

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. There is one enrollment card which enrolls you in the Plan(s) negotiated for you. If you have not already done so, you can obtain an enrollment card by calling the Fund at **1-800-EBF-CSEA** or **(518) 782-1500**.

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 card and any additional information required by the Fund.

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. If both parents are Fund members, coverage for children may not be claimed under both parents.

Dependents

- If your collective bargaining agreement includes dependent coverage, your dependents become eligible 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:

- Your spouse, provided he or she is not legally separated from you. Spouse includes a person of the same sex to whom the covered employee was married in a marriage ceremony performed in a jurisdiction permitting same sex marriages.
- Your unmarried children, including stepchildren who permanently reside with you and legally adopted children, under the age of 19.
- Your legal ward under the age of 19 who permanently resides with you pursuant to a court order awarding legal guardianship 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 19.

- Any child or ward described above under the age of 25 who is a **full time student** (minimum of 12 undergraduate or 6 graduate credit hours) enrolled in a regionally accredited college or university and working toward a Bachelor's Degree (e.g., B.A. or B.S.), Master's Degree (e.g., M.A. or M.S.) or Associate's Degree (e.g., A.A. or A.S.). Technical courses of short duration do not qualify, even if a diploma is awarded. The Fund requires that **current proof of student status be provided annually** (letter or statement from the college's Registrar's Office or completion of Student Status Form available from the Fund).

NOTE: This form is used only to update/validate the CSEA EBF dependent student eligibility file. Your Health Insurance carrier may require different or additional evidence of dependent student enrollment. We suggest that you obtain a letter of student enrollment from the school registrar to avoid delays in processing health insurance claims for your child.

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.

Appeal Procedure

- If you feel that you did not receive full benefits, you may appeal to the Director of the Fund.
- Send a letter to the Director explaining why you feel you did not get the full amount to which you were entitled. Include copies of any supporting documentation.
- This procedure is **not** designed to cover clerical mistakes on claims, which may be corrected by a phone call to the Fund.
- Nor is it meant for services clearly not covered by the Plans or for exemptions to or waivers of required waiting periods.

CSEA EMPLOYEE BENEFIT FUND WEBSITE

Find the most up to date information on your dental benefits by visiting our website at www.cseaebf.com. Save valuable time by printing dental plan information, provider listings and EBF forms.

SUNRISE DENTAL PLAN

How To Use This Plan

- You may use any licensed dentist for dental care.
- Over 1400 participating dental offices in New York State accept the fee schedule as full payment for covered services, whether payment is made by you or by the Fund through an assignment of benefits.
- 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 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 would like a copy of our current participating Dentist Directory call us at **1-800-EBF-CSEA** or **(518) 782-1500**.

- If you choose a non-participating dentist, and are charged more than the amount listed under the schedule of allowances, you must pay the difference. (See schedule of allowances.)

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

- A universal American Dental Association (ADA) claim form, available through your dental provider, or a CSEA claim form, which may be obtained from the Benefit Fund or downloaded from our website at www.cseaebf.com, must be used to submit for completed services.

**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 \$2500.00 a year maximum on dental benefits.
- \$2500.00 a year of covered dental benefits is available for *each* member and dependent.
- This maximum is on a calendar-year basis (January through December).
- Under this maximum, we are assuming liability for up to the first \$2500.00 of *covered* dental work per year. This maximum does not apply to orthodontia.
- 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 \$250.00, **it must be submitted to the Employee Benefit Fund before 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 you have work done for over \$250.00 without submitting a pre-authorization first, your claim will be reviewed under the alternate treatment provision.
- We strongly recommend that whenever you are discussing your treatment plan with your dentist, you clearly understand what is being proposed. If we recommend alternate benefits, you should also discuss this with your dentist.

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

CSEA EBF SUNRISE DENTAL PLAN SCHEDULE OF ALLOWANCES COVERED SERVICES

DIAGNOSTIC SERVICES

EXAMINATION - periodic, comprehensive, detailed (only 1 exam per 6 month period)	\$ 27.00
LIMITED EXAMINATION (evaluation) (same frequency limitation as Palliative treatment) . . .	\$ 27.00
DENTAL RADIOGRAPHS	
Intraoral complete series, including bitewings (1 per 3 years)	\$ 60.00
or	
Panoramic film	\$ 60.00
<i>There is a three-year limitation for full series and panoramic radiographs. Periapical and bitewing x-rays are not covered if performed during the same 12 month period as a complete series. Periapical x-rays are not covered during same 12 month period as a panoramic film.</i>	
Periapical x-rays, each film (max. 10 per 12 month period)	\$ 6.00
Bitewing x-ray, each film (max. 4 per 12 month period)	\$ 6.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over (1 per 6 month period)	\$ 58.00
Dental prophylaxis, child-under age 12 (1 per 6 month period)	\$ 45.00
Fluoride, child-under age 19 (1 per 6 month period)	\$ 15.00
Sealants, child-under age 19, per tooth, covered on bicuspid and molars in the permanent dentition only (1 per 3 years)	\$ 20.00
Space maintainers, child-under age 19 (1 per 3 years)	
Unilateral space maintainer	\$ 57.00
Bilateral space maintainer	\$104.00

RESTORATIVE - FILLINGS

AMALGAM RESTORATIONS - (1 per 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	\$ 70.00
Amalgam-two surface	\$ 85.00
Amalgam-three surfaces	\$100.00
Amalgam-four or more surfaces	\$100.00

RESIN-BASED COMPOSITE RESTORATIONS (1 per surface per tooth per 12 month period) <i>Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of materials called resin-based composites.</i>	
PERMANENT OR PRIMARY TEETH (Anterior or Posterior)	
Resin-based, one surface	\$ 75.00

Resin-based, two surfaces	\$ 87.00
Resin-based, three surfaces	\$105.00
Resin-based four or more surfaces, or involving incisal angle	\$105.00

RESTORATIVE - CROWNS AND INLAYS/ONLAYS

These services are limited to permanent (not deciduous) teeth as scheduled. Crowns and inlays are covered for the restoration of teeth which, as a result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite material. All crown work 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.

CROWNS - (1 per 5 years)	
Resin (permanent, anterior teeth only)	\$147.00
Resin fused to metal	\$357.00
Porcelain/Ceramic	\$580.00
Implant/abutment supported, porc/ceram	\$580.00
Porcelain fused to metal	\$580.00
Implant/abutment supported, porc fused to metal	\$580.00
Full cast metal	\$475.00
Implant/abutment supported, full cast metal	\$475.00
3/4 cast metal	\$425.00

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	\$ 23.00
Stainless Steel crowns, deciduous teeth only (1 per tooth per 3 years)	\$ 56.00
Pin retention - per tooth (1 per 12 month period)	\$ 20.00
Post and core, cast or prefabricated, per tooth (1 per 5 years)	\$ 90.00

ENDODONTICS

ROOT CANAL THERAPY (1 per tooth per lifetime) <i>This procedure consists of the removal of all pulp contents and filling the pulp canals of teeth having damaged pulps. This service is limited to permanent teeth. Benefits are payable upon completion of the root canal therapy.</i>	
Root canal therapy, anterior	\$290.00
Root canal therapy, bicuspid	\$325.00
Root canal therapy, molar	\$425.00

OTHER ENDODONTIC/PERIRADICULAR SERVICES	
Pulpotomy, deciduous teeth only (1 per lifetime)	
Apicoectomy, 1st root (1 per lifetime)	\$180.00
Apicoectomy, each additional root	\$100.00
(General Anesthesia covered with Apicoectomy)	
Retrograde filling, per root, in conjunction with apicoectomy (1 per lifetime)	\$ 60.00

PERIODONTICS

Periodontics consists of treatment of diseases of the tissues (gums and bone) which support the teeth. When such services are provided, the allowance shall be made on a quadrant or sextant basis. All periodontal work will be professionally reviewed for appropriateness and necessity of the planned treatment, taking into consideration the exclusions and limitations of the Plan. The treatment plan should include periodontal charting and x-rays may be requested. Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. Periodontic benefits will not usually be paid for patients under 19 years of age. Exceptions can be made, based on documented medical necessity. Retreatment of periodontal surgery, such as gingivectomy and osseous surgery, is allowed only if five years has elapsed since the previous periodontal surgery.

Gingivectomy or gingivoplasty, per quadrant (1 per 5 years)	\$275.00
Osseous surgery, per quadrant (1 per 5 years)	\$425.00
Periodontal scaling and root planing, per quadrant (1 per 6 month period) limited to 2 quadrants per visit	\$ 30.00
Periodontal maintenance procedure (1 per 6 months-either prophylaxis or periodontal maintenance procedure)	\$ 58.00

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. The Plan will pay for no other installation within the next 5 year period. Benefits are payable upon insertion.

COMPLETE DENTURES (including routine post delivery care) (1 per 5 years)	
Full upper or lower denture (permanent) . . .	\$600.00
Full upper or lower denture, implant/abutment supported	\$600.00
Full upper or lower denture (interim)	\$166.00

PARTIAL DENTURES (including routine post delivery care) (1 per 5 years)	
Partial upper or lower denture, permanent . .	\$600.00
Partial upper or lower denture, implant/abutment supported	\$600.00
Unilateral partial denture, permanent	\$300.00
Partial upper or lower denture, interim (anterior teeth only)	\$144.00

REPAIRS TO FULL/COMPLETE DENTURES	
Repair broken complete denture base	\$ 75.00
Replace missing or broken teeth (any number)	\$ 50.00

REPAIRS TO PARTIAL DENTURES	
Repair resin denture base	\$ 75.00
Repair cast framework	\$ 75.00
Repair or replace broken clasp	\$ 55.00
Replace broken teeth (any number)	\$ 50.00
Add tooth to existing partial denture (any number)	\$ 50.00
Add clasp to existing partial denture	\$ 55.00

REBASE FULL DENTURE - (1 per 2 years)	
Rebase-process of refitting a denture by replacing the base material.	
Rebase-maxillary or mandibular (full denture only)	\$164.00
RELINE OF DENTURES (1 per 2 years)	
Reline-process of resurfacing the tissue side of a denture with new base material.	
Reline full denture	\$150.00
Reline partial denture	\$150.00

PROSTHODONTICS (FIXED)

All fixed bridge units 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, full	\$300.00
Porcelain fused to metal	\$400.00
Porcelain/Ceramic	\$400.00
Resin fused to metal	\$250.00

ABUTMENTS (FIXED BRIDGE RETAINERS) CROWNS (1 per 5 years)	
3/4 Cast metal	\$425.00
Cast metal	\$475.00
Implant/abutment supported, cast metal	\$475.00
Porcelain fused to metal	\$580.00
Implant/abutment supported, porc fused to metal . .	\$580.00
Porcelain/Ceramic	\$580.00
Implant/abutment supported, porcelain/ceramic . .	\$580.00
Resin fused to metal	\$357.00
Retainer for Maryland-type bridge	\$230.00
Recement bridge	\$ 33.00

ORAL SURGERY

EXTRACTIONS (1 per tooth per lifetime)	
Extract coronal remnants, primary tooth	\$ 65.00
Erupted tooth or exposed root	\$ 75.00
Surgical removal	\$110.00
Soft tissue impaction	\$135.00
Partial bony impaction	\$175.00
Full bony impaction	\$240.00
Surgical removal of residual roots	\$110.00

OTHER ORAL SURGICAL PROCEDURES	
Biopsy of oral tissue, hard or soft (tissue removal)	\$ 75.00
Alveoplasty, per quadrant (1 per lifetime)	\$150.00
Removal of odontogenic cyst or tumor	\$ 95.00
Removal of exostosis or torus, per site	\$200.00

Incision and drainage, intraoral	\$ 75.00
(General anesthesia/IV sedation not covered with this procedure)	
Frenulectomy	\$115.00
Excision of hyperplastic tissue, per arch	\$140.00

ORTHODONTICS

Provided for employees and unmarried dependent children enrolled in the Plan. Orthodontic appliances must be in place before age 19.

Lifetime orthodontic maximum - \$2061.00	
Limited/Interceptive/Appliance Therapy including adjustments (prior to comprehensive treatment)(1 per lifetime) . .	\$300.00
Comprehensive orthodontic treatment, appliance insertion, Includes diagnostic survey (1 per lifetime)	\$375.00
Periodic orthodontic treatment visit (24 monthly visits per lifetime)	\$ 54.00
Orthodontic retention (after 6 months of retention)	\$ 90.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation (per covered oral surgery visit)	\$200.00
or	
Intravenous sedation (per covered oral surgery visit)	\$200.00
Palliative (emergency) treatment of dental pain (1 per 6 month period, same frequency limit as Limited examination, evaluation)	\$ 27.00

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 have elapsed since the crown was inserted.

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.
- charges for surgical implants.
- 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.
- treatment covered by Workers' Compensation or similar law.
- charges for expenses which are reimbursable through "no-fault" automobile insurance.
- any benefit that is claimed after a period that exceeds one year from the calendar year in which dental services were rendered.
- temporary dental services which will be considered 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. If both parents are Fund members, coverage for children may not be claimed under both parents.

Birthdays Rule

Coordination of benefits regulations state that the primary payer of benefits for dependent children is determined by the parent who has the earlier date by month and day, without regard to the year of birth.

SUNRISE DENTAL PLAN



SUMMARY PLAN DESCRIPTION



CSEA EMPLOYEE BENEFIT FUND

Danny Donohue, Chairman
One Lear Jet Lane, Suite 1
Latham, NY 12110-2395

1-800-EBF-CSEA • 518-782-1500
(Telephone Device For The Deaf)
TDD # 1-800-532-3833