SUMMARY PLAN DESCRIPTION
FOR EMPLOYEES IN THE

OLYMPIC REGIONAL DEVELOPMENT AUTHORITY

VISION CARE & DENTAL CARE

CSEA
EMPLOYEE
BENEFIT FUND

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Dear Fund Member:

I am pleased to send you this booklet containing important information concerning your CSEA EBF Dental and Vision benefits.

Please take some time to read this booklet to become familiar with your benefits so as to maximize your payments and minimize your out-of-pocket expenses.

I sincerely hope you and your family members enjoy success and good health in the coming months and years.

In Solidarity,

Mary E. Sullivan
Chairperson

General Information

ENROLLMENT

Coverage under the plans offered by the CSEA Employee Benefit Fund is not automatic. You must first enroll yourself and your dependents in the Fund. Upon receipt of notice of your eligibility, we will send you a welcome packet which includes an enrollment form. Please complete and return the form to the CSEA EBF. If you need another form, you can call **1-800-323-2732** to request one or visit **www.cseaebf.com** to download a form from our website. When you visit the website, you can register for our Member Portal which will allow you to view plan information, make enrollment changes and submit requested documentation.

Enrollment in the plan does not vest any right in the covered employee except the right to receive benefits under the plan only so long as

payments are being received by the Fund on behalf of the employee.

Return the completed enrollment form and any additional information required by the Fund.

SUBMIT ALL ENROLLMENT FORMS TO:
CSEA Employee Benefit Fund
P.O. Box 516
Latham, NY 12110-0516

WHO IS ELIGIBLE?

Full-Time Employee

- If you are a full-time employee in a CSEA represented bargaining unit that has negotiated with your employer for Fund coverage.

Part-Time or Seasonal Employee

- If your collective bargaining agreement includes coverage for certain part-time and seasonal employees.

NOTE: An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are Fund members, coverage for children may not be claimed under both.

Dependents

- If your collective bargaining agreement includes dependent coverage, your dependents become eligible at the same time you do.
- You must notify the Fund promptly of changes in dependent status to ensure that new dependents receive the appropriate coverage and to avoid responsibility for charges incurred by an individual after he/she has ceased to be your dependent.

Dependents Include:

- Your Spouse - This includes a person of the same sex to whom the covered employee was

married in a jurisdiction permitting same sex marriages. A spouse can be removed upon entry into a legal separation. If you become divorced, **you must** remove your ex-spouse upon the finalization of divorce.

Children (Effective 7/1/2020)

- Your children, stepchildren and legally adopted children, under the age of 26 whether residing with you or not and regardless of marital status and/or student status.
- Your legal ward under the age of 26 who permanently resides with you pursuant to a court order awarding legal guardianship/ custody to you.
- Any child or ward described above, regardless of age, who is incapable of self-support by reason of mental or physical disability, provided he or she became so disabled prior to reaching the age of 26.

COBRA

If you become ineligible for Fund coverage because of retirement, termination, layoff, leave without pay or reduction in hours, you may have certain rights to continue Plan coverage through COBRA.

If you die, or become divorced or legally separated, or a dependent ceases to be a dependent, your spouse and/or dependent has certain rights to continue Plan coverage through COBRA. In the event of divorce, legal separation or a child losing dependent status, you or a family member must inform the Fund of the qualifying event within 60 days of the event or the date on which coverage would be lost because of the event.

CSEA Employee Benefit Fund Website

- Find the most up to date information on your dental and vision benefits by visiting our website at **www.cseaebf.com** where you can register for our Member Portal.
- Save valuable time by printing plan information, provider listings and EBF forms.

Platinum 12 Vision Care Plan

The Platinum 12 Vision Care Plan offers quality services at no cost to the members within the designated plan when using a participating provider. This includes:

- Routine eye exam. This includes dilation if professionally indicated.
- Eyeglasses **OR** contact lenses
- Eligibility for services is every 12 months from your last date of service under the plan

USING THIS BENEFIT

- Call the CSEA EBF at **1-800-323-2732** to verify your eligibility.
- Make an appointment with a participating provider and advise that you have the CSEA EBF vision plan.
- The provider will obtain authorization for services from the CSEA EBF.

There are over 3,000 participating providers. Visit **www.cseaebf.com** or call **1-800-323-2732** for a listing.

Eyeglasses

If you choose to get eyeglasses, there are select lenses and frames covered under the plan.

Frames

- The frame collection includes a large selection in multiple styles and is updated periodically.
- If you opt for a frame that is not part of the collection, you will be given a $75 allowance from the plan and you must pay the difference to the provider.

Covered Lenses

- Standard Single Vision, Bifocals and Trifocals
- Photo Gray Lenses (Glass)
- Blended Invisible Bifocals and Trifocals
- Standard Progressive-Addition Lenses
- Premium Progressive-Addition Lenses
- Prescription Sunglasses

** Scratch proofing is covered on plan lenses.*

Contact Lenses

- Plan contacts consist of soft planned replacement or disposable lenses.
- You are allowed $125 toward non-plan contact lenses.

For plan contacts, a contact lens formulary is used which allows for an initial supply of the most popular and commonly prescribed brands of soft contact lenses.

For non-plan contacts, the $125 allowance will be applied toward the total cost of the contacts.

Please note that the duration of the initial supply may vary depending on the lens type, wearing habits and prescribing doctor's instructions regarding replacement schedule.

FIXED CO-PAYS

At the time of the eligible service through a participating provider, members and eligible dependents who wish to purchase lenses and coatings not currently covered under the plan are entitled to a set co-pay, resulting in substantial out-of-pocket savings.

Fixed Co-Pays Include:

Standard Anti-Reflective Coating	$ 35.00
Premium Anti-Reflective Coating	$ 48.00
Ultra Anti-Reflective Coating	$ 55.00
Ultimate Anti-Reflective Coating	$ 85.00
Ultraviolet (UV) Coating	$ 12.00
Plastic Photosensitive Lenses	$ 65.00
High Index Lenses	$ 55.00
Polarized Lenses	$ 75.00
Ultra Progressive Addition Lenses	$ 50.00
Ultimate Progressive Addition Lenses	$175.00

Members and dependents must be eligible under an existing vision plan with CSEA EBF to be eligible for fixed co-pay(s). This discount is available only at the time of the patient's eligible

date of service. They are not available as a separate service outside of your eligibility date.

OCCUPATIONAL BENEFIT

Employees whose job duties require 50% or more of their work hours working on a computer will be examined and a determination made which may warrant a different prescription and an additional pair of glasses.

- Spouses and dependents are not eligible for this benefit.
- The second pair's prescription must be different from the first pair.
- Both sets of eyewear must be done at the same time.
- The participating provider determines if the additional pair of glasses is needed.

USING A NON-PARTICIPATING PROVIDER

When you choose to receive services from a provider who does not participate with CSEA EBF, an indemnity payment will be made directly to you for expenses not to exceed:

Exam	$ 16.00
Frame	$ 11.00
Standard Lenses	$ 14.00
Bifocals	$ 23.00
Trifocals	$ 32.00
Photochromic Lenses (Glass)	$ 12.00
Contact Lenses	$125.00
Cataract Lenses	$ 25.00
Cataract Bifocals	$ 35.00

Substantial out-of-pocket expenses can be avoided by using a CSEA EBF vision care participating provider. If you use a non-participating provider, you can contact the CSEA EBF at **1-800-323-2732** for a claim form or visit our website at **www.cseaebf.com** to download a form.

PLATINUM 12 VISION CARE PLAN EXCLUSIONS AND LIMITATIONS

- All portions of the benefit (exam plus corrective eyewear selection) must be performed on the same day.
- Benefits cannot be split between 2 participating providers or between a participating and non-participating provider.
- Any service that is claimed after a period that exceeds one year from the calendar year in which the vision services were rendered.
- Fixed co-pays are not refundable. Payment for items not covered under the plan are the responsibility of the patient.

Dental Care Plan

HOW TO USE THIS PLAN

- You may use any licensed dentist for dental care.
- The Fund contracts with participating dental offices to accept the fee schedule as payment in full for covered dental services whether payment is made by you or the Fund.
- If you would like to view our current Directory of Dental Care Providers, you can request a copy by calling us at **1-800-323-2732** or visit our website at **www.cseaebf.com**
- Specialists within participating general practices have the right to bill members for the difference between the specialist's customary charge and the allowance which the CSEA Employee Benefit Fund pays under the State Dental Plan. The Specialist must inform the Fund and the member that he/she will not be accepting the plan allowance as payment in full and must provide proof of specialty status to the Fund.
- If you choose a non-participating dentist and are charged more than the amount listed under the Schedule of Allowances, you must pay the difference.
- A universal American Dental Association (ADA) claim form, available through your

dental provider, or a CSEA claim form, which may be obtained from our website, **www.cseaebf.com** must be used to submit for completed services. Electronic claims are also accepted.

- **The Fund does not recommend that you use any particular dentist, either participating or non-participating.**

SUBMIT ALL DENTAL CLAIMS TO:
CSEA Employee Benefit Fund
P.O. Box 489
Latham, NY 12110-0516

MAXIMUM BENEFIT-DENTAL PLAN

- There is a $3,000.00 annual maximum dental benefit for each covered member and dependant.
- For year 2014 and on, there is no annual maximum for children under the age of 19, per the Affordable Care Act guidelines.
- This maximum is on a calendar-year basis (January through December).
- Under this maximum, the Benefit Fund is assuming liability for up to the first $3,000.00 of covered dental work per year. This maximum does not apply to orthodontics, implant body placement, implant abutments, prophylaxis or oral evaluations.
- We encourage those about to undergo extensive dental treatment to discuss those plans with the dentist beforehand. There are often less expensive alternatives available which will provide high quality dental care.

APPEAL PROCEDURE

- If you feel that you did not receive full benefits, you may appeal to the Fund. Please call customer service at **1-800-323-2732** and request a dental claim appeal form which can be emailed or mailed to you. Include copies of supporting documentation.
- ALL appeals must be submitted within 60

days of the determination being appealed.
- Please note the appeal process could take up to 4-6 weeks.
- This appeal procedure is not designed to cover services not covered by the Plans.

PRE-AUTHORIZATION OF BENEFITS

- Whenever the estimated cost of a recommended dental treatment exceeds $500.00, we advise the submission of a pre-authorization before the work begins.
- Use a dental claim form for this submission, and include the related x-rays.
- After review, the Benefit Fund will notify the member and the dentist of the benefits payable based upon the treatment plan.
- In determining the amount of benefits payable, consideration will be given to alternate procedures that will accomplish a professionally acceptable result.
- If the member and the dentist agree to a more expensive method of treatment than that pre-authorized by the Benefit Fund, the amount exceeding the pre-authorization will not be paid by the Fund even if it would otherwise be a covered service. If we recommend alternative benefits, you should also discuss this with your dentist.
- **For Example:** If your dentist submitted a pre-authorization for a crown which would cost $850.00 and review by our dental consultant showed that an amalgam restoration for $135.00 would give an acceptable result, the Benefit Fund would pay only $135.00. If the member decided to have the crown, he or she would pay the difference of $715.00 ($850.00 minus the $135.00).

A pre-authorization is not a guarantee of benefits. Payment is always subject to eligibility at the time of service.

CSEA EBF State Dental Plan Schedule of Allowances for Covered Services

DIAGNOSTIC SERVICES

CONSULTATION *(1 per calendar year)*.....$100.00

Clinical Oral Evaluation (Examination)

Evaluation - periodic, comprehensive, limited or detailed *3 evaluations per calendar year (outside annual maximum)*.....$ 55.00

Dental Radiographs

Intraoral complete series, including bitewings *(1 per 3 years)*.....$115.00

or

Panoramic *(1 per 3 years)*.....$115.00

There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed within the same 12 month period as a complete series. Periapical x-rays are not covered within the same 12 month period as a panoramic image.

Periapical x-ray, each image *(Maximum 10 per calendar year)*.....$ 10.00

Bitewing x-rays *(Maximum 4 per calendar year)*

- One.....$ 10.00
- Two.....$ 25.00
- Three.....$ 30.00
- Four.....$ 50.00

Occlusal image *(2 per 3 years)*.....$ 20.00

2-D Cephalometric image *(1 per 5 years)*...$150.00

Cone beam CT images (limited, mandibular, maxillary or both jaws) *(1 per 5 years)*.....$275.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over *3 per calendar year (outside annual maximum)*.....$ 95.00

Dental prophylaxis, child-under age 12 *(3 per calendar year)*.....$ 75.00

Fluoride *(2 per calendar year)*.....$ 30.00

Sealants, child under age 19, per tooth *covered on bicuspids and molars in the permanent dentition only. (1 per 3 years)*.....$ 30.00

Space maintainers, child, under age 19 *(once per lifetime)*

Unilateral space maintainer.....$120.00

Bilateral space maintainer.....$176.00

RESTORATIVE - FILLINGS

Amalgam Restorations *(1 per each surface per tooth per 12 month period). Includes tooth preparation, all*

adhesives, liners and bases and polishing to restore a tooth to proper form and function.

PERMANENT OR PRIMARY TEETH

Amalgam-one surface.....$110.00
Amalgam-two surfaces.....$135.00
Amalgam-three surfaces.....$155.00
Amalgam-four or more surfaces.....$165.00

Resin-Based Composite Restorations

(1 per each surface per tooth per 12 month period). Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.

PERMANENT OR PRIMARY TEETH (Anterior)

Resin based, one surface.....$130.00
Resin based, two surfaces.....$150.00
Resin based, three surfaces.....$165.00
Resin based, four or more surfaces or involving incisal angle.....$185.00

PERMANENT OR PRIMARY TEETH (Posterior)

Resin based, one surface.....$120.00
Resin based, two surfaces.....$145.00
Resin based, three surfaces.....$160.00
Resin based, four or more surfaces or involving incisal angle.....$175.00

RESTORATIVE: CROWNS AND INLAYS/ONLAYS

- Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling.
- The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan.
- Any type of crown restoration that has been in place for 12 months is considered permanent and subject to the frequency limitation.
- Benefits are payable upon insertion of the crown or inlay/onlay.
- **Pre-op radiographs are required for the review of this procedure.**

Crowns - *(1 per 5 years)*

Resin *(permanent, anterior teeth only)*.....$200.00
Resin fused to metal.....$490.00
Porcelain/Ceramic.....$850.00
Porcelain fused to metal.....$850.00
3/4 cast metal.....$425.00
Full cast metal.....$700.00

Implant/Abutment Supported Crowns - *(1 per 10 years)*

Implant/abutment supported, porc/ceram $850.00
Implant/abutment supported, porc fused to metal $850.00
Implant/abutment supported, full cast metal $700.00

Inlays/Onlays - *(1 per 5 years)*
Inlay/onlay, one surface $178.00
Inlay/onlay, two surfaces $208.00
Inlay/onlay, three or more surfaces $250.00

Other Restorative Services
Recement crown, implant crown *(1 per calendar year)* ..... $ 40.00
Stainless steel crowns, deciduous teeth only *(1 per tooth per 3 years)* ..... $ 80.00
Pin retention, per tooth *(1 per calendar year)* ..... $ 20.00
Post and core, cast or prefabricated, per tooth *(1 per 5 years)* $140.00

ENDODONTICS

Root Canal Therapy *(1 per tooth per lifetime)*
Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.
Root canal therapy, anterior ..... $ 850.00
Root canal therapy, bicuspid ..... $ 900.00
Root canal therapy, molar $1,000.00

Other Endodontic/Periradicular Services
Pulpotomy, deciduous teeth only *(1 per tooth per lifetime)* ..... $ 90.00
Apicoectomy, 1st root *(1 per tooth per lifetime)* $600.00
Apicoectomy, each additional root $300.00
(General Anesthesia/IV Sedation covered with Apicoectomy)
Retrograde filling, per root, in conjunction with Apicoectomy *(1 per tooth per lifetime)* $175.00

PERIODONTICS

Gingivectomy, Osseous Surgery and Bone Replacement Graft will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. ***The treatment plan must be accompanied by x-rays and periodontal charting.*** *Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity. There is a frequency limit of 2*

bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Gingivectomy or gingivoplasty, per quadrant *(1 per 5 years)* $400.00
Osseous surgery, per quadrant *(1 per 5 years)* $725.00
Bone replacement graft, per tooth (D4263) *(2 per calendar year)*.....$250.00
Periodontal scaling and root planing, per quadrant *(2 per calendar year, limited to 2 quadrants per visit)* $100.00
Periodontal maintenance procedure *3 per calendar year (outside annual maximum), either prophylaxis* **or** *periodontal maintenance procedure*.....$ 95.00

PROSTHODONTICS (REMOVABLE)

A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next ***5 or 10*** *year period. Benefits are payable only upon insertion of denture. Allowance includes post-delivery care, relines and adjustments for 6 months.*

Complete Dentures - *(1 per 5 years)*
Full upper or lower denture, permanent $900.00
Full upper or lower denture, interim $225.00

Partial Dentures - *(1 per 5 years)*
Partial upper or lower denture, permanent $900.00
Unilateral partial upper or lower denture, permanent $350.00
Interim partial dentures, upper or lower, anterior teeth only $225.00

Implant/Abutment Supported Dentures *(1 per 10 years)*
Implant/abutment supported full upper or lower denture, permanent.....$1,000.00
Implant/abutment supported partial upper or lower denture, permanent.....$1,000.00

Repairs to Full/Complete Dentures
Replace missing or broken teeth *(limited to 4 per calendar year)* .....$ 60.00

Repairs to Partial Dentures
Repair, replace or add clasp to existing partial denture *(limited to 4 per calendar year)*.....$ 60.00
Replace or add tooth to existing partial denture *(limited to 4 per calendar year)* .....$ 60.00

Rebase Full Denture - *(1 per 2 years)*
Rebase - upper or lower $250.00

Reline of Dentures - upper or lower *(1 per 2 years)*
Reline full denture $225.00
Reline partial denture.....$225.00

PROSTHODONTICS (FIXED)

Services are limited to permanent teeth replacement. The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

Pontics *(1 per 5 years)*
Cast metal.....$600.00
Porcelain fused to metal.....$675.00
Porcelain/Ceramic.....$675.00
Resin fused to metal.....$258.00

Abutment Crowns for Fixed Bridge Retainers *(1 per 5 years)*
Cast metal.....$700.00
Porcelain fused to metal.....$850.00
Porcelain/Ceramic.....$850.00
Resin fused to metal.....$490.00
Retainer for Maryland-type bridge $290.00

Implant/Abutment Supported Crowns for Fixed Bridge Retainers *(1 per 10 years including pontics part of implant fixed bridge retainer)*
Implant/abutment supported, cast metal.$700.00
Implant/abutment supported, porc fused to metal.....$850.00
Implant/abutment supported, porcelain/ceramic.....$850.00

Other Fixed Partial Denture Services
Recement bridge, implant bridge *(1 per calendar year)*.....$ 80.00

ORAL SURGERY

Extractions *(1 per tooth per lifetime)*
Extract coronal remnants, primary tooth..$ 80.00
Erupted tooth or exposed root.....$115.00
Surgical removal.....$180.00
Soft tissue impaction.....$305.00
Partial bony impaction.....$400.00
Full bony impaction.....$500.00
Surgical removal of residual roots.....$180.00

Other Surgical Procedures
Surgical Placement of Implant Body (D6010: 1 per tooth position per 10 years)
- An allowance will be provided for the surgical placement of the Implant Body. The plan will not

pay for a replacement within the next 10 year period.

- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the $1,000.00 per implant benefit as an **allowance** against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-onlay) placed within the last 5 years and is/are being replaced by a covered **Implant/Abutment Supported Prosthetic** would be subject to the 5 year replacement rule.
- Implant/Abutment Supported Prosthetics- (Removable Dentures, Fixed Dentures, Fixed Partial Dentures/Retainers & Single Crowns) will be subject to a 10 year replacement rule.
- Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.
- Implant Body *(per tooth position)* .....$1,000.00 *(2 teeth per calendar year)*

Supporting Structures (1 per tooth position per 10 years/2 per calendar year)

Prefabricated Abutment (D6056).....$250.00
Custom Abutment (D6057).....$250.00

- A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the $250.00 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the implant abutments will be outside of the member's annual plan maximum.

Bone Graft at time of implant placement
There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 & D7953. *(1 per tooth position per 10 years / 2 per calendar year: D6104)*.....$350.00

Surgical access of an unerupted tooth *(1 per tooth per lifetime)*.....$200.00

Biopsy of oral tissue, hard or soft *(tissue removal)*.....$190.00

Alveoplasty in conjunction with extractions, per quadrant *(1 per lifetime)* $145.00

Alveoplasty not in conjunction with extractions,

per quadrant *(1 per 5 years)*.....$145.00
Frenulectomy *(3 per lifetime)*.....$300.00
Excision of lesion *(1 per calendar year)*.....$200.00
Bone replacement graft for ridge preservation *(1 per tooth per lifetime / 2 per calendar year: D7953)*.....$250.00

ORAL SURGERY

This plan does not cover adult orthodontics. Provided for employees under the age of 19 and unmarried dependent children enrolled in the plan. Orthodontic appliances must be in place before age 19.

If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.

Limited/Interceptive/Appliance Therapy ..$300.00 *(once per lifetime, prior to and not in the same month as comprehensive treatment. Additional appliances and office visits are the responsibility of the member.)*
Comprehensive orthodontic treatment, appliance insertion *(once per lifetime)*.....$1,000.00
Periodic orthodontic treatment visit *(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the EBF allowance rate, when treatment is provided by a participating provider.)*.....$150.00
Passive Treatment (for cases started after 01/01/14) *(one treatment benefit per lifetime following comprehensive treatement, includes retainers)*.....$300.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation -each 15 minute increment with a maximum benefit of $300.00 *(per covered oral surgery visit)*.....$150.00
or
Intravenous sedation -each 15 minute increment with a maximum benefit of $300.00 *(per covered oral surgery visit)*.....$150.00
Palliative (emergency) treatment of dental pain *(2 per calendar year)*.....$ 75.00

EXCLUSIONS AND LIMITATIONS

- There is coverage for replacement of an existing crown, partial or full removable denture or replacement of fixed bridgework by a new denture or bridgework, or the addition

of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if the Plan is furnished satisfactory evidence that:

(a) The existing denture or bridgework was inserted at least **five** years prior to its replacement and that the existing denture or bridgework cannot be made serviceable by a dentist, or
(b) In the case of a crown, that at least **five** years has elapsed since the crown was inserted or
(c) The existing implant supported crown, bridge or denture was inserted at least **ten** years prior to it's replacement and that the existing implant supported crown, bridgework or denture cannot be made serviceable by a dentist.

In addition to the Exclusions and Limitations as stated in the CSEA Dental Plan Schedule of Allowances and those listed above, THIS PLAN DOES NOT COVER:

- charges for any type of service or appliance not described in Schedule of Allowances
- treatment by other than a licensed dentist or dental hygienist acting within the scope of licensure
- services and supplies that are primarily cosmetic in nature
- replacement of a **lost** or **stolen** prosthetic appliance
- duplicate prosthetic appliances or services
- dentures, crowns, inlays, bridgework or appliances to change or maintain vertical dimension
- precision or other elaborate attachments or features for dentures, bridgework or any other dental appliances
- any service rendered or appliance inserted before the eligibility date or after the termination date under this Plan
- any procedure not completed prior to date

of termination/Per guidelines, termination is effective 28 days from last day worked
- splinting
- mini implants
- treatment covered by Workers' Compensation or similar law
- charges for expenses which are reimbursable through "no-fault" automobile insurance
- any claim or appeal that is submitted after a period that exceeds one year from the calendar year in which dental services were rendered
- temporary dental services which are determined by the Employee Benefit Fund to be an integral part of the final dental service rather than a separate service

COORDINATION OF BENEFITS

Since it is not intended that the patient receive greater benefits than the actual expenses covered, the amount of benefits payable under the NYS Dental Plan will take into account any coverage the employee (or eligible dependent) has under other group plans. In other words, the benefits under the NYS Dental Plan will be coordinated with the benefits of other group plans.

Note: An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are Fund members, coverage for children may not be claimed under both.

BIRTHDAY RULE

Coordination of benefits regulation states that the primary payer of benefits for dependent children is determined by the parent who has the earlier birth date by month and day, without regard to year of birth. (other determining factors may apply)

This description of coverage is only a summary of the benefits provided under the Workplace

Security Program. Coverage will continue as long as the insured remains a public employee and receives one or more other benefits from the CSEA Employee Benefit Fund and the master policy remains in force.

CSEA
EMPLOYEE
BENEFIT FUND

Mary E. Sullivan, Chairperson
One Lear Jet Lane, Suite 1
Latham, NY 12110-2395

(800) 323-2732 | **WWW.CSEAEBF.COM**

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