

**NASSAU COMMUNITY COLLEGE
FEDERATION OF TEACHERS
LOCAL 3150
SELF-INSURED DENTAL PLAN**

NEWMAN COMPANY – Plan Administrators
A Tradition of Excellence in Service
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This document replaces all others that were previously issued covering this Plan.

SCHEDULE OF BENEFITS

PLAN EFFECTIVE DATE: September 1, 1990

EMPLOYEES ELIGIBLE: All members of the Nassau Community College Federation of Teachers Bargaining Unit, Employees of the NCCFT, *Eligible Retirees* and all Nassau Community College Administrators Defined by Contract as Managerial and/or Confidential.

DEPENDENTS ELIGIBLE: All dependents as defined.

NON-CONTRIBUTORY DENTAL BENEFITS FOR YOU AND CONTRIBUTORY DENTAL BENEFITS FOR YOUR DEPENDENTS:

Maximum Dental Benefit per Calendar Year: \$1,900

Maximum Orthodontic Benefit-Lifetime: \$1,500 -This is subject to the Maximum Dental Benefits

Dental Deductible: **There shall be no deductible for the active faculty member.**

The individual Deductible for any calendar year is \$25.00
The Family Deductible for any calendar year is \$75.00

Any expenses incurred by the covered person in the last three months of a calendar year used to meet the Dental Deductible for that year will count toward the Dental Deductible for the next year.

For more details, consult your Plan Administrator, Newman Company at 516-488-1100.

Dental Benefits and Contributions For Retirees:

Dental coverage may be continued into retirement if you maintain your membership in the NCCFT and have been a member in good standing for at least 90 days prior to retirement. Before retirement, please *notify* the NCCFT office to initiate transfer to retirement status.

In addition, you may continue to cover your spouse and any eligible dependents provided they were covered at least 90 days prior to your retirement.

If a retiree becomes legally responsible for a minor, that minor may be enrolled in the dental plan before the age of four (4) without penalty.

WHEN YOUR COVERAGE BEGINS

Becoming Eligible

There shall be a two (2) month waiting period from the date of employment before new employees shall be eligible for dental coverage. Coverage will begin the first of the month following the completion of this eligibility period.

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

You will be covered on the day you become eligible.

WHEN YOUR DEPENDENTS' COVERAGE BEGINS

Dependent

This term means:

- a) YOUR SPOUSE: Your spouse must not be legally separated from you.
- b) YOUR SINGLE CHILDREN: The term "children" also includes any child who is related to you by blood or marriage. It also includes any other child, *provided* that child lives in your household in a parent-child relationship and is dependent on you for support.

Each child must be under age nineteen (19), or a full-time student under age twenty-five (25) to be considered a dependent.

If your child is mentally ill, developmentally disabled or mentally retarded, or has a physical handicap when coverage would *normally* end due to the child's age, coverage may be continued. Ask your Plan Administrator within thirty-one days of the date your child's coverage ends for details and forms.

In addition, should an eligible dependent of an active or retired NCCFT member become mentally ill, developmentally disabled or mentally retarded, or develop a physical handicap, that dependent may be enrolled in the dental plan and will not be considered a "Late Entrant".

- c) A DOMESTIC PARTNER: You and your domestic partner must have been in a committed relationship as each other's sole domestic partner for at least one year.
- d) Dependent children of members who have enrolled domestic partners.

Becoming Eligible

Each person who is 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 may also be eligible as a dependent. In addition, if both you and your spouse are covered under this plan as employees, your children may be covered as dependents of both you and your spouse. Day of birth determines the primary. The parent whose birthday falls earlier in the calendar year, without regard to age, will be primary for all dependent children.

Promptly enroll your dependents for coverage. If your dependents are enrolled late they will fall under the "Late Entrant" status. Refer to the "NOTE" at the end of Dental Benefits. A dependent will be considered a "Late Entrant" for dependent coverage if:

- a) You elect the coverage more than thirty days after you become eligible; or
- b) You again elect the coverage after you cancel your payroll deduction; or
- c) You elect the coverage after a dependent reaches 4 years of age.

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

Predetermination of 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 give the Plan Administrator 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 Maximum Dental Benefit that will be paid for a covered person in a calendar year is shown in the Schedule of Benefits.

The Maximum Orthodontic Benefit that will be paid in the lifetime of a covered person for orthodontic treatment, including diagnosis, evaluation and pre-care, is shown in the Schedule of Benefits. The orthodontic benefit is also limited in any given year by the calendar year Maximum Dental Benefit.

Course of Orthodontic Treatment - This term means that period which

- a) begins when the first orthodontic appliance is installed; and
- b) ends when the last appliance is taken off.

Two or more courses of treatment are treated as one course unless they are separated by at least two years.

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.

What Are Covered Dental Charges

Covered Dental Charges are charges incurred for any service or supply included in the Schedule of Dental Services. A list of common procedures and the maximum amount for each are shown on the following pages. Covered Dental Charges do not include that part of any such charge that exceeds the maximum amount shown in the Schedule of Dental Services.

How Much

You will be paid for Covered Dental Charges incurred by a covered person in a calendar year that exceed the Dental Deductible shown in the Schedule of Benefits.

NOTE: Late Entrant Limit

The amount payable is 50% of the amount otherwise payable for:

- (i) all procedures other than preventative and diagnostic
- (ii) first replacement of teeth that are missing when a person become covered for these benefits.

After a person has been continuously covered for these benefits for 24 months, this limit will no longer apply.

The above will not apply to a child under the age of four years.

When Is A Charge Incurred

A charge is incurred on:

- a) in the case of fixed bridges and full or partial dentures, the date the first impressions are taken and/or abutment teeth fully prepared
- b) in the case of crown, inlay or onlay, the date the preparation of the tooth is begun
- c) in the case of root canal therapy, the date the pulp chamber of the tooth is opened
- d) in the case of any other work, the date the work is performed.

Alternate Benefit Provision

When more than one Dental Service could provide suitable treatment based on accepted standards of dental practice, the Administrator will determine the Dental Service on which payment will be based and the charges that will be included as Covered Dental Charges

If There Is An Accident

If two or more covered persons in a family are in the same accident, only one cash deductible will apply to all Covered Dental Charges for all such persons due to that accident for that policy year and again in the next year.

If one of these persons incurs Covered Dental Charges in the same policy year that do not relate to the common accident, the cash deductible for these charges will be reduced by the charges for that person that were used toward the common accident cash deductible.

Limitations

Periodic oral examination – Only two per person in any calendar year.

X-Rays – Complete series (with or without bitewings) - Only one per person, including Panoramic film, in any 3 calendar years.

Bitewing X-rays – Only two charges per person in any calendar year.

Prophylaxis (Cleaning) – Including Periodontal Prophylaxis – Only three per person in any calendar year.

Topical application of fluoride – Limited to persons less than 19 years old; only one per person in any calendar year.

Fixed or Cemented Appliances-Only one appliance per person

Topical application of sealant on a posterior tooth for a person less than 14 years old - Only one treatment per tooth in any 3 calendar years.

Gold or Crown restorations are covered Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, silicate, acrylic or plastic restoration.

Local anesthetic, analgesic and routine post-operative care for extractions and other oral surgery are part of the allowance for each Dental Service. The administration of a general anesthetic is a Dental Service covered by the Schedule only: (a) when medically necessary in conjunction with oral or dental surgery; and

(b) if the anesthetic agent produces a state of unconsciousness with absence of pain sensation over the whole body.

Subject to the above limitations, all preventative and diagnostic services shall be covered at 100% of usual, reasonable and customary expenses.

Not Covered

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

- (a) not ordered by a doctor.
- (b) In a Veterans' Administration Hospital.
- (c) due to loss or theft of an appliance.
- (d) Which a covered person would not legally have to pay if there were no coverage.
- (e) due to war if declared or not.
- (f) from a health department maintained by an employer, a union, a trustee or a similar type of entity.
- (g) which are payable by a government agency, local or other.
- (h) for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance.
- (i) for these items:
 - (1) oral hygiene, dietary, plaque control and other educational programs.
 - (2) duplicate prosthetic appliances.
 - (3) bite registrations; precision or semi-precision attachments; or splinting
- (j) for porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second or third molars.
- (k) for appliances or restorations, other than full dentures, whose main purpose is to:
 - (1) change vertical dimension; (2) stabilize periodontically involved teeth; or (d) restore occlusion.
- (l) for replacing of a bridge, crown or denture within five years following the date of its original installation unless
 - (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth, or
 - (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an accidental injury occurring while covered.
- (m) for replacing a bridge, crown or denture which is or can be made usable according to common dental standards
- (n) for which would not have been in the absence of coverage.
- (o) for dental services that do not meet common dental standards.
- (p) for which benefits are provided under the Employer's group medical care plan.
- (q) for an injury or sickness due employment with any employer or self employment.

Note: The provisions in(l) and (m) will not apply if the person's teeth were extracted while such person was covered under this plan in effect just prior to and had no break in coverage since he or she first became covered.

Important: See "General Information" for other conditions that may affect this coverage.

EXTENDED BENEFITS

An expense incurred in connection with a Dental Service that is completed after a person's benefits end will be deemed to be incurred while he is covered if:

- (a) for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while covered and the device installed or delivered within 3 calendar months after coverage ends.
- (b) for a crown, inlay or onlay, the tooth prepared while covered and the crown, inlay or onlay, installed within 3 calendar months after coverage ends.
- (c) for root canal therapy, the pulp chamber of the tooth is opened while covered and the treatment is completed within 3 calendar months after coverage ends.

There is no extension for any Dental Service not shown above.

GENERAL INFORMATION

Active Work/Actively At Work

This term means the performance of all the duties that pertain to your work at the place where it is normally done, or where it is required to be done by your Employer.

Doctor

For purposes of Dental Benefits, the term "doctor" means a dentist or physician. The term:

- (a) "dentist" means a Doctor of Dental Surgery or a Doctor of Medical Dentistry;
- (b) "physician" means a legally qualified physician.

Charges/Fees/Expenses

The term "charges", "fees" or "expenses" will not include any amount:

- (a) for a service or supply not generally accepted in health care practice as needed in the diagnosis or treatment of the patient, even if ordered by a doctor;
- (b) for repeated tests which are not needed, even if ordered by a doctor;
- (c) more than what is reasonable and customary in the locale where incurred, as determined by the Plan Administrator.

These amounts will be determined by the Plan Administrator.

Non-Duplication of Benefits

If a covered person is entitled to benefits for dental care under this Plan and at least one other plan, the amount of benefits provided by this Plan for that care, if this Plan is the Secondary Plan, may be reduced to the extent that the total benefits paid or provided by all plans during a Claim Determination Period are not more than the total of the Allowable Expenses that the person incurs in that period. The amount by which the Secondary Plan's benefits have been reduced shall be used by the Secondary Plan to pay the stated percentage of Allowable

Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligations to pay for the stated percentage of Allowable Expenses based on all claims that submitted up to that point in time during the Claim Determination Period.

This will be done as set forth in Order of Payment (see below).

Allowable Expenses

This term means any necessary, reasonable and customary item or expenses as part of the cost of which is covered by (a) this Plan, or (b) one of the other plans, 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.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room will not be deemed to be an Allowable Expense, but it will be deemed to be an Allowable Expense only during the period of time the patient’s confinement to a private hospital room is deemed necessary as generally accepted in health care practice.

Claim Determination Period

This term means the time during any one plan year when a person is covered and incurs charges for one or more items of expense covered under: (i) this Plan; and (ii) at least one other plan.

As each Claim is submitted, each Plan is to determine the liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. But the 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 medical or 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 for persons in a group.
- (b) an insured 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 law or plan when, by law, its benefits are 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” types contracts.

“Plan” shall not include:

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

This Plan

This term means that part of the Group Plan, which provides dental care.

Primary Plan

This term means This Plan, or any other Plan, which determines its medical or dental care benefits for a covered person without taking into account any other Plan. A Plan is Primary if either:

- (i) the Plan does not have a Non-Duplication of Benefits provision like This Plan; or
- (ii) the Plan, in accord with Order of Payment, would determine its benefits first.

Secondary Plan

This term means any plan which is not a Primary Plan.

Medicare

This term means TITLE XVIII of the Federal Social Security Act, as it now is, or as it may be changed.

A person who is eligible for Medicare will be deemed to have all the coverage for which he or she is so eligible.

No-fault Motor Vehicle Plan

This term means a motor vehicle plan, which is required by law and provides medical or dental care payments that are made, in whole or in part, without regard to fault.

A person subject to such law who has not complied with the law will be deemed to have received the benefits required by the law.

Order of Payment

When a person is covered under two or more plans, the rules that follow will decide the order in which the plan will pay benefits:

- 1) A plan which does not have a provision like this Non-Duplication of Benefits will pay before this Plan.
- 2) A plan which covers a person other than as a dependent will pay before a plan which covers a person as a dependent.

3) A plan which covers a person as a dependent of a person whose date of birth occurs earlier in a calendar year will pay before a plan which covers the person whose date of birth occurs later in a calendar year; provided that:

(i) if said dates of birth are the same, the plan which has covered a person for the longer time will pay first.

(ii) if the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a rule, the Plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

In item 3, above, date of birth means day and month of birth, not year of birth.

However, if the person is a dependent child of divorced or separated parents, the order will be as follows:

- (i) first, the Plan of the parent with custody of the child;
- (ii) then, the Plan of the spouse of the parent with custody of the child;
- (iii) finally, the Plan of the parent not having custody of the child.

However, if there is a court decree which sets forth a financial duty for the health 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 the actual knowledge.

4) The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that person's dependent) are determined before those of a plan which covers such person as a laid-off or retired employee (or as that person's dependent).

5) If these four rules do not decide which plan will pay its benefits first, the plan which has covered the person for the longest time will pay first. The length of time a person has been covered under a Plan is determined by the following:

- (a) Two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
- (b) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, then it is measured from the date the claimant first became a member of the group.

To administer claims, the Plan Administrator, without the consent of any person, will have the right:

- (a) to give or to get any data needed to determine benefits under this provision; and each person claiming benefits under a Plan must give the Plan Administrator any data needed to pay the claims.

- (b) to pay an organization for the payment made under its Plan which should have been paid by the Plan Administrator. Amounts so paid will be deemed benefits paid under this Plan; and to the extent so paid there will be no more liability under this Plan. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.
- (c) to recover any excess if the amount paid is more than it should have paid under this provision from one or more of:
 - (i) the person it has paid or for whom it has paid;
 - (ii) insurance companies; or
 - (iii) other organizations.

A Secondary Plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the Primary Plan, the extent that benefits for the services are covered by the Primary Plan and have not already been paid or provided for by the Primary Plan. Nothing in this provision shall be interpreted to require a Plan to reimburse a covered person in cash for the value of services provided by a Plan, which provides benefits in the form of services.

Family Survival Benefit

If you are currently employed and covered for Dental coverage when you die, any of your dependents that are then covered for such coverage will remain so covered without further payment of premiums for them. However, the coverage on any of those dependents will cease on the earliest date below:

- (a) the last day of the twenty-fourth month after your death;
- (b) the date of remarriage of a surviving spouse, if any;
- (c) the date that dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you.

The dependent benefits payable after you die will be those in effect for your dependents on the day prior to your death.

A surviving spouse who was covered for dental benefits under the family survival benefit may continue coverage in the group dental plan after the family survival benefit ends by paying the appropriate premiums. There shall be no restrictions as to age or marital status. However, should a surviving spouse remarry, the new spouse/dependent will not be eligible for coverage.

A surviving child who was covered for dental benefits shall be entitled to participate in the group dental plan under the same conditions as if the parent were alive. A surviving child who is no longer considered a dependent, may continue under the terms of the COBRA Law.

When Coverage Ends

Your coverage ends when any of the following events occurs:

- (a) the last day of the month in which you leave our employ.
- (b) you are no longer eligible.
- (c) the Group Plan ceases.

A dependent's coverage ends when any of the following events occur:

- (a) your coverage ends;
- (b) that dependent is no longer an eligible dependent.

Note: If you cease active work, ask if arrangements may be made to continue coverage – contact your Plan Administrator, Newman Company

COBRA

On April 7, 1986, the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 was signed into law. The provision of the federal law are outlined below

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; or
- (d) discharge from your Employer's employ (other than for gross misconduct).

Newman Company will notify you of your right to continue coverage within 45 days of the occurrence of an above event.

If your dependent's coverage ends, he or she may elect to continue for a maximum period of thirty-six months the Dental coverage under the Group Plan for him or her, as follows:

- (a) Your dependent spouse may elect to continue coverage on his or her own behalf and on that of any dependent children whose coverage would otherwise end, provided that the coverage ends due to:
 - (i) your death; or
 - (ii) your divorce or legal separation.
- (b) Your dependent child/ren whose coverage would otherwise end may elect to continue coverage on his or her own behalf provided that the coverage ends due to:
 - i) the death of the employee when there is no surviving parent, or
 - ii) 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) (ii) or (b) above. The notice should be given to your Employer as soon as 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, Newman Company shall send notice to your dependent of the right to continue the coverage.

To continue coverage, you or your dependent must apply in writing to Newman Company within 60 days of the later of (1) the date the coverage ends; and (2) the date you or your dependent receive notice of the right to continue coverage.

You or your dependent must pay the required amount, if any, for the continued coverage. Newman Company will inform you of the monthly amount to be paid. You or your dependent must also pay such amount for any period of continued coverage that 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 day after the date coverage would have ended. It will end when the first of the following events occurs:

- (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 become covered under a group plan;
- (e) the date you or your dependent become eligible for Medicare;
- (f) the date your former spouse remarries and thereby becomes covered under a group plan.

If you would like further clarification concerning the effective date for your Dental Care coverage plan, contact your Plan Administrator, Newman Company directly at 516-488-1100.

Dental Coverage

On receipt of due proof of claim, Dental Benefits are payable to you.

Benefits payable under your dental expense coverage for covered services may be assigned by you to the provider who performed the service.

Notice of Claim

Written notice of the event on which claim is based must be given to the Administrator within 20 days after the loss for which claim is made. Late notice will be accepted only if it is furnished as soon as 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 given written proof of: (i) the occurrence of the loss; (ii) the nature of the loss; and (iii) the extent of the loss.

Such proof must be given within the time stated in the "Proof of Claim" below.

Proof of Claim

Written proof of claim must be given to the Plan Administrator within 90 days after the loss for which claims are made. Late proof will be accepted only if it is furnished as soon as is reasonably possible. Itemized bills may be required as part of proof of claim.

Examinations

The Plan Administrator has the right to have a doctor examine any person when it deems reasonably necessary while there is a claim pending under the plan.

Legal Actions

No one may sue for payment of claim less than sixty days after due proof of claim is furnished or more than 2 years after the date proof of claim is required by the plan.

APPEALS PROCEDURES

If the result of Newman Company's reviewing a claim results in a declination, partial denial of benefits, reduction of benefits, etc., the insured and/or dentist may appeal to Newman Company.

The initial appeal should be in writing, in the form of a narrative, giving full detail as to why the original decision should be amended or revised.

The claim will be reviewed by the Claims Examiner and Claims Manager. If it is determined that the claim was processed in error it will be returned to the claims examiner with the approval for further payment.

In the event that additional reimbursement cannot be made, a written appeal may be made to the NCCFT Executive Committee for a final determination. Upon receipt of such an appeal, the NCCFT Executive Committee will refer the appeal to Newman Company. Newman Company will assemble all pertinent information, assign the appeal a unique appeals number and remove all indications of name, tax ID#, etc. to maintain confidentiality of the claims process.

Newman Company will then forward this appeal material to the NCCFT Executive Committee for a final determination.

The NCCFT will make final determination on appeals and will notify Newman Company in writing as to the result of the appeal. The NCCFT will also be responsible for notifying the insured as to the results.

**All Claims should be mailed to
NEWMAN COMPANY at the following address:**

**NEWMAN COMPANY
925 Hempstead Turnpike
Suite No. 340
Franklin Square, New York 11010**

**All Benefit and Claim inquiries should be directed to
NEWMAN COMPANY
At the following phone number:**

(516) 488-1100