metal Full cast high noble metal Full cast base metal; noble metal | 93.00 83.00 83.00 97.00 88.00 86.00 86.00 86.00 91.00 82.00 | Allowances are per abutment. Porcelain crowns or abutments on second and third molars are not covered. If used, allowance will be limited to the maximum for a full cast gold crown. |
| Fixed Partial Denture Repairs Repair or replace broken pontic | 23.00 | |
| Recement Fixed Partial Denture | 12.00 | Not covered if done within six months after date of placement. |
| Stress Breaker | 20.00 | |
| Occlusal Orthotic Device | \$ 55.25 | |

10. Oral Surgery

Allowances include local anesthesia and routine follow up care. Separate payment is available for general anesthesia rendered for covered oral surgery.

| Covered Oral Surgery Procedures | Maximum Allowance | Special Limits |
|--|--|--|
| Extractions, Simple, per tooth Surgical Extractions, per tooth Erupted tooth Soft tissue impacted tooth Partial bony impacted Complete bony impacted Surgical removal residual root | \$ 10.00 19.00 24.00 39.00 52.00 \$ 19.00 | Allowances are per tooth. Surgical extractions include tissue flap and bone removal. |
| Surgical Ridge Preparation for Bridgework - Alveoplasty In conjunction with extractions Not in conjunction with extractions | 22.00 32.00 | Allowance is based on <i>per quadrant</i> . Plan makes separate payment for covered extractions. |
| Other Surgical Procedures Tooth reimplantation accidentally avulsed tooth Oroantral fistula closure Biopsy – hard Biopsy – soft tissue Frenulectomy (frenectomy or frenotomy) – separate procedure Excision of hyperplastic tissue – per arch Excision of pericoronal gingiva | 40.00 94.00 29.00 23.00 41.00 31.00 9.77 | |

| Covered Oral Surgery Procedures | Maximum Allowance | Special Limits |
|---|---|----------------|
| Surgical Incision Incision and drainage of abscess Intraoral soft tissue Extraoral soft tissue Removal of foreign body mucosa skin, or subcutaneous alveolar tissue Removal of exostosis or torus; reduction osseous tuberosity – per site | 17.00 19.00 20.00 58.00 | |
| Removal of Tumors, Cysts, and Neoplasm Excision benign tumor-lesion diameter up to 1.25 cm Excision Intra -Osseous Lesions Onodontogenic benign tumor-lesion diameter up to 1.25 cm Non-onodontogenic benign tumor-lesion diameter up to 1.25 cm Destruction of lesion(s) by physical or chemical method, by report | 40.00 42.00 48.00 \$ 15.00 | |

11. Orthodontics

Coverage is limited to the active course of treatment for Dependent child to age 19. Interceptive or retention orthodontia is not covered. Orthodontic Lifetime benefit maximum is \$1250 payable per Covered Person for any combination of Orthodontic Expenses.

| Covered Orthodontic Procedures | Maximum Allowance | Special Limits |
|--|------------------------|---|
| Diagnostic Preliminary Study | \$ 38.00 | Allowance includes all services related to diagnostic orthodontic survey including, but not limited to, initial consultation or exam, and diagnostic procedures and treatment plan. |
| Active Treatment, First Month Active Treatment per month after the first month. | 183.00 \$ 24.00 | Allowance includes first month of active treatment and includes all active and retention appliances. <i>After 1st month</i> , allowance is per month up to the \$1250.00 Lifetime benefit maximum for all orthodontic expenses. Benefits begin the month following the placement of appliances. Monthly allowance includes all services related to active treatment including but not limited to appliance adjustments, therapy, related exams and tests. |

9. Other Covered Procedures

| Other Covered Procedures | Maximum Allowance | Special Limits |
|---|---------------------------------|---|
| General Anesthesia | \$ 20.00 | Must be for a covered oral/dental surgical procedure. |
| Other Anesthetics Local anesthesia not in conjunction with operative or surgical procedures | 2.97 | |
| ----- Regional or trigeminal division block anesthesia Local anesthesia Analgesia, anxiolysis, inhalation nitrous oxide | 1.27 1.53 1.27 | ----- Must be for covered oral/dental surgical procedure |
| Professional Consultation Consultation Hospital call Office visit for observation Office visit – after regularly scheduled hours | 12.00 22.00 7.00 15.00 | |
| Drugs Therapeutic drug injection, by report Other drugs and/or medicaments, by report | 6.00 4.00 | |
| Miscellaneous Services Application of desensitizing medicament Occlusal guard, by report | 5.00 \$ 34.00 | |

Please contact the SSMC Human Resources Department if you have any questions concerning the information in this summary. The Human Resources Department can be reached at (914) 632-5000 during normal workdays/hours. Or you can write them at 16 Guion Place, New Rochelle, NY 10802