Retiree

DENTAL & VISION
BENEFITS

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

CSEA
EMPLOYEE
BENEFIT FUND

Letter from the Chairperson

Dear Retiree,

As Chairperson of the CSEA Employee Benefit Fund, I respect your commitment to both public service and to this Union. Retirees are an invaluable resource and have helped to make our Union what it is today.

In July, 2002, the Employee Benefit Fund introduced our Retiree Dental Plan. Throughout the years, participants requested the EBF offer a Retiree Vision Plan. It was with great pleasure that we launched the EBF Retiree Vision Plan in June, 2016. Both programs have become a great success.

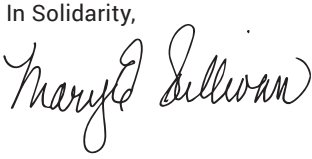
This book incorporates Retiree Dental and Vision Programs. Both programs require a signed Retiree Memorandum of Agreement from your employer for each program.

Retirees who are eligible and enroll in both programs will enjoy a discount on your premiums.

Our goal is to encourage you to maintain your health and well-being by providing benefits that are carefully designed with you and your family in mind.

I wish you success and good health in your retirement.

In Solidarity,



Mary E. Sullivan, Chairperson

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ENROLLMENT:

Coverage under the Plans offered by the CSEA EBF are not automatic. You must first enroll yourself and your dependents in the Fund. There is one enrollment form for each program which enrolls you in the CSEA EBF Retiree Dental or Vision Plans. This must be filled out even if you have previously had dental/vision benefits with the Fund. If electing both programs, programs must start in the same month. If you have not received an enrollment form in the mail from the Fund, please contact the Retiree Department at **(800) 323-2732**.

Submitting Your Enrollment Form

Retiree enrollment forms can be:

- Uploaded through your member portal on www.cseaebf.com
- Emailed to retirees@cseaebf.org
- Faxed to (518) 782-1234
- Mailed to CSEA EBF Retiree Department, PO Box 516, Latham, NY 12110-0516

Access to the EBF Retiree Dental and/or Vision Program is contingent upon a signed employer Retiree Dental and Vision Memorandum of Agreement with the Fund.

Enrollment in the Plan does not vest any right in the covered retiree except the right to receive benefits under the Plan only so long as payments have been received by the Fund.

Paying for Coverage

- Payment is due on the 1st of each month.
- Payment is made through a Recurring Payment Program (electronic transfer of funds from your bank to EBF).
- Checks and phone payments are not accepted.
- If a monthly payment is not made, benefits will be suspended until payment is received.
- If there has been non-payment of premium for 60 days, coverage will be terminated and there will be no reinstatement in the Plan.

Account Changes

- If your bank account information changes or your credit card expires, **you must notify the Retiree Department immediately** of your new account information and expiration/security code on your credit card.
- Checking account changes must be submitted on a new Recurring Payment Form found on www.cseaebf.com/downloadforms section of the EBF website. Write **Account Change** at the top of the form. A voided check OR bank letter stating your account and routing number **must be attached** to the recurring payment form.
- A $20 fee will be charged if your bank declines payment on your account. The fee is **in addition** to your monthly premium.

RETURNING TO WORK

Retirees who return to active work status in a benefits eligible position that provides CSEA EBF dental or vision coverage must notify EBF. Retiree Plan benefits will be terminated and billing stopped until employment in the position terminates. The retiree may be reinstated in the same retiree benefits they previously carried the day after employer paid benefits terminate.

IMPORTANT: The Retiree must notify the EBF when employment has terminated.

WHO IS ELIGIBLE?

Retiree Dental Plan Eligibility

You are eligible for the CSEA EBF Retiree Dental Plan if you meet all of the following criteria:

- You were previously covered by a CSEA EBF Dental Plan on or after July 1, 2002.
- Your previous employer has signed a retiree language side letter (Memorandum of Agreement) to its contract with the Fund.
- You retire directly from employment with your employer during or after the term of the collective bargaining agreement in which the Memorandum was executed and you were covered by an EBF Dental Plan on your last day of employment.
- You have had continuous dental coverage from retirement, through a date, not more than 90 days prior to enrolling.

» A minimum of 12 months participation is required for all enrollees and dependents unless a qualifying event occurs.

You are **not** eligible for the CSEA EBF Retiree Dental Plan if:

» You are covered under another CSEA EBF Dental Plan as a member or a dependent.
» You were never an employee covered by a negotiated EBF Dental Plan in the contract you retired under.
» You waited longer than 90 days from your benefits termination date to enroll in the EBF Retiree Dental Plan.
» **Survivor Benefits** – To be eligible for the CSEA EBF Retiree Dental Plan, you must have been an active CSEA **employee** who was previously covered for a CSEA EBF Dental Plan at the time of **your** retirement. **Your** employer must have signed the CSEA EBF's Retiree Dental Memorandum of Agreement. If you are a spouse who was covered by the Fund when **you** were employed, ask about continuing coverage. If you do not meet the above criteria, coverage terminates upon the death of the member. Please contact the Fund at **(800) 323-2732** for additional information.

Termination of coverage in the CSEA EBF Retiree Dental Plan results in non-eligibility for future coverage. Premiums will be re-evaluated annually.

NOTE: A Retiree cannot obtain coverage for himself/herself or dependents if covered under another CSEA EBF Dental Plan as a dependent. Dependents (spouse and children) cannot be covered under the Retiree Dental Plan if covered under another CSEA EBF Dental Plan.

Retiree Vision Plan Eligibility

You are eligible for the CSEA EBF Retiree Vision Plan if you meet all of the following criteria:

» You were previously covered by a CSEA EBF Vision Plan on or after June 1, 2016.
» Your previous employer has signed a Retiree Vision Memorandum of Agreement with the Fund.

- You retire directly from employment with your employer during or after the term of the collective bargaining agreement in which the Retiree Memorandum was executed and you were covered by an EBF Vision Plan on your last day of employment.
- You elect the Retiree Vision Plan within 90 days of your last day of active coverage with the Fund.

A minimum of 12 months participation is required for all enrollees and dependents unless a qualifying event occurs.

Termination of coverage in the CSEA EBF Retiree Vision Plan results in non-eligibility for future coverage. Premiums will be re-evaluated annually.

You are **not** eligible for the CSEA EBF Retiree Vision Plan if:

- You are covered under another CSEA EBF Vision Plan as a member or a dependent.
- You were never an employee covered by a negotiated EBF Vision Plan in the contract you retired under.
- You waited longer than 90 days from your benefits termination date to enroll in the EBF Retiree Vision Plan.
- **Survivor Benefits** – To be eligible for the CSEA EBF Retiree Vision Plan, you must have been an active CSEA **employee** who was previously covered for a CSEA EBF Vision Plan at the time of **your** retirement. **Your** employer must have signed the CSEA EBF's Retiree Vision Memorandum of Agreement. If you are a spouse who was covered by the Fund when **you** were employed, ask about continuing coverage. If you do not meet the above criteria, coverage terminates upon the death of the member. Please contact the Fund at **(800) 323-2732** for additional information.

NOTE: A Retiree cannot obtain coverage for himself/herself or dependents if covered under another CSEA EBF Vision Plan as a dependent. Dependents (spouse and children) cannot be covered under the Retiree Vision Plan if covered under another CSEA EBF Vision Plan.

DEPENDENTS

If you opt for 2 person coverage or family coverage, your dependents become eligible at the same time you do. If you elect individual coverage, your dependents can be added at a later date. Eligible dependents must remain on the Plan for 12 months unless a qualifying event occurs making them ineligible. Dependents who are removed are ineligible for reinstatement. Prompt notification to the Fund of dependent changes will ensure dependents receive the appropriate coverage and avoid charges incurred by an individual after he or she has ceased to be your dependent.

Dependents Include:

- Your spouse. This includes a person of the same sex to whom the covered employee was married in a jurisdiction permitting same sex marriages. A spouse can be removed upon entry into a legal separation. If you become divorced, you **must remove** your ex-spouse upon finalization of divorce.
- Domestic Partner. Eligibility for Domestic partner coverage may be available. Please contact the Member Services Department at the EBF for instructions on enrolling a domestic partner.

Children *(Effective 7/1/2020)*

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

APPEAL PROCEDURE

- If you feel that you did not receive full benefits, you may appeal to the Fund. Please call customer service at **(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 4-6 weeks.
- This appeal procedure is not designed to cover services not covered by the Plan.

CSEA EBF Website

- Find the most up to date information on dental and vision benefits by visiting **www.cseaebf.com**
- Save valuable time by printing Dental / Vision Plan information, provider listings and EBF forms.

Retiree Dental Plan

HOW TO USE THIS PLAN

- You may use any licensed dentist for dental care.
- The Fund contracts with participating dental offices to accept the fee schedule as payment in full for covered dental services whether payment is made by you or the Fund.
- For a current listing of dental providers, visit our website at **www.cseaebf.com** and click on **Provider Search**, or call **1-800-323-2732** for a listing.
- Specialists within participating general practices may 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 Retiree 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 claim form, found on the **Download Forms** link of **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 DENTAL PLAN BENEFIT

- There is an annual maximum of $2,000.00 a year on dental benefits for each member and dependent.
- For year 2014 and on, there is no annual maximum for children under the age of 19, per the Affordable Care Act guidelines.
- This maximum is on a calendar-year basis (January through December).
- Under this maximum, the Fund is assuming liability for up to the first $2,000.00 of covered dental work per year.
- 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.

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 Fund will notify the member and the dentist of the benefits payable based on 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 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 $745.00 and review by our dental consultant showed that an amalgam restoration for $120.00 would give an acceptable result, the Fund would pay only $120.00. If the member decided to have the crown, he or she would pay the difference of $625.00 ($745.00-$120.00).

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

Retiree 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 of annual maximum)* .....$ 42.00

Dental Radiographs

Intraoral complete series, including bitewings *(1 per 3 years)* .....$ 75.00

or

Panoramic *(1 per 3 years)* .....$ 75.00

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

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

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

- One .....$ 10.00
- Two .....$ 20.00
- Three .....$ 30.00
- Four .....$ 38.00

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

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over (*3 per calendar year) (outside of annual maximum)* .....$ 75.00

Dental prophylaxis, child-under age 12 *(3 per calendar year)*.....$ 58.00

Fluoride *(2 per calendar year)* .....$ 15.00
Sealants, child under age 19, per tooth
covered on bicuspids and molars in the permanent dentition only.
(1 per 3 years) .....$ 25.00
Space maintainers, child-under age 19
(once per lifetime)
Unilateral space maintainer .....$ 97.00
Bilateral space maintainer.....$146.00

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.....$ 75.00
Amalgam-two surfaces.....$ 90.00
Amalgam-three or more surfaces $120.00

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.....$100.00
Resin based, two surfaces.....$120.00
Resin based, three surfaces.....$140.00
Resin based, four or more surfaces or involving incisal angle.....$140.00

PERMANENT OR PRIMARY TEETH (Posterior)
Resin based, one surface.....$ 95.00
Resin based, two surfaces.....$125.00
Resin based, three surfaces.....$140.00
Resin based, four or more surfaces or involving incisal angle.....$140.00

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

- **Pre-op radiographs are required for the review of this procedure.**

Crowns - *(1 per 5 years)*
Resin *(permanent, anterior teeth only)*.....$200.00
Resin fused to metal.....$490.00
Porcelain/Ceramic.....$745.00
Porcelain fused to metal.....$745.00
3/4 cast metal.....$335.00
Full cast metal.....$580.00

Implant/Abutment Supported Crowns - *(1 per 10 years)*
Implant/abutment supported, porc/ceram...$745.00
Implant/abutment supported, porc fused to metal.....$745.00
Implant/abutment supported, full cast metal.....$580.00

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

Other Restorative Services
Recement crown, implant crown *(1 per calendar year)*.....$ 32.00
Stainless steel crowns, deciduous teeth only *(1 per tooth per 3 years)*.....$ 80.00
Pin retention, per tooth *(1 per calendar year)*.....$ 20.00
Post and core, cast or prefabricated, per tooth *(1 per 5 years)*.....$130.00

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.....$550.00
Root canal therapy, bicuspid.....$625.00
Root canal therapy, molar.....$750.00

Other Endodontic/Periradicular Services
Pulpotomy, deciduous teeth only *(1 per tooth per lifetime)*.....$ 60.00
Apicoectomy, 1st root *(1 per tooth per lifetime)*.....$375.00
Apicoectomy, each additional root.....$110.00
(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. 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 calendar year. Covered bone grafts include D4263, D6104 and D7953.*

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 quadrant (D4263)
There is a frequency limit of 2 bone grafts per calendar year. Covered bone grafts include D4263, D6104 and D7953.
(1 per 5 years) $275.00
Periodontal scaling and root planing, per quadrant *(2 per calendar year, limited to 2 quadrants per visit)* .....$ 85.00
Periodontal maintenance procedure
(3 per calendar year, either prophylaxis **or** *periodontal maintenance procedure)* .....$ 75.00

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.....$725.00
Full upper or lower denture, interim $175.00

Partial Dentures - *(1 per 5 years)*
Partial upper or lower denture, permanent $725.00
Unilateral partial upper or lower denture, permanent.....$300.00
Interim partial dentures, upper or lower, anterior teeth only.....$175.00

Implant/Abutment Supported Dentures
(1 per 10 years)
Implant/abutment supported full upper or lower denture, permanent.....$850.00

Implant/abutment supported partial upper or lower denture, permanent $850.00

Repairs to Full/Complete Dentures
Replace missing or broken teeth
(limited to 4 per calendar year) .....$ 55.00

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) .....$ 55.00

Rebase Full Denture - *(1 per 2 years)*
Rebase - upper or lower $235.00

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

OTHER REMOVABLE PROSTHETIC SERVICES

Precision Attachments
Covered precision attachments include D5862, D6950 and D6192. 1 per tooth position per 5 or 10 years, depending on denture frequency. 2 per calendar year.
D5862 .....$325.00

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.....$450.00
Porcelain fused to metal.....$555.00
Porcelain/Ceramic.....$555.00
Resin fused to metal.....$275.00

Abutment Crowns for Fixed Bridge Retainers
(1 per 5 years)
3/4 cast metal $335.00
Full cast metal.....$580.00
Porcelain fused to metal.....$745.00
Porcelain/Ceramic.....$745.00
Resin fused to metal.....$490.00
Retainer for Maryland-type bridge $250.00

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.....$580.00
Implant/abutment supported, porc fused to metal.....$745.00
Implant/abutment supported, porcelain/ceramic.....$745.00

OTHER FIXED PARTIAL DENTURE SERVICES

Recement bridge, implant bridge
(1 per calendar year).....$ 60.00
Precision Attachments
Covered precision attachments include D5862, D6950 and D6192. 1 per tooth position per 5 or 10 years, depending on denture frequency. 2 per calendar year.
D6950 .....$325.00

ORAL SURGERY

Extractions *(1 per tooth per lifetime)*
Extract coronal remnants, primary tooth.....$ 75.00
Erupted tooth or exposed root.....$100.00
Surgical removal.....$155.00
Soft tissue impaction.....$200.00
Partial bony impaction.....$300.00
Full bony impaction.....$425.00
Surgical removal of residual roots.....$160.00

Other Surgical Procedures

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

- An allowance will be provided for the surgical placement of the Implant Body. The Plan will not pay for a replacement within the next 10 year period.
- A provider **either participating or non-participating** will be permitted to charge their customary fee for the implant body procedure and accept the $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.
- **Post-op Radiographs are required for the payment of this procedure.** Benefits are payable upon insertion.

Implant Body *(per tooth position)*.....$500.00
(2 teeth per calendar year)
Implant Supporting Structures (1 per tooth position per 10 years/2 per calendar year)
IMPLANT ABUTMENTS
Covered implant abutments include D6056, D6057 and D6191.
Prefabricated Abutment (D6056) $125.00

Custom Abutment (D6057) $125.00
Semi-Precision Abutment (D6191) $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.

Precision Attachments
Covered precision attachments include D5862, D6950 and D6192. 1 per tooth position per 5 or 10 years, depending on denture frequency. 2 per calendar year.
D6192 .....$325.00

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

Biopsy of oral tissue, hard or soft
(tissue removal) $100.00

Alveoplasty in conjunction with extractions, per quadrant *(1 per lifetime)* $125.00

Alveoplasty not in conjunction with extractions, per quadrant *(1 per 5 years)* .....$ 95.00

Removal of odontogenic cyst or tumor $175.00

Removal of exostosis or torus, per site $200.00

Incision and drainage (intraoral)
(one per calendar year; general anesthesia/IV sedation not covered with this procedure) $125.00

Frenulectomy *(3 per lifetime)* $200.00

Excision of lesion *(1 per calendar year)* $175.00

Bone replacement graft for ridge preservation (D7953)
There is a frequency limit of 2 bone grafts per calendar year. Covered bone grafts include D4263, D6104 and D7953.
(1 per tooth per lifetime) $275.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation -each 15 minute increment with a maximum benefit of $300.00
(per covered oral surgery visit) $150.00
or
Intravenous sedation -each 15 minute increment with a maximum benefit of $300.00
(per covered oral surgery visit) $150.00

Palliative (emergency) treatment of dental pain
(2 per calendar year) .....$ 60.00

- There is coverage for replacement of an existing crown, partial or full removable denture or replacement of fixed bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if the Plan is furnished satisfactory evidence that:

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

In addition to the Exclusions and Limitations as stated in the CSEA EBF Retiree 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 the 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 Fund to be an integral part of the final dental service rather than a separate service
- » orthodontics is not covered under this Plan

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 EBF Retiree 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 EBF Retiree 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).

Retiree Vision Plan

EFFECTIVE 1/1/2021

The Retiree Vision Plan offers quality services at no cost to the members within the designated Plan

when using a participating provider. This includes:

- Routine eye exam. This includes dilation if professionally Indicated.
- Eyeglasses **OR** contact lenses.
- You are allowed one full service (exam and eye wear) each calendar year.

USING THIS BENEFIT

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

There are over 1,500 providers in New York State and over 13,000 nationwide. Visit **www.cseaebf.com** or call **1-800-323-2732** for a listing.

Using a Participating Provider

Use a participating provider to have your exam and select your eyewear on the same day or use your exam benefit and return to the same provider later in the calendar year to select your eyewear.

-**OR**-

Use a participating provider for your exam and select a different participating provider to get your eyewear during the calendar year. *

Using a Non-Participating Provider

Have your exam and select your eyewear at one non-participating provider on the same day.

-**OR**-

Have your exam at one time and select your eyewear later in the calendar year using the same non-participating provider or a different one. *

Using a Participating & Non-Participating Provider

Use a non-participating provider for your exam or eyewear and use a participating provider for the other portion of the benefit during the calendar year. *

** Please Note the Following:*

- Services must take place in the same calendar year. You are not able to "save up" unused services.
- You must be eligible with CSEA EBF at the time of your exam and at the time you select eyewear.
- If you use your exam benefit and wait to select your eyewear, the doctor may require a new eye exam which will not be covered.
- If you use the eyeglass portion without an exam, you are not eligible for new eyewear again in the same calendar year even if there is a change in prescription.
- Non-participating eye doctors cannot bill the Plan directly. You must submit a Vision Care Reimbursement Form found on the Download Forms section of **www.cseaebf.com**.
- Non-participating provider expenses are reimbursed based on the indemnity payment schedule found in this book.

BENEFIT PROVISIONS

Eyeglasses

If you select eyeglasses, there are select lenses and frames covered under the Plan.

Frames

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

Covered Lenses

- Standard single vision, bifocals and trifocals
- Photo gray lenses (Glass)
- Blended invisible bifocals and trifocals
- Standard progressive-addition lenses
- Premium progressive-addition lenses
- Prescription sunglasses

** Scratch proofing is covered on Plan lenses.*

Contact Lenses

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

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

For non-plan contacts, the $125 allowance will be applied toward the total cost of the contact lenses. Please note that the duration of the initial supply may vary depending on the lens type, wearing habits and prescribing doctor's instructions regarding replacement schedule.

VISION DISCOUNT FIXED CO-PAYS

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

Fixed Co-Pays Include:

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

Members and dependents must be eligible under an existing vision plan with CSEA EBF to be eligible for fixed co-pay(s). This discount is available only at the time of the patient's eligible date of service. Fixed co-pays are not available as a separate service outside of your eligibility date.

Fixed co-pays are only available when using a participating provider. Fixed co-pays are not refundable. Payment for items not covered under the Plan are the responsibility of the patient.

USING A NON-PARTICIPATING PROVIDER

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

Exam	$ 16.00
Frame	$ 11.00
Standard Lenses	$ 14.00
Bifocals	$ 23.00
Trifocals	$ 32.00
Photochromic Lenses (Glass)	$ 12.00
Contact Lenses	$125.00
Cataract Lenses	$ 25.00
Cataract Bifocals	$ 35.00
Cataract Contacts	$ 33.00

Substantial out-of-pocket expenses can be avoided by using a CSEA EBF vision care participating provider. If you use a non-participating provider, you can contact the CSEA EBF at **1-800-323-2732** for a claim form or visit our website at **www.cseaebf.com** to download a form. Services must be claimed by the end of the calendar year following the calendar year in which the services were performed.

Submit ALL Vision Claim Forms to:
CSEA EMPLOYEE BENEFIT FUND
P.O. Box 516 | Latham, NY 12110-0516

Retiree

DENTAL & VISION BENEFITS

CSEA EMPLOYEE BENEFIT FUND

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

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

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