SUMMARY PLAN DESCRIPTION
FOR EMPLOYEES OF

ERIE COUNTY

DENTAL CARE



CSEA
EMPLOYEE
BENEFIT FUND

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ERIE COUNTY MEDICAL CENTER &
ERIE COMMUNITY COLLEGE

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Dear Fund Member:

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

Individual Coverage General Information

ENROLLMENT

Coverage under the plan offered by the CSEA Employee Benefit Fund is not automatic. You must first enroll yourself in the Fund. Upon receipt of notice of your eligibility from your employer, we will send you a welcome letter 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 allows you to view plan information, submit certain enrollment updates and request an Explanation Of Benefits (EOB) for dental claims submitted for you.

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.

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 cannot be claimed under both.

C.O.B.R.A.

- 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 C.O.B.R.A. Under these and certain additional circumstances, your spouse and/or dependent(s) may have rights to continue coverage through C.O.B.R.A. as well.
- Before your payroll status changes, ask your employer for details about continuing coverage through C.O.B.R.A.

CSEA EMPLOYEE BENEFIT FUND WEBSITE

- Find the most up to date information on your dental 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.

Dental Plan for Erie County Enrollees in Individual Coverage

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 by visiting **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 individual Dental Plan for Erie County. 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 provider, 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 form which can be obtained from our website at **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 Claim Forms To:
CSEA EMPLOYEE BENEFIT FUND
P.O. Box 489 | Latham, NY 12110-0489

Maximum Benefit – Dental Plan

- There is a $2,000.00 a year maximum on dental benefits for each member.
- 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 $2,000.00 of covered dental work per year. This maximum does not apply to 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 Plan.

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 alternate benefits, you should also discuss this with your dentist.
- For Example: If your dentist submitted a pre-authorization for a crown which would cost $650.00 and review by our dental consultant showed that an amalgam restoration for $102.00 would give an acceptable result, the Benefit Fund would pay only $102.00. If the member decided to have the crown, he or she would pay the difference of $548.00 ($650.00-$102.00).

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

ERIE COUNTY INDIVIDUAL 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)*.....$ 31.00

Dental Radiographs
Intraoral complete series, including bitewings *(1 per 3 years)* .....$ 70.00
or
Panoramic *(1 per 3 years)* .....$ 70.00

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) .....$ 8.00

Bitewing x-rays, each image
(Maximum 4 per calendar year) ..... $ 8.00
Occlusal image *(2 per 3 years)* ..... $ 21.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-18 yrs and over
3 per calendar year
(outside annual maximum) ..... $ 65.00

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 ..... $ 72.00
Amalgam-two surfaces ..... $ 87.00
Amalgam-three surfaces $102.00
Amalgam-four or more surfaces $102.00

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 or Posterior)
Resin based, one surface ..... $ 80.00
Resin based, two surfaces ..... $ 92.00
Resin based, three surfaces $110.00
Resin based, four or more surfaces or involving incisal angle $110.00

RESTORATIVE: CROWNS & 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)* $147.00
Resin fused to metal $357.00
Porcelain/Ceramic $650.00
Porcelain fused to metal $650.00
3/4 cast metal $425.00
Full cast metal $545.00

Implant/Abutment Supported Crowns *(1 per 10 years)*
Implant/abutment supported, porc/ceram $650.00
Implant/abutment supported, porc fused to metal $650.00
Implant/abutment supported, full cast metal..$545.00

Inlays/Onlays *(1 per 5 years)*
Inlay/onlay, one surface.....$243.00
Inlay/onlay, two surfaces.....$293.00
Inlay/onlay, three or more surfaces.....$307.00

Other Restorative Services
Recement crown, implant crown *(1 per calendar year)* .....$ 28.00
Stainless steel crowns, deciduous teeth only *(1 per tooth per 3 years)* .....$ 56.00
Pin retention, per tooth *(1 per calendar year)* .....$ 20.00
Post and core, cast or prefabricated, per tooth *(1 per 5 years)* $100.00

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.....$450.00
Root canal therapy, bicuspid.....$475.00
Root canal therapy, molar $565.00

Other Endodontic/Periradicular Services
Pulpotomy, deciduous teeth only *(1 per tooth per lifetime)* .....$ 55.00
Apicoectomy, 1st root *(1 per tooth per lifetime)* $380.00
Apicoectomy, each additional root $120.00
(General Anesthesia/IV Sedation covered with Apicoectomy)
Retrograde filling, per root, in conjunction with Apicoectomy *(1 per tooth per lifetime)*.....$100.00

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.*

Gingivectomy or gingivoplasty, per quadrant *(1 per 5 years)* $300.00
Osseous surgery, per quadrant *(1 per 5 years)* $525.00
Bone replacement graft, per tooth (D4263) *(2 per calendar year)* $250.00
Periodontal scaling and root planing, per quadrant *(2 per calendar year, limited to 2 quadrants per visit)* .....$ 90.00

Periodontal maintenance procedure
3 per calendar year (outside annual maximum), either prophylaxis **or** *periodontal maintenance procedure* ..... $ 65.00

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.....$650.00
Full upper or lower denture, interim $166.00

Partial Dentures *(1 per 5 years)*
Partial upper or lower denture, permanent.....$650.00
Unilateral partial upper or lower denture, permanent.....$300.00
Interim partial dentures, upper or lower, anterior teeth only.....$144.00

Implant/Abutment Supported Dentures *(1 per 10 years)*
Implant/abutment supported full upper or lower denture, permanent.....$650.00
Implant/abutment supported partial upper or lower denture, permanent.....$650.00

Repairs to Full/Complete Dentures
Replace missing or broken teeth *(limited to 4 per calendar year)* ..... $ 50.00

Repairs to Partial Dentures
Repair, replace or add clasp to existing partial denture *(limited to 4 per calendar year)* ..... $ 55.00
Replace or add tooth to existing partial denture *(limited to 4 per calendar year)* ..... $ 50.00

Rebase Full Denture *(1 per 2 years)*
Rebase - upper or lower.....$164.00

Reline of Dentures - Upper or Lower *(1 per 2 years)*
Reline full denture $150.00
Reline partial denture.....$150.00

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	$400.00
Porcelain fused to metal	$500.00
Porcelain/Ceramic	$500.00
Resin fused to metal	$300.00

Abutment Crowns for Fixed Bridge Retainers
(1 per 5 years)

3/4 Cast metal	$425.00
Full Cast metal	$545.00
Porcelain fused to metal	$650.00
Porcelain/Ceramic	$650.00
Resin fused to metal	$357.00
Retainer for Maryland-type bridge	$230.00

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	$545.00
Implant/abutment supported, porc fused to metal	$650.00
Implant/abutment supported, porcelain/ceramic	$650.00

Other Fixed Partial Denture Services

Recement bridge, implant bridge *(1 per calendar year)*	$ 40.00

ORAL SURGERY

Extractions *(1 per tooth per lifetime)*

Extract coronal remnants, primary tooth	$ 80.00
Erupted tooth or exposed root	$ 90.00
Surgical removal	$125.00
Soft tissue impaction	$225.00
Partial bony impaction	$240.00
Full bony impaction	$300.00
Surgical removal of residual roots	$125.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body (D6010: 1 per tooth position per 10 years)

- **Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.**
- 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 $500.00 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.

- Implant Body *(per tooth position)*.....$500.00 *(2 per calendar year)*

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

Prefabricated Abutment (D6056) $125.00
Custom Abutment (D6057).....$125.00

- A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the $125.00 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.

Biopsy of oral tissue, hard or soft *(tissue removal)*.....$110.00
Alveoplasty in conjunction with extractions, per quadrant *(1 per lifetime)*.....$150.00
Alveoplasty not in conjunction with extractions, per quadrant *(1 per 5 years)*.....$150.00
Removal of odontogenic cyst or tumor.....$200.00
Removal of exostosis or torus, per site $200.00
Incision and drainage, intraoral.....$125.00 *(1 per calendar year) (General anesthesia / IV sedation not covered with this procedure.)*
Frenulectomy $200.00
Excision of lesion *(1 per calendar year)* $200.00
Bone Graft at time of implant placement *(1 per tooth position per 10 years / 2 per calendar year: D6104)*.....$350.00
** Implant placement remains a non-covered benefit **
Bone replacement graft for ridge preservation *(1 per tooth per lifetime / 2 per calendar year: D7953)* $250.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation -each 15 minute increment with a maximum benefit of $200.00 *(per covered oral surgery visit)* $100.00
or
Intravenous sedation -each 15 minute increment with a maximum benefit of $200.00 *(per covered oral surgery visit)* $100.00
Palliative (emergency) treatment of dental pain *(2 per calendar year)* .....$ 40.00

Exclusions and Limitations

- There is a 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 & Limitations as stated in the CSEA EBF Individual Coverage Dental Plan for Erie County 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
- 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 this plan will take into account any coverage the employee (or eligible dependent) has under other group plans. In other words, the benefits under this plan will be coordinated with the benefits of the 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.

Family Coverage 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 letter 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 cannot 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 or she has ceased to be your dependent.

Dependents Include:

Spouse

- 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.

Domestic Partner

- Domestic partner coverage may be offered by your employer. Please contact your employer for additional information.

Children

- 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.

C.O.B.R.A.

- 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 C.O.B.R.A. Under these and certain additional circumstances, your spouse and/or dependent(s) may have rights to continue coverage through C.O.B.R.A. as well.
- Before your payroll status changes, ask your employer for details about continuing coverage through C.O.B.R.A.

CSEA EMPLOYEE BENEFIT FUND WEBSITE

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

Dental Plan for Erie County Enrollees in Family Coverage

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, 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 Sunrise 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 provider, 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 form which can be obtained from our website at **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 Claim Forms To:
CSEA EMPLOYEE BENEFIT FUND
P.O. Box 489 | Latham, NY 12110-0489

Maximum Benefit – Dental Plan

- There is a $2,850 annual maximum dental benefit for each covered member and dependent. This maximum is on a calendar-year basis (January through December).
- There is no annual maximum for children under the age of 19, per the Affordable Care Act guidelines.
- Under this maximum, the Benefit Fund is assuming liability for up to the first $2,850 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 claim 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, 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 alternate benefits, you should also discuss this with your dentist.
- For Example: If your dentist submitted a preauthorization for a crown which would cost $855 and after professional review a restoration for $216 would give an acceptable result, the Benefit Fund would pay only $216. If the member decided to have the crown, he or she would pay the difference of $639 ($855-$216).

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

ERIE COUNTY FAMILY DENTAL PLAN SCHEDULE OF ALLOWANCES FOR COVERED SERVICES

DIAGNOSTIC SERVICES

CONSULTATION *(1 per calendar year)*.....$122.00

Clinical Oral Evaluation (Examination)

(3 evaluations per calendar year, outside annual maximum)

Periodic, detailed, limited, oral child evaluation.....$ 64.00

Comprehensive oral and periodontal evaluation.....$ 69.00

Dental Radiographs

Intraoral complete series, including bitewings *(1 per 3 years)*.....$137.00

or Panoramic *(1 per 3 years)*.....$137.00

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)*.....$ 22.00

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

- **One**.....$ 32.00
- **Two**.....$ 48.00
- **Three**.....$ 53.00
- **Four**.....$ 70.00

Occlusal image *(2 per 3 years)*.....$ 25.00

Cone beam CT images (limited, mandibular, maxillary or both jaws) *(1 per 5 years)*.....$265.00

PREVENTIVE SERVICES

Prophylaxis (Adult and Child) *3 per calendar year, outside maximum*

- **Dental prophylaxis, adult-12 yrs and over**.$ 97.00
- **Dental prophylaxis, child-under age 12**...$ 77.00

Fluoride *(2 per calendar year)*.....$ 35.00

Sealants, child-under age 19, per tooth *covered on bicuspids and molars in the permanent dentition only (1 per 3 years)*....$ 51.00

Space maintainers, child-under age 19 *(1 per tooth per lifetime)*

- **Unilateral space maintainer**.....$145.00
- **Bilateral space maintainer**.....$190.00

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.....$132.00
Amalgam-two surfaces.....$154.00
Amalgam-three surfaces.....$189.00
Amalgam-four or more surfaces.....$189.00

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.....$156.00
Resin based, two surfaces.....$186.00
Resin based, three surfaces.....$216.00
Resin based, four or more surfaces or involving incisal angle.....$216.00

PERMANENT OR PRIMARY TEETH (Posterior)

Resin based, one surface.....$161.00
Resin based, two surfaces.....$191.00
Resin based, three surfaces.....$227.00
Resin based, four or more surfaces or involving incisal angle.....$227.00

RESTORATIVE: CROWNS & 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 tooth per 5 years)*
Resin *(permanent, anterior teeth only)*.....$155.00

Resin fused to metal $415.00
Porcelain/Ceramic $855.00
Porcelain fused to metal $855.00
3/4 cast metal $525.00
Full cast metal $700.00

Implant/Abutment Supported Crowns

(1 per implant per 10 years)

Implant/abutment supported, porc/ceramic $855.00
Implant/abutment supported, porc fused to metal $855.00
Implant/abutment supported, full cast metal $700.00

Inlays/Onlays *(1 per tooth per 5 years)*

Inlay/onlay, one surface $243.00
Inlay/onlay, two surfaces $293.00
Inlay/onlay, three or more surfaces $307.00

Other Restorative Services

Recement crown, implant crown *(1 per crown per calendar year)* ..... $ 40.00
Stainless steel crowns, deciduous teeth only *(1 per tooth per 3 years)* ..... $ 83.00
Core buildup, including pins *(1 per tooth per lifetime)* ..... $ 80.00
Pin retention, per tooth *(1 per calendar year)* ..... $ 22.00
Post and core, cast or prefabricated, per tooth *(1 per 5 years)* $154.00

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 $750.00
Root canal therapy, bicuspid $800.00
Root canal therapy, molar $925.00

Other Endodontic/Periradicular Services

Pulpotomy, deciduous teeth only *(1 per tooth per lifetime)* ..... $ 76.00
Apicoectomy, 1st root *(1 per tooth per lifetime)*
- **Anterior** $510.00
- **Bicuspid** $515.00
- **Molar** $525.00

Apicoectomy, each additional root $250.00
(General Anesthesia/IV Sedation covered with Apicoectomy)
Retrograde filling, per root, in conjunction with apicoectomy *(1 per tooth per lifetime)* $150.00

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)* $375.00
Osseous surgery, per quadrant *(1 per 5 years)* $725.00
Bone replacement graft, per tooth (D4263) *(2 per calendar year)* $275.00
Periodontal scaling and root planing, per quadrant *(2 per calendar year)* $120.00
Periodontal maintenance procedure *3 per calendar year (outside annual maximum), either prophylaxis or D4346 or D4910* ..... $ 97.00

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 ... $910.00
Full upper or lower denture, interim $240.00

Partial Dentures *(1 per 5 years)*
Partial upper or lower denture, permanent . $910.00
Unilateral partial upper or lower denture, permanent $375.00
Interim partial dentures, upper or lower, anterior teeth only $240.00

Implant/Abutment Supported Dentures

(1 per 10 years)

Implant/abutment supported full upper or lower denture, permanent $1,010.00

Implant/abutment supported partial upper or lower denture, permanent $1,010.00

Repairs to Full/Complete Dentures

Replace missing or broken teeth *(limited to 4 per calendar year)* ..... $ 70.00

Repairs to Partial Dentures

Repair, replace or add clasp to existing partial denture *(limited to 4 per calendar year)* ..... $ 70.00

Replace or add tooth to existing partial denture *(limited to 4 per calendar year)* ..... $ 70.00

Rebase Full Denture *(1 per 2 years)*

Rebase - upper or lower $247.00

Reline of Dentures - upper or lower *(1 per 2 years)*

Reline full denture $210.00

Reline partial denture $210.00

Other Removable Prosthetic Services

Precision Attachments

Covered precision attachments include D5862, D6950 and D6192. One per tooth position per 5 or 10 years, depending on denture frequency. 2 per calendar year.

D5862 ..... $350.00

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 unit per 5 or 10 years)*

Cast metal $555.00

Porcelain fused to metal $725.00

Porcelain/Ceramic $725.00

Resin fused to metal $325.00

Abutment Crowns for Fixed Bridge Retainers

(1 per tooth per 5 years)

3/4 Cast metal $525.00

Full Cast metal $700.00

Porcelain fused to metal $855.00

Porcelain/Ceramic $855.00

Resin fused to metal $415.00

Retainer for Maryland-type bridge $280.00

Implant/Abutment Supported Crowns for Fixed Bridge Retainers *(1 per implant 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 $855.00

Implant/abutment supported, porcelain/ceramic $855.00

Other Fixed Partial Denture Services

Recement bridge, implant bridge *(1 per bridge per calendar year)* ..... $ 80.00

Other Removable Prosthetic Services

Precision Attachments

Covered precision attachments include D5862, D6950 and D6192. One per tooth position per 5 or 10 years, depending on denture frequency. 2 per calendar year.

D6950 ..... $350.00

ORAL SURGERY

Extractions *(1 per tooth per lifetime)*

Extract coronal remnants, primary tooth .. $100.00

Erupted tooth or exposed root $139.00

Surgical removal $200.00

Soft tissue impaction $300.00

Partial bony impaction $395.00

Full bony impaction $500.00

Surgical removal of residual roots $190.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body (D6010: 1 per tooth position per 10 years)

- **Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.**
- 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 $1,035.00 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.
- **Implant Body** *(per tooth position)*..... $1,035.00 *(2 teeth per calendar year)*

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

Prefabricated Abutment (D6056) $280.00
Custom Abutment (D6057) $280.00
Semi-precision Abutment (D6191).....$280.00

- A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the $280.00 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 and D7953. (1 per implant position per 10 years / 2 per calendar year: D6104) $380.00

Surgical access of an unerupted tooth
(1 per tooth per lifetime).....$250.00

Biopsy of oral tissue, hard or soft
(tissue removal) $180.00

Alveoplasty in conjunction with extractions, per quadrant *(1 per lifetime)* ..$160.00

Alveoplasty not in conjunction with extractions, per quadrant *(1 per 5 years)* ..$160.00

Removal of odontogenic cyst or tumor.....$200.00

Removal of exostosis or torus, per site....$220.00

Incision and drainage, intraoral.....$135.00
(1 per tooth per calendar year, General anesthesia / IV sedation not covered with this procedure)

Frenulectomy *(3 per lifetime)* $240.00

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).....$270.00

Precision Attachments
Covered precision attachments include D5862, D6950 and D6192. One per tooth position per 5 or 10 years, depending on denture frequency. 2 per calendar year. D6192 .....$350.00

ORTHODONTICS

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.

Limited orthodontic treatment.....$500.00
(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.) $160.00
Passive treatment *(1 treatment benefit per lifetime following comprehensive treatment, includes retainers)* $350.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation -each 15 minute increment with a maximum benefit of $360.00
(per covered oral surgery visit).....$180.00
or
Intravenous sedation -each 15 minute increment with a maximum benefit of $360.00
(per covered oral surgery visit).....$180.00
Palliative (emergency) treatment of dental pain
(2 per calendar year).....$ 85.00

Exclusions and Limitations

- There is a 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 Sunrise 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
- any service rendered or appliance inserted before the eligibility date or after the termination date under this Plan
- 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 CSEA Sunrise 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 CSEA Sunrise Dental Plan will be coordinated with the benefits of the 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).

YOUR UNION. YOUR BENEFITS.

$2,000 Annual Max	$2,850 Annual Max
Individuals	Families

NO COPAYS, DEDUCTIBLES OR WAITING PERIODS!



3 Cleanings / Exams per year outside the annual max.

Dependents Covered Until the Age of 26 regardless of student or marital status.*





Orthodontic Coverage for dependent children up to age 19.*

Allowances are accepted at any licensed provider. Participating providers accept allowances as full payment.

Dental Implant Allowance:

Individual Plan	Family Plan
$500	**$1,000**

(up to two per year, outside annual max)



**Only applicable to the Family Plan*

CSEA EMPLOYEE BENEFIT FUND

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