SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

30 ORVILLE DRIVE
SUITE D
BOHEMIA, NY 11716-2513

PHONE (631) 319-4099
FAX (631) 218-7970
www.scmebf.org

TRUSTEES
JEFFREY L. TEMPERA
CHAIRPERSON

DENNIS M. BROWN
JENNIFER K. MCNAMARA
FRANK NARDELLI

ADMINISTRATION
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UPDATES TO JANUARY 2008 BENEFIT REFERENCE GUIDES

As you have been made aware of over the years, via newsletter and general correspondence, the Board of Trustees of the SCME Benefit Fund have instituted several enhancements to your Benefit Fund coverage since the publication of the 2008 Benefit Reference Guide ("booklet") and 2008 Legal Reference Guide. The following is a summary of those **"ENHANCEMENTS"** to your benefit coverage. All other terms and conditions set forth in the 2008 Guides remain effective and applicable. The page number referenced at the end of each summary is the page number of the pertinent 2008 booklet, for your reference.

DENTAL BENEFITS

Effective 4/1/09: Benefits are now allowable for the extraction of supernumerary (extra) teeth. Benefit is based upon ADA code submitted. (pg. 27)

Effective 5/1/10: The following ADA codes have been added as covered procedures under the Fund's dental benefits schedule. All providers may charge their usual and customary fees. You will be responsible for the difference between that fee and the fee schedule allowance below:

- 4263: Bone replacement graft, 1st site in quadrant - allowance $150.00. Frequency of 1/5 years for general dentistry; 1/lifetime when implant related. (pg. 41)
- 4264: Bone replacement graft, additional site in quadrant – allowance $100.00. Frequency 1/5 years for general dentistry; 1/lifetime when implant related. (pg. 41)
- 7950: Ridge augmentation, by report - allowance $225.00. Frequency 1/5 years for general dentistry; 1/lifetime when implant related. (pg. 49)
- 7953: Bone replacement graft for ridge preservation, per site - allowance $225.00. Frequency 1/5 years for general dentistry; 1/lifetime when implant related. (pg. 49)

Effective 9/1/10: Relining of implant supported dentures – fee $85.00 for chairside; $130.00 for laboratory. Frequency 2/lifetime. No benefit if relined within 24 months of insertion. (pg. 43)

Effective 6/1/11:

Prosthodontics Dental Fee Increase				
ADA Codes	Procedure		Current Fee	Increased Fee
5110	Complete denture-upper	(pg. 42)	$440	$650
5120	Complete denture-lower		$440	$650
5130	Immediate denture-upper		$500	$675
5140	Immediate denture-lower		$500	$675
5211	Partial denture-upper-resin base		$255	$450
5212	Partial denture-lower-resin base		$255	$450
5213	Partial denture-upper-cast metal w/resin		$400	$695
5214	Partial denture-lower-cast metal w/resin		$400	$695
5410	Adjust complete denture-upper		$20	$25
5411	Adjust complete denture-lower		$20	$25
5421	Adjust partial denture-upper		$20	$25
5422	Adjust partial denture-lower		$20	$25
5510	Repair broken complete denture base		$40	$65
5520	Repair missing/broken teeth (max 4)		$40	$55
5610	Repair resin denture base		$40	$65
5620	Repair cast framework		$40	$100
5630	Repair or replace broken clasp - 1st clasp		$60	$90
5640	Repair broken teeth-per tooth (max 4)		$40	$55
6930	Recement fixed partial denture	(pg. 47)	$35	$62

Effective 2/1/12: Benefits are available for congenitally missing teeth. Benefit is dependent on type of replacement. (pg. 27)

Effective 10/11/12: Benefits are available for ADA code 2955 (removal of post) – fee $140.00. (pg. 38)

Effective 10/11/12: Pre-determination for services estimated to cost over $1,000 was restored. Therefore, if a procedure or series of dental treatments is expected to be more than $1,000, you MUST obtain a pre-determination by the Fund's third-party administrator, Healthplex BEFORE the service is commenced. If you fail to obtain the pre-determination, coverage may be denied (pg. 24). However, note, that **effective 8/22/12**, when the plan of treatment is expected to exceed $1,000.00, a Pre-determination penalty of $250.00 will be imposed if the member/patient fails to obtain the necessary pre-determination.

Effective 1/1/13: Benefits under ADA code 1351 (sealant – per tooth) – fee $20.00; eligibility for coverage extended through the age of 15 for permanent virgin molars. (pg. 34)

Clarification: All Orthodontic treatment must be provided by a Board Certified Orthodontist **AND** be clinically approved or benefits will not be paid. (pg. 50)

PRESCRIPTION DRUG CO-PAY REIMBURSEMENT BENEFIT

Effective 1/1/09: The Prescription Reimbursement benefit remains at $350.00 annually per family, for all members, with a maximum of $20.00 co-payment per prescription reimbursed. (pg. 18)

Effective 1/1/12: Drug names are not required to be listed on the Printout if a Third-Party payment is shown. If there is no coverage by another plan, then the drug name & co-pay amount must be shown to receive co-pay reimbursement for the prescription. This change applies to all 2011 and all future prescription co-payment reimbursement claims. (pp. 17-19)

OPTICAL BENEFIT

Effective 6/22/09: Dual members (members married to or in a domestic partnership with another member of the Fund) may combine their two respective optical vouchers towards the purchase of one pair of glasses. A paid itemized bill must include the date of service, name of patient & type of services provided. All must be submitted with the completed optical voucher. (pp. 19-21)

LEGAL SERVICES BENEFITS

Effective 4/6/10: Divorce mediation is a covered benefit under the Domestic Relations Representation benefit and will be reimbursed up to $500.00 upon presentment of a final decree of divorce. (pg. 12 of "Legal Reference Guide" dated January 2008.)

ELIGIBILITY

Effective 11/23/10: The Funds eligibility rules for disabled dependents are now consistent with those in the Employee Medical Health Plan (EMHP) as follows:

"DISABLED DEPENDENTS: Your unmarried, disabled children, incapable of supporting themselves because of a mental or physical disability acquired before the termination of eligibility, are eligible for coverage. (For example, if your child becomes disabled prior to age nineteen (19), he/she may qualify to continue coverage as a disabled dependent.) If you anticipate eligibility for your unmarried dependent child, you must apply for continued coverage with the Fund prior to your child's 19th birthday. If your child(ren) is covered as a full-time student and becomes disabled while in that status, you must apply for continued coverage with the Fund and provide medical documentation at the time the disability occurs and before the age your child would otherwise lose eligibility under the plan. In either case, if you receive recognition of the disabled status of your child from the EMHP, you can submit a copy of that letter from EBU." (pp. 5-6)

Effective for retirements occurring on or after 11/8/11: Retiree eligibility for members of the Corrections Officers, Deputy Sheriffs, Park Police and Probation units, who have 20 years of service with Suffolk County **AND** are in receipt of a pension from either the New York State Retirement System or any appropriate New York State Retirement System, irrespective of age, are no longer required to self-pay until reaching age 55 for their "Basic Retiree Plan" and are thus eligible for retiree benefits from the Fund upon retirement. (pg. 16)

Effective 2/8/12: Retirees with less than 10 years of service with Suffolk County **AND** are 55 years of age **AND** in receipt of a New York State Retirement System pension **AND** are granted a waiver from the EMHP Suffolk County Waiver Committee must submit a copy of the waiver to the Fund to be eligible to receive Fund benefits.

NOTE: BRG = Benefit Reference Guide, LRG = Legal Reference Guide

To the extent that this 2008 Benefit Reference Guide Update describes any benefit provided by this Fund, which is already described in the Fund's comprehensive Benefit Reference Guides, or as amended in subsequent writings by the Fund, or a policy of insurance (e.g., life insurance), the language of the 2008 Benefit Reference Guide, as amended, and/or the group insurance contract, which specify the exact benefits provided, will govern in the event of inconsistency between it and the language of this 2008 Benefit Reference Guide Updates.