SUMMARY PLAN DESCRIPTION FOR EMPLOYEES OF

ERIE COUNTY

DENTAL CARE



EMPLOYEE
BENEFIT FUND

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FOR EMPLOYEES OF ERIE COUNTY, 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 Dullwan

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 preauthorization 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 \$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

	IC SERVICES ATION (1 per calendar year)\$1	00.00
Evaluation detailed 3	ral Evaluation (Examination) a - periodic, comprehensive, limited o evaluations per calendar year nnual maximum)\$	
(1 per 3 ye or	diographs complete series, including bitewings ars)\$ c (1 per 3 years)\$	

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

REVENTIVE 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

72.00
87.00
102.00
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

(1	۱nt	erior	or	Pos	terior)
~	7116	CIIOI	O.	1 03	terior,

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,
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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	J
Implant/abutment supported, full cast metal\$545.00)
•	
Inlays/Onlays (1 per 5 years)	
Inlay/onlay, one surface\$243.00	J
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	J
Stainless steel crowns, deciduous	
teeth only (1 per tooth per 3 years)\$ 56.00)
Pin retention, per tooth	
(1 per calendar year)\$ 20.00	J
Post and core, cast or prefabricated,	
per tooth (1 per 5 years)\$100.00	C
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	J
Apicoectomy, 1st root	_
(1 per tooth per lifetime)	
Apicoectomy, each additional root\$120.00 (General Anesthesia/IV Sedation covered	J
with Apicoectomy)	
Retrograde filling, per root, in conjunction with	
Apicoectomy (1 per tooth per lifetime)\$100.00	า
Aprodectomy (1 per toom per memme)	,
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	J

	Periodontal	maintenance	procedure
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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.

Comp	ete [)ent	ures (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\$650.0	00
Unilateral partial upper or lower	
denture, permanent\$300.0	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

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	
Resin fused to metal	
Resili rused to illetar	0000.00
Abutment Crowns for Fixed Bridge Retaine	re
(1 per 5 years)	
3/4 Cast metal	\$425.00
Full Cast metal	
Porcelain fused to metal	
Porcelain/Ceramic	
Resin fused to metal	
Retainer for Maryland-type bridge	
Retainer for Marylana type bridge	\$200.00
Implant/Abutment Supported Crowns for F	ixed
Bridge Retainers (1 per 10 years including p	
part of implant fixed bridge retainer)	,0,11,00
Implant/abutment supported, cast metal	\$545.00
Implant/abutment supported,	00-10.00
porc fused to metal	\$650.00
Implant/abutment supported,	0000.00
porcelain/ceramic	\$650.00
porceiani, ceraniic	0000.00
Other Fixed Partial Denture Services	
Recement bridge, implant bridge	
(1 per calendar year)	\$ 40.00
(. po. carondar jour)	10.00

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

 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)	
Alveoplasty not in conjunction with extract	
per quadrant (1 per 5 years)	
Removal of odontogenic cyst or tumor	
Removal of exostosis or torus, per site	
Incision and drainage, intraoral	\$125.00
(1 per calendar year) (General anesthesia / I	
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 preservat	ion
(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 calendaryear 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 preauthorization 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 and	nual
maximum)	
Periodic, detailed, limited, oral child	
evaluation\$	64.00
Comprehensive oral and periodontal	
evaluation\$	69.00
Dental Radiographs	
Intraoral complete series, including bitewi	ngs
(1 per 3 years)\$	
or Panoramic (1 per 3 years)\$	
There is a 3 year limitation for complete seri	es
and/or panoramic radiographs. Periapical a	
bitewing x-rays are not covered if performed	l within
the same 12 month period as a complete se	ries.
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)\$	
Bitewing x-rays (Maximum 4 per calendar y	,
One\$	
Two \$	
Three\$	
Four\$	
Occlusal image (2 per 3 years)\$	
Cone beam CT images (limited, mandibula	
maxillary or both jaws) (1 per 5 years)\$	205.00
PREVENTIVE SERVICES	
Prophylaxis (Adult and Child) 3 per calenda	or voor
outside maximum	ii yeai,
Dental prophylaxis, adult-12 yrs and over .\$	97 00
Dental prophylaxis, child-under age 12\$	
Fluoride (2 per calendar year)\$	
Sealants, child-under age 19, per tooth	00.00
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\$	

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 (A	nterior)
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 (P	osterior)
PERMANENT OR PRIMARY TEETH (PResin based, one surface	-
•	\$161.00
Resin based, one surface	\$161.00 \$191.00
Resin based, one surface	\$161.00 \$191.00

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,	0000.00
porc fused to metal	\$855.00
Implant/abutment supported,	🗸 0 0 0 1 0 0
full cast metal	\$700.00
	•
Inlays/Onlays (1 per tooth per 5 years)	0040.00
Inlay/onlay, one surface	
Inlay/onlay, two surfaces	
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
per tooth (1 per 5 years)	\$154.00
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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.

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

lower, anterior teeth only.....\$240.00

Interim partial dentures, upper or

Implant/Abutment Supported Dentures (1 per 10 years)	
Implant/abutment supported full upper or lower denture, permanent	¢1 010 00
Implant/abutment supported partial	\$1,010.00
upper or lower denture, permanent	\$1,010.00
Repairs to Full/Complete Dentures	
Replace missing or broken teeth	A 70.00
(limited to 4 per calendar year)	.\$ 70.00
Repairs to Partial Dentures Repair, replace or add clasp to existing p	ortial
denture (limited to 4 per calendar year)	
Replace or add tooth to existing partial d	
(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	
Reline full denture	,
Reline partial denture	.\$210.00
Other Removable Prosthetic Services Precision Attachments	
Covered precision attachments include D58	62, D6950
and D6192. One per tooth position per 5 or 1	
depending on denture frequency. 2 per cale	-
D5862	.\$350.00
PROSTHODONTICS (FIXED)	
Services are limited to permanent teeth rep	
The treatment plan must be accompanied	•
radiographs and will be professionally rev for necessity and appropriateness of the p	
treatment taking into account the exclusion	
limitations of the Plan. Benefits are payab	
insertion of the fixed bridge.	
Pontics (1 per unit per 5 or 10 years)	
Cast metal Porcelain fused to metal	
Porcelain/Ceramic	
Resin fused to metal	
Abutment Crowns for Fixed Bridge Retai	ners
(1 per tooth per 5 years)	
3/4 Cast metal	
Full Cast metal Porcelain fused to metal	
Porcelain/Ceramic	
Resin fused to metal	.\$415.00
Detainer for Manuford type bridge	000000

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
(1 per bridge per carefidal year)

Other Removable Prosthetic Services

Precision Attachments

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.

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

- 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		

.....\$350.00

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.

Precision Attachments

D6192

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		

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JUNCTIVE GENERAL SERVICES			
General anesthesia/deep sedation -each 15 minute			
increment with a maximum benefit of \$360.00			
(per covered oral surgery visit)\$1	80.00		
or			
Intravenous sedation -each 15 minute increment			
with a maximum benefit of \$360.00			
(per covered oral surgery visit)\$1	80.00		
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 \$500 Family Plan



(up to two per year, outside annual max)



*Only applicable to the Family Plan

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04/25

