

SECTION F



DENTAL BENEFITS

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F. DENTAL BENEFITS

ELIGIBILITY



Members and dependents are eligible for dental benefits by virtue of their meeting the eligibility and enrollment requirements as outlined in the “Fund Eligibility and Membership” section of this booklet.

BENEFIT YEAR

The dental benefit year runs from January 1st through December 31.

WHAT IS COVERED

Benefits are payable for Covered Dental Charges incurred during a benefit year during which the member or dependent is eligible for these benefits. Covered Dental Charges include charges for:

- Routine oral exams (including diagnosis) and prophylaxis (including scaling and polishing) but not more than once in any consecutive six-month period for each covered person.
- X-rays (limitation: charges for full-mouth x-rays series or panoramic x-rays will be covered once every 36-month period).
- Topical application of fluoride for covered persons who have not reached age 16, but not more than two applications in a benefit year for each covered person.
- Drugs prescribed by a provider for a dental condition. (Please note - if you utilize a PPO Provider, medication(s) prescribed by such Provider is covered through the Out-of-Network benefits - subject to deductible and co-payment.)
- Extractions, fillings, inlays, onlays and crowns. Inlays, onlays and crowns are limited for replacement due to decay, fracture or loss of natural tooth structure beyond the point of restoring with amalgam or composite. (Limitation: replacement of inlays/onlays or crowns less than five years old, by another such restoration or bridge unit, will not be covered.)
- The localized delivery of antimicrobial agents is only covered if rendered by a periodontist.
- Oral surgery, and root canal therapy.
- Installing for the first time, or adding to, a denture or fixed bridge if:
 - the work is needed due to extraction of injured or diseased natural teeth or to the congenital absence of deciduous or permanent teeth; and
 - the work includes replacing the missing tooth (teeth).

If such tooth (teeth) was missing before the date the person became covered for these benefits, such charges will be covered only if incurred at least twelve (12) months after the person became covered.

A denture or bridge is considered to be installed for the first time if it does not replace any existing denture or bridge.

- Replacing or altering a denture or fixed bridge if the change is needed due to oral surgery which involves changing the position of muscle attachment or removal of a tumor, cyst, torus, or excess tissue.
- Replacing a full or partial denture if needed due to a change in the structure of the mouth or the prosthetic device because of which the device cannot be made serviceable, if replaced five years after the date the bridge or denture was installed, which was covered under this plan.
- Replacing a fixed bridge that cannot be made serviceable, if replaced five years after the date the bridge was installed, which was covered under this plan.
- Repairing a denture or bridge.
- Application of pit and fissure sealants on unrestored permanent molars (limited to one treatment per tooth in a 24-month period and only for covered dependents up to age 16).
- Orthodontic appliances and treatment for dependent children, if incurred during a course of orthodontic treatment. This term means that period which:
 - begins when the first orthodontic appliance is installed; and
 - ends when the last appliance is removed.
- Implants (Limitation: Replacement of implant less than seven years old after the date the previous initial implant was installed, will not be covered).

Please refer to the section “Important Limitations” on Page F.5 for information on limitations on implants.



Approval of all implant cases will be subject to the dental claims administrator’s discretion based on such issues as cost effectiveness, clinical appropriateness and likelihood of success. In addition, pre-treatment authorization is required for all dental implants.

Please also refer to F. 5, “Charges Not Covered.”

HIGHLIGHTS OF THE PROGRAM

The MBF Dental Plan pays a benefit for covered expenses. The amount of your benefit depends on whether you go to an in-network or out-of-network provider.

In-Network Benefits (Preferred Provider Organization (PPO) Plan)

The Dental Plan provides quality dental coverage through the Healthplex and SIDS PPO Networks of licensed providers and dental specialists who agree to provide care at a discounted price for covered services. By using a PPO provider, you maximize the value you derive from this plan and receive the highest level of benefit. In-network dentists file claim forms with Healthplex, and receive reimbursement directly from them. In-network dentists accept what the Plan pays (less any deductibles or co-insurance or amounts over the benefit maximum) as payment in full. Covered preventive and diagnostic services are reimbursed at 100% of the discount price and are not subject to the deductible. They are subject to the annual benefit maximum.

Out-of-Network Benefits

Out-of-network dentists are those who have not entered into an agreement with Healthplex or SIDS to provide covered services at a discounted price. If you receive dental services from an out-of-network dentist during a benefit year, Covered Dental Charges are subject to a deductible and co-insurance and the benefit maximum. The deductible is waived for preventive and diagnostic expenses such as oral exams, cleanings, and X-rays.

After satisfying the deductible amount, benefits are paid based on the charges submitted for covered Dental services, up to scheduled maximum allowance for each type of service in a certain geographical area, as determined by Healthplex. Out-of-network dentists may accept an assignment of benefits and may bill you for the difference between what the plan pays as a benefit and what their actual charge is. Therefore, you are responsible for paying any charges in excess of that amount. Additionally, they may or may not file claim forms for you. Once services have been rendered, claim forms must be sent to Healthplex.

	In-Network	Out-of-Network
Annual Deductible (Amount you must pay out-of-pocket to a provider before MBF will issue reimbursement)	\$50/Individual \$150/Family	\$100/Individual \$300/Family
Preventive/Diagnostic*	100%	80%
Basic Restorative (Extractions, fillings, root canals and periodontal treatment)	90%	70%
Major Restorative (Crowns, dentures and bridges)	90%	70%
Implants	50%	50%
Annual Maximum (Per Individual)	\$4,000	
Lifetime Orthodontic Maximum**	\$4,000	
* Not subject to deductible		
** Separate deductible (\$50 in-network and \$100 out-of-network per individual) and payment (100% of the discounted price for in-network services and 80% up to the maximum fee allowance for out-of-network services, up to the lifetime benefit maximum amount).		

ORTHODONTIC TREATMENT

In addition to the annual dental benefit of \$4,000, there is a separate \$4,000 lifetime maximum for orthodontic treatment. The orthodontic benefit covers care for diagnosis, evaluation and pre/post installation of braces up to the lifetime maximum. In certain situations, orthodontic services may be covered for adults, but only if there is documented medical evidence that the malocclusion interferes with speech or breathing.



PROCEDURE FOR OBTAINING PPO SERVICES

Just follow these steps to select a PPO dentist:

1. Select a provider from the Fund's dental PPO directory, which is available on the Fund's Web site at <http://nyc.gov/html/olr>. Once you have entered the Web site, click on Dental PPO, and then "Healthplex." When the page loads, you can search providers by city, county, zip code or specialty. You can also click on MBF-SIDS Select. For members residing outside of NY, NJ or CT, you should click on CONNECTION Dental Provider Organization.

OR

2. Call Healthplex at 1-888-468-5179 or MBF-SIDS Select PPO at 1-718-204-7172 ext. 5501, 1-516-396-5501 or 1-800-537-1238 ext. 5501 (if outside of the 516 area code). For members residing outside of NY, NJ or CT, call the CONNECTION Dental Provider Organization at 1-877-277-6872.
3. Contact the Provider to arrange an appointment, identify yourself as an eligible member (or a dependent) of the Management Benefits Fund with coverage through Healthplex, and confirm that the Provider is a current PPO provider.
4. At the time of the appointment, complete the member statement section of the claim form provided by the dentist. Participating and non-participating providers may use any standard ADA type claim form.
5. Sign the claim form allowing the provider to submit a pre-treatment estimate (when necessary) for confirmation from the Claims Administrator of the covered benefits or sign the form upon completion of services authorizing Fund payment directly to the provider for services rendered.

If the dentist who submits the claim form (billing dentist) is a participating provider and the treating dentist is not a participating provider, the claim(s) will be paid to the billing dentist as an in-network claim. Tax identification numbers will be used to determine the participation status of the billing dentist.

Note: It is important to understand that the Management Benefits Fund does not recommend or endorse any provider. You are responsible for selecting the provider of your choice, participating or non-participating, and you should exercise the same care and apply the same criteria in selecting a participating provider that you would in selecting a non-participating provider. Because many providers may practice at a site which is listed as participating, you should verify the participation status of the dentist who is actually providing treatment.

PPO PERFORMANCE REVIEW

The performance of the PPO panel is reviewed on a continuing basis to monitor for quality dental services.

Healthplex systematically monitors and evaluates the delivery and appropriateness of dental care provided by its participating providers. In addition, all Healthplex providers have been fully credentialed according to the highest standards in the industry. Healthplex, as a Credentials Verification Organization, is certified by the National Committee for Quality Assurance (NCQA) in 10 out of 10 verification services. The National Committee for Quality Assurance is an independent, non-profit organization dedicated to measuring the quality of America's healthcare.

The Healthplex program, the CONNECTION Dental Provider Organization and the MBF-SIDS Select PPO program employs, among other means, patient satisfaction surveys, evaluation of treatment outcomes, and monitoring of disciplinary actions taken by official agencies.

Fund members are encouraged to notify the MBF Administrative Office as well as the appropriate PPO Administrator immediately, by telephone or mail, of any complaint involving services received.

PPO ADMINISTRATORS

The PPO Administrators for the Fund's Dental program are Healthplex, Inc., 333 Earle Ovington Blvd., Suite 300, Uniondale, NY 11553 and SIDS, P.O. BOX 9005, Lynbrook, N.Y. 11563-9005. For information regarding participating providers, please refer to the MBF PPO directories or call:

Healthplex, Inc.
1-800-468-0600
1-888-468-5179 (Dedicated customer service line for MBF members)



MBF-SIDS Select PPO Program
1-718-204-7172 ext. 5501
1-516-396-5501
1-800-537-1238 ext. 5501 (outside of New York City)

HOW AND WHERE TO FILE AN OUT-OF-NETWORK CLAIM

1. Out-of-Network providers should use a Management Benefits Fund claim form. To request a claim form, you may call 1-212-306-7290 or 1-800-4000-MBF (623) if outside New York State or download a claim form at www.nyc.gov/olr. Standard ADA dental claim forms will also be accepted by the Administrator.
2. Complete the employee's portion of the claim form for dental expense benefits. Use a separate form for each member of your family. Follow the instructions given on the form.
3. Have your provider complete the provider's portion of the claim form.
4. Send the completed form to the Management Benefits Fund's Claims Administrator:

HEALTHPLEX, INC.
333 EARLE OVINGTON BLVD., SUITE 300
UNIONDALE, NEW YORK 11553

In order to be considered for payment, claims must be submitted within 24 months from the date of services. If you have any questions regarding your claim, please call Customer Service at 1-888-468-5179.

WHEN A CHARGE IS INCURRED

A charge is incurred on the date dental services are provided, on the date of insertion for dentures, bridges and crowns, and on the date of completion for root canal therapy.

ALTERNATE TREATMENT PROVISION

The Claims Administrator currently applies the Alternate Treatment Provision in determining coverage for certain services. This means that, in certain instances where there is more than one course of treatment available that can provide a professionally acceptable result, payment is based on the least costly treatment option. Guidelines for applying the Alternate Treatment Provision are established by the Fund, its consultants, and the Claims Administrator. For example, suppose your provider can restore a tooth with a filling (amalgam), and you request a more costly type of restoration, like a crown. In this case, the plan will pay a benefit equal to the amount normally paid to the provider for the filling. You do not have to accept the less expensive procedure. You must pay any additional charges if you choose the more expensive procedure.

BENEFITS PRE-CERTIFICATION

A treatment plan is required for orthodontic treatment and prosthetic procedures including crowns, laminates, inlays, onlays, implants, dentures, bridgework, partials, and periodontal surgery. This plan is a provider's written report giving the results of his/her exam of the covered person and the suggested treatment and charges. A treatment plan can be submitted for other courses of treatment where it would be useful to know in advance the amount of reimbursement prior to starting the course of treatment. (See the "Alternate Treatment Provision" under "Important Limitations.")

The Claims Administrator will estimate the benefits to be paid. Alternate procedures, services or courses of treatment will be considered in determining the benefits. As previously stated, Covered Dental Charges will be limited to the charge for the least costly method of treatment that will produce a professionally acceptable result.

Pre-certification helps you make an informed decision before treatment begins by letting you know **in advance** the level of benefits available for certain services. Pre-certification is required for orthodontic treatment and prosthetic procedures including crowns, laminates, inlays and onlays, dentures, bridgework, partials, implants and periodontal surgery. The pre-certification process requires your provider to complete a claim form noting the entire treatment plan **before treatment begins**. To reduce processing time, please ask your provider to submit a copy of your x-rays for treatment involving such services as single crowns, inlays, onlays, implants, bridges, dentures, periodontics, and orthodontics.

The Claims Administrator will process the treatment plan and send both the provider and the member pre-certification statements identifying covered and non-covered services as well as the amount of benefits available under the plan.



IMPORTANT LIMITATIONS

The following list contains important limitations of your dental coverage:

- Prophylaxis (cleaning) and scaling & root planning cannot be performed on the same day. Payment will be made only for scaling in the presence of inflammation.
- No payment will be made for crown build-ups.
- If payment for osseous surgery and gingival curettage or scaling of teeth is requested when performed on the same day, payment will be made for osseous surgery only. Payment for gingival curettage or scaling of teeth is not allowed when performed in conjunction with osseous surgery.
- Payment will be allowed for post and core only if there is root canal history for that specific tooth or an x-ray demonstrates that root canal therapy has been successfully performed.
- Preventive periodontal maintenance is limited to four visits per benefit year and each date of service must be separated by at least three full calendar months.
- Replacement of a crown less than five years old will not be covered even if replacement is by a bridge unit or implant.

CHARGES NOT COVERED

Covered Dental Charges do not include charges for services and supplies:

- not ordered by a licensed provider.
- that are in excess of those that are reasonable and customary covered dental charges.
- performed or furnished by a member of the covered person's immediate family.
- in a Veterans' Administration Hospital.
- due to loss or theft of an appliance.
- which a covered person would not legally have to pay if there were no coverage.
- due to war, declared or not.
- from a health department maintained by an employer, a union, a trustee or a similar type of entity.
- which are payable by a government agency, local or otherwise.
- for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance.
- for chairside labial veneers.
- for hemisection(s).
- for dental work or dentures or bridges except as Covered Dental Charges previously specified.
- for an injury or sickness due to employment with any employer or self-employment.
- for dental charges due to an accidental injury to teeth. These charges may be covered under the member's primary health insurance plan and the Fund's Superimposed Major Medical Plan.
- for diagnosing or treating conditions or dysfunctions of the temporomandibular joint.
- for multiple bridge abutments.
- for stabilizing periodontally involved teeth.
- for broken appointments.

Important: See "Other Important Facts" for other conditions that may affect this coverage.

EXTENDED DENTAL BENEFITS

If, at the time a person's coverage ends, he/she has not completed a dental procedure which began while covered, benefits will be paid for Covered Dental Charges incurred for the unfinished dental work as if coverage had not ended, but only for the following Covered Dental Charges:

- fixed bridgework and full or partial dentures
- crowns, inlays or onlays
- root canal therapy
- orthodontic treatment
- implants



Such coverage under this extended dental benefits provision is provided for the following time periods if pre-certification is received while covered:

- for up to one month after the date the person's coverage ends, if it ends because the plan ceases or coverage ends for the class of which the person is a member.
- for up to three months after the date the person's coverage ends, if it ends for any other reason.

COORDINATION OF BENEFITS (COB)

If you or a dependent is covered by another group dental plan in addition to the Fund dental plan, the Fund's plan will take into account benefits paid or payable by the other coverage(s) in determining if additional benefit payments can be made under the Fund dental plan. Coordination of Benefits (COB) allows both plans, and in some cases a third plan, to share expenses. One plan will be considered the "primary plan" and pay its benefits first, without regard to any other plan. Then, the "secondary plan" will adjust its benefits based on the amount paid by the primary plan. As a result, your benefits from this plan may be reduced by any other benefits you are eligible to receive.

Order of Payment

When two or more plans provide benefits for the same covered persons, the plans will pay benefits in the following order:

- A plan without a Coordination of Benefits feature is always the primary plan.
- The plan covering the patient directly, rather than as a dependent, is the primary plan.
- If a dependent child is covered under both parents' plans and the parents are not separated or divorced, the plan of the parent whose birthday (using month and day only) falls earlier in the year is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan. However, if the other plan does not have this "birthday" rule and as a result, the plans do not agree on the order of benefits, the plan without the birthday rule will determine which plan will be primary.
- If a child is covered under both parents' plans and the parents are separated or divorced, the plans pay benefits in this order:
 1. If the court has established one parent as financially responsible for the child's health care, the plan of the parent with that responsibility is the primary plan. The insurance company or the Plan Administrator must be informed of the court decree.
 2. The plan of the parent with custody of the child.
 3. The plan of the spouse of the parent with custody of the child.
 4. The plan of the parent who does not have custody of the child.
- If the court decree states that the parents have joint custody, without mentioning which parent is responsible for the child's health care expenses, the plans covering the child will follow the order of the benefit determination rules that apply to dependents of parents who are not separated or divorced.
- A plan covering a person as a laid-off or retired employee member (or his or her dependent) will be secondary to a plan that covers the person (or his/her dependent) as an active employee or member who is not laid-off or retired.

If none of the rules above apply, the plan that has covered the claimant for the longer period of time is the primary plan.

The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available, then it is measured from the date the person first became a member of the group.

How Benefits are Coordinated

When the Fund's plan is secondary, submit your claim to the primary plan first. After the primary plan has rendered a payment determination, submit your claim and primary plan's Explanation of Benefits (EOB) statement(s) to the Fund's plan. The Fund's plan will determine the allowable expense for each service, deduct what has been paid by the primary (and any other group plan) and apply any applicable deductible against the remaining balance. When coordinating benefits, the total payments from all plans (including the Fund's plan) will not exceed 100% of the Fund's allowable expense.

Plan's Right to Recover Benefits Paid (Subrogation)

If someone causes you to be injured or ill, the plan has the right to recover expenses from the party in question or that party's insurer. If the Fund plan pays benefits that should have been paid by another plan or organization, the plan may get its money back from the other plan or organization. If the Fund plan paid too much, it may recover the excess payment.



ASSIGNMENT OF BENEFITS

All payments for in-network care will be paid automatically to the participating providers. Benefits for services provided by an out-of-network provider will be payable to the member or provider. To allow assignment of benefits to the provider, the member must sign the appropriate section of the dental claim form prior to submission.

If the dentist who submits the claim form (billing dentist) is a participating provider and the treating dentist is not a participating provider, the claim(s) will be paid to the billing dentist as an in-network claim. Tax identification numbers will be used to determine the participation status of the billing dentist.

CLAIMS APPEALS PROCESS

When appealing a determination made by the Dental Claims Administrator (Healthplex), state the reason you believe the claim was improperly denied and submit documentation, questions or comments you deem appropriate to the address on page F.4. Healthplex has thirty (30) days once all documentation has been received, to review the appeal, investigate and make a determination.

OTHER IMPORTANT FACTS

Allowable Expense. This term means any necessary item of expense within the maximum allowable fee schedule for in-network claims and reasonable and customary allowance for out-of-network claims, which is covered by (a) this plan, or (b) another plan, except Medicare or a “no-fault” motor vehicle plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

Claim Determination Period. This term means the time during any one calendar year when a person is covered and incurs charges for one or more items of expenses covered under this plan and under at least one other Plan.

As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

Plan. This term means any plan that provides dental care coverage written on an expense-incurred basis with which coordination is allowed.

“Plan” may include:

- (a) any group insurance or any other method of coverage of persons in a group.
- (b) an uninsured arrangement of group coverage.
- (c) group coverage through HMOs and other prepayment, group practice and individual practice plans.
- (d) any governmental plan, but not including a state plan under Medicaid.
- (e) any plan required by law, but shall not include a plan when, by law, its benefits are in excess to those of any private insurance plan or other non-governmental plan.
- (f) the medical benefits coverage in group and individual mandatory automobile “no-fault” and traditional mandatory automobile “fault” type contracts.
- (g) Medicare.

“Plan” shall not include:

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

DEFINITIONS

Charges/Fees/Expenses

The terms “charges,” “fees,” or “expenses,” as they relate to dental care, will not include any amount:

- (a) for a service or supply not generally accepted in dental care practice as necessary for the diagnosis or treatment of the patient, even if ordered by a provider;
- (b) for repeated tests which are not needed, even if ordered by a provider;
- (c) 1. as it applies to charges, fees or expenses of participating providers; more than that which is negotiated between the participating provider and Healthplex for covered services.



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2. as it applies to all other charges, fees or expenses more than what is an R&C covered dental charge in the geographic area where the charge was incurred, as determined by Healthplex.

These amounts will be determined by Healthplex.

Preferred Provider

This term refers to a Provider that has an agreement with the Fund's PPO Administrators to provide covered services at a pre-negotiated rate. This arrangement does not limit a covered person to the use of services provided only by a Preferred Provider.

PROOF OF CLAIM

Written proof of claim must be given to Healthplex at the address noted on the Healthplex dental claim form(s) within six months after the date of service for which a claim is made. Itemized bills may be required as part of proof of claim. **Late proof will be accepted only if it is furnished as soon as is reasonably possible, but in no event will such proof be accepted if two years have elapsed from the date of service for which a claim is made.**

COBRA OPTIONAL CONTINUANCE

If your coverage or that of a dependent ends, you and your dependent may each have the right to continue coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA Optional Continuance). A notice of each person's rights under this option will be provided by your employer agency. Any person who has questions regarding COBRA Optional Continuance of dental benefits should refer to Section K in this benefits booklet or contact the Fund Administrative Office at 212-306-7290 or 1-888-4000 MBF(623) if outside New York City, or at (TTY) 1-212-306-7629 if hearing impaired.

CLAIMS ADMINISTRATOR

The Claims Administrator is the entity that reviews and determines whether to pay benefits to you. The Claims Administrator for the Fund's dental care program is Healthplex, Inc., 333 Earle Ovington Blvd., Suite 300, Uniondale, NY 11553.

Please note that the Management Benefits Fund does not recommend or guarantee any of the dental services covered by the Dental Program and does not endorse or recommend any of the providers offering those services. You should exercise independent judgment in screening and selecting an appropriate service provider. Your decision to receive services and your selection of a particular provider are solely your responsibility.

