SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND

As of January 26, 2022

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Suffolk County Municipal Employees Benefit Fund

Benefit Reference Guide

30 Orville Dr., Suite D

Bohemia, New York 11716

(631) 319-4099

(631) 218-7970 fax

www.scmebf.org

Rev. 1/2008

NOTES

UNCLASSIFIED TREATMENT

Code	Procedure	* Freq Limit	GP Allw	Spec Allw
9110	Palliative (emergency) treatment of dental pain-minor procedure	0 *	25	
9220	General anesthesia-1st 30 minutes, per session		120	
9221	General anesthesia- each additional 15 minutes (maximum 30 minutes) per session		40	
9241 *	Sedation-IV conscience sedation 1st 30 min. per session		120	
9242 *	Sedation-IV conscience sedation each additional 15 minutes (maximum 30 minutes) per session		40	
9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	2/C	35	
9940 **	Occlusal guard; by report. To minimize the effects of bruxism (grinding) & other occlusal factors	1/5	225	

* Effective 1/1/2007

** Effective 1/1/2008

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General Information

INTRODUCTION

Fund Operation

The Suffolk County Municipal Employees Benefit Fund ("Fund") is a legal entity established as a result of collective bargaining agreement between the Association of Municipal Employees ("Union") representing county employees, and the County of Suffolk. Several other municipal unions such as the SCCOA, SCDSBA and the SCPOA have negotiated with the County for participation in the Fund. Such participation is subject to receipt of adequate contributions from the County for the provision of benefits. The Fund provides health, welfare and other benefits to its members and eligible dependents. The Fund directly finances the administrative and benefit costs of the Legal Services Fund. Contributions to the Fund are predicated on amounts stipulated in the Collective Bargaining Agreements and other agreements.

The source of contributions to the Fund is the employer, such as the County of Suffolk and other municipalities. Contributions are provided at an annual rate, prorated bi-monthly, on behalf of each covered employee. In accordance with the Agreement and Declaration of Trust, as amended, the contributions are used to provide benefits for the covered employee and eligible dependents and to finance the cost of administration. The Fund has no requirement that employees contribute in order to become eligible for its benefits. In addition to the Agreement and Declaration of Trust and other agreements governing the operation of the Fund, the Fund is subject to a large body of statutory law designed to protect the beneficiaries of the Fund. Under its Trust Agreement, the Fund is mandated to submit its books to audit by certified public accountants. All of the benefits provided by the Fund are self-insured and, as a result, the Fund maintains benefit accounts at various banks and investments in other institutions.

Staff

The Funds are governed by a joint Board of Trustees comprised of eight members, four of whom are designated by the Union or Association and four of whom are designated by the County or Management, according to the Agreement and Declaration of Trust by which the Funds were created.

The Board of Trustees employ personnel who are responsible for the daily functioning and operation of the Fund, foremost of which is the processing of claims.

The Fund Administrator is officially designated as agent for service of legal process on the Fund.

All decisions of the Fund Administrator and the staff are subject to appeal in writing to the Board of Trustees.

ADULT ORTHODONTIA (19 AND OLDER)

NON-PARTICIPATING PROVIDERS ONLY

Code	Procedure	Freq Limit	GP Allw	Spec Allw
PRIOR APPROVAL IS REQUIRED. Lifetime maximum for adult orthodontics is $1,995 including diagnostic workup. Maximum of $555 for preventive treatment planning, including diagnostic workup (applied to lifetime ortho maximum). A claim is deemed payable when the teeth are banded and each month of adjustment(s) for orthodontia.				
8040	Limited treatment –adult dentition	1/L	120	
	Comprehensive Orthodontic Treatment			
8091	Comprehensive treatment- adult dentition	1/L	455	
	Minor treatment to Control Harmful Habits			
8211	Removable appliance therapy	1/L	120	
8221	Fixed appliance therapy	1/L	120	
	Other Orthodontic Services			
8661	Diagnostic workup (includes exam, x-rays/photos, diagnostic models and treatment planning)	1/L	100	
8671	Periodic orthodontic treatment (active)	24/L	50	
8673	Interceptive adjustments	6/L	30	
8681	Orthodontic retention (passive)	12/L	20	

ADULT ORTHODONTIA (19 AND OLDER)

PARTICIPATING PROVIDERS ONLY

Code	Procedure	Freq Limit	GP Allw	Spec Allw
PRIOR APPROVAL IS REQUIRED. Lifetime maximum for adult orthodontics is $1,995 including diagnostic workup. Maximum of $595 for preventive treatment planning, including diagnostic workup (applied to lifetime ortho maximum). Participating provider fees with new treatment starting 5/1/2007. A claim is deemed payable when the teeth are banded and each month of adjustment(s) for orthodontia.				
8040	Limited treatment –adult dentition	1/L	120	
	Comprehensive Orthodontic Treatment			
8090	Comprehensive treatment- adult dentition	1/L	495	
	Minor treatment to Control Harmful Habits			
8211	Removable appliance therapy	1/L	120	
8221	Fixed appliance therapy	1/L	120	
	Other Orthodontic Services			
8661	Diagnostic workup (includes exam, x-rays/photos, diagnostic models and treatment planning)	1/L	100	
8668	Periodic orthodontic treatment (active)	14/L	100	
8671	Periodic orthodontic treatment (active) Effective for cases prior to 5/1/07	24/L	50	
8673	Interceptive adjustments	6/L	30	
8681	Orthodontic retention (passive) Effective for cases prior to 5/1/07	12/L	20	

NOTICE OF PRIVACY PRACTICES

The federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires that Suffolk County Municipal Employees Benefit Fund ("the Fund") to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund's privacy notice, which was distributed to all current members of the Fund prior to April 14, 2003 and to all new members upon enrollment, a copy of which is available from the Fund office.

The Fund will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, operation of the Fund, or as permitted or required by law. By law, the Fund has required all business associates to also observe the Fund's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

Plan Provisions

ELIGIBILITY

Who is Eligible

Covered Members

Covered members include all employees of Suffolk County covered by the collective bargaining agreement between the County of Suffolk and The Association of Municipal Employees for whom contributions are made to the Suffolk County Municipal Employees Benefit Fund (herein "the Benefit Fund"); any other employees of the County of Suffolk, that may be deemed eligible by the Board of Trustees and for whom contributions are made to the Benefit Fund; the judges and court administrative personnel of the County of Suffolk for whom contributions are made to the Benefit Fund; employees of towns, villages and subdivisions of municipalities located in Suffolk County that may be deemed eligible by the Board of Trustees and for whom contributions are made to the Benefit Fund; employees of other entities, such as the Vanderbilt Museum that may be deemed eligible by the Board of Trustees and for whom contributions are made to the Benefit Fund; employees of The Association of Municipal Employees for whom contributions are made to the Benefit Fund by the Union and employees of the Benefit Fund for whom contributions are made to the Benefit Fund.

Dependents

Lawful spouses, duly enrolled domestic partners and dependent children of covered members are eligible for certain benefits as specifically hereinafter described in this booklet. Dependents, as defined by the Fund, are: your spouse; enrolled domestic partner; unmarried dependent children who have

not reached their 19th birthday; unmarried dependent children who are full-time students at a college, university or other accredited secondary educational facility, who have not reached their 25th birthday; or until date of graduation, if earlier; and unmarried children, regardless of age, incapable of self-sustaining employment by reason of mental or physical handicap, who became so prior to the age of nineteen (19) and reside with, and wholly depend upon the covered member for support. Dependent children include legally adopted children (including those in the waiting period) and step-children who chiefly depend on (derive more than 50% of support on an annual basis from the member) and reside with the covered member.

Status

1. In general, subject to the requirements pertaining as to the definition of a covered member, employees are eligible for benefits only so long as they are in an active payroll status. Eligibility for benefits terminates as of the effective date your employment is terminated.
2. Active payroll status here means the period for which contributions are paid, or should have been paid, for the employees by the employer to the Benefit Fund.
3. Members who go on an approved medical leave of absence from active employment due to extended illness, job-related injury that results in Workers Compensation status, or an approved leave will remain eligible for benefits for one year, commencing with the date of such leave. If the member does not return to active employment at the end of the approved medical leave of absence for reasons other than the continuation of the medical condition, then the member shall be responsible to reimburse the Fund for all expenditures made by the Fund to, or on behalf of, the member for the duration of the subject leave of absence.
4. Upon the death of an active member, benefits for the spouse/domestic partner and dependents of the member will continue for a period of 90 days after the date of death.
5. Retirement benefits are available to members aged 55 or older, unless disabled, who meet other eligibility requirements as defined on Page 13 of this booklet.

REQUIREMENTS FOR COVERAGE AND EXTENSIONS

Enrolling

All employees must file an enrollment card with the Fund office and keep it updated in order to avail themselves of the benefits provided by the Fund. Obtain a card from your payroll representative. It is essential for the orderly processing of claim forms. After filling out and filing the card, you are required to promptly notify the Fund, in writing, of any of the following:

(1) Change of Name

(2) Change of Address and/or Telephone Numbers

(3) Change of Marital/Domestic Partner Status

ADOLESCENT ORTHODONTIA (18 AND UNDER)

NON-PARTICIPATING PROVIDERS ONLY

Code	Procedure	Freq Limit	GP Allw	Spec Allw
PRIOR-APPROVAL IS REQUIRED. Lifetime maximum for adolescent orthodontics is $1,995 including diagnostic workup. Maximum of $525 for preventive treatment planning, including diagnostic workup (applied to lifetime ortho maximum). A claim is deemed payable when the teeth are banded and each month of adjustment(s) for orthodontia.				
	Limited Orthodontic Treatment			
8010	Limited treatment -primary dentition	1/L	120	
8020	Limited treatment -transitional dentition	1/L	120	
8030	Limited treatment-adolescent dentition	1/L	120	
	Interceptive Orthodontic Treatment			
8050	Interceptive treatment-primary dentition	1/L	120	
8060	Interceptive treatment-transitional dentition	1/L	120	
	Comprehensive Orthodontic Treatment			
8071	Comprehensive treatment-transitional dentition	1/L	425	
8081	Comprehensive treatment- adolescent dentition	1/L	425	
	Minor treatment to Control Harmful Habits			
8210	Removable appliance therapy	1/L	210	
8220	Fixed appliance therapy	1/L	250	
	Other Orthodontic Services			
8660	Diagnostic workup (includes exam, x-rays/photos, diagnostic models and treatment planning)	1/L	100	
8669	Periodic orthodontic treatment (active)	18/L	75	
8672	Interceptive adjustments	6/L	30	
8680	Orthodontic retention (passive)	6/L	20	

ADOLESCENT ORTHODONTIA (18 AND UNDER)

PARTICIPATING PROVIDERS ONLY

Code	Procedure	Freq Limit	GP Allw	Spec Allw
PRIOR-APPROVAL IS REQUIRED. Lifetime maximum for adolescent orthodontics is $1,995 including diagnostic workup. Maximum of $595 (for participating providers only) for preventive treatment planning, including diagnostic workup (applied to lifetime ortho maximum). Participating provider fees with new treatment starting 5/1/2007. A claim is deemed payable when the teeth are banded and each month of adjustment(s) for orthodontia.				
	Limited Orthodontic Treatment			
8010	Limited treatment -primary dentition	1/L	120	
8020	Limited treatment -transitional dentition	1/L	120	
8030	Limited treatment-adolescent dentition	1/L	120	
	Interceptive Orthodontic Treatment			
8050	Interceptive treatment-primary dentition	1/L	120	
8060	Interceptive treatment-transitional dentition	1/L	120	
	Comprehensive Orthodontic Treatment			
8070	Comprehensive treatment-transitional dentition	1/L	495	
8080	Comprehensive treatment- adolescent dentition	1/L	495	
	Minor treatment to Control Harmful Habits			
8210	Removable appliance therapy	1/L	210	
8220	Fixed appliance therapy	1/L	250	
	Other Orthodontic Services			
8660	Diagnostic workup (includes exam, x-rays/photos, diagnostic models and treatment planning)	1/L	100	
8669	Periodic orthodontic treatment (active) Effective for cases prior to 5/1/07	18/L	75	
8670	Periodic orthodontic treatment (active) Effective for cases after 5/1/07	14/L	100	
8672	Interceptive adjustments	6/L	30	
8680	Orthodontic retention (passive) Effective for cases prior to 5/1/07	6/L	20	

(4) Any Addition of Dependents

(5) Loss of Dependent Status Due to Marriage, Death, Age or their Change of Residence

The Fund reserves the right to request any documents necessary to establish eligibility of a member or dependent. Failure to provide timely written notification and the required documentation to the Fund may result in a suspension of benefits.

Waiting Period

1. As an employee, you must be in an active payroll status with an employer who has funded the required contribution. This establishes the period of employment for which contributions are paid or should have been paid to the Benefit Fund by the employer.
2. Eligibility for benefits commences on the first of the month after completion of at least two full months, but not more than three months, of such status. In other words, if you start work on the first of the month, you will be able to participate in benefits in exactly two months. However, if you start on the second day of the month (or later) the remainder of that month must be added to the two full-months waiting period. Example: Hired January 1, benefits start March 1. Hired January 2, benefits start April 1.

Benefit Payment Requirements

Once the waiting period is over, and provided the eligible employee has filed a Fund enrollment card, benefit coverage starts. Before starting payment of benefits to you, the Fund may request confirmation from you or your employer of pertinent payroll, address, and dependent data. Payment of benefits can be put in jeopardy if the employee fails to notify the Fund of changes in marital status, dependent status, or domicile; or neglects to confirm college attendance status of a dependent child of their household. College attendance must be confirmed directly to the Fund each semester. Benefits are payable to those eligible members or their dependents only to the extent of the terms of each benefit as defined in this booklet.

Ending of Coverage

Coverage and eligibility ends upon the effective date of termination of employment for the employee; this includes all spouse/domestic partner and dependent participation except as provided for under **Status,** Sections 3 and 4 on page 5. Eligibility for benefits end for dependents with a change in their status, such as in cases where they cease to be dependents of the employee or otherwise cease to be a dependent as defined by the Fund. The Fund requires proof from the student's school each semester. Student proof must be signed by the school registrar and for an undergraduate must state that the student is enrolled for 12 or more credits; for a graduate student 9 or more credits are required. Proof for the Spring Semester covers the dependent from January 1st to May 31st. Proof for the Fall semester covers the dependent from September 1st to December 31st. To keep your dependent's coverage active between semesters you must file with the

Fund a statement of intent (a school bill, a listing of tentative classes or a class schedule is acceptable). Extension of benefits for a terminated member or dependents under various circumstances may be available under COBRA.

Eligibility For Future Retiree Benefits

See Section entitled "Retiree Benefits" at page 13.

The length of time a future retiree may continue benefits under COBRA has been extended to accommodate any additional months needed for retiree benefit eligibility.

COBRA notifications are mailed directly to the member's home by the Fund as soon as the employer has advised the Fund of termination of employment. The member has 60 days from receipt of the COBRA notification to choose to continue benefits. Payments must be made continuously, without delinquency, in order to be eligible for benefits at a future date.

Failure to select the self-payment of premium option under COBRA will result in a permanent loss of retiree benefits.

COBRA CONTINUATION OF COVERAGE

COBRA continuation coverage is a continuation of Fund coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed on page 8. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Fund because of a qualifying event. Depending on the type of qualifying event, employees, spouses/domestic partners of employees, and dependent children of employees may be qualified beneficiaries. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You or your dependents will be required to pay the necessary premium for the following benefits:

- Dental Benefit
- Optical Benefit
- Hearing Aid Benefit
- Prescription Drug Co-Pay Benefit

COBRA continuation coverage for the Fund is administered by the Fund Administrator at the Fund Office located at 30 Orville Drive, Suite D, Bohemia, New York 11716, telephone 631-319-4099.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Fund because any one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross

ORAL SURGERY

Code	Procedure	* Freq Limit	GP Allw	Spec Allw
7400	***Removal of Tumors, Cysts and Neoplasm***			
Biopsy report required				
7450	Removal odontogenic cyst-up to 1.25 cm	1/L	97	150
7451	Removal odontogenic cyst-over 1.25 cm	1/L	150	250
7460	Removal non-odontogenic cyst-up to 1.25 cm	1/L	97	150
7461	Removal non-odontogenic cyst-over 1.25 cm	1/L	150	250
7500	***Surgical Incision***			
7510	Incision & drainage of abscess, intraoral	0 *	50	77
7520	Incision/drainage of abscess, extraoral	0 *	163	252
7900	***Other Repair procedures***			
	X-ray(s) and a narrative are required			
7960	Frenulectomy	0 *	125	220

* Effective 1/1/2007

ORAL SURGERY				
Code	**Procedure**	**Freq Limit**	**GP Allw**	**Spec Allw**
7100	***Extractions-***Includes local anesthesia and routine postoperative care			
7111 *	Extraction-simple, primary tooth	1/L	57	87
7140 *	Extraction-Erupted tooth or exposed roots	1/L	76	117
7200	***Surgical Extractions***			
	Pre-operative x-rays required. Includes local anesthesia, suturing and routine postoperative care			
7210	Surgical removal of erupted tooth	1/L	90	140
7220	Removal of impacted tooth-soft tissue	1/L	102	157
7230	Removal of impacted tooth-partially bony	1/L	132	203
7240	Removal of impacted tooth-completely bony	1/L	152	234
7241	Removal of impacted tooth-completely bony (unusual surgical complications)	1/L	163	280
7250	Removal of residual roots-cutting procedure	1/L	105	162
7280	Exposure of impacted or unerupted tooth for ortho reasons-including ortho attachments	1/L	152	252
7283 *	Placement of ortho devise to aid in eruption	1/L	11	28
7285	Biopsy of oral tissue-hard	1/1	138	212
7286	Biopsy of oral tissue-soft	1/1	105	162
7300	***Alveoloplasty (surgical prep of ridge for dentures)***			
7310	Alveoloplasty w/extractions-per quad	1/L	104	160
7311	Alveoloplasty w/extractions-1-3 teeth	1/L	78	120
7320 *	Alveoloplasty w/o extractions-per quad	1/5	234	360
7321 *	Alveoloplasty w/o extractions-1-3 teeth	1/5	176	270

* Effective 1/1/2007

misconduct..

If you are the spouse/domestic partner of an employee, you will become a qualified beneficiary if you lose your coverage under the Fund because any one of the following qualifying events happens;

1. Your spouse/domestic partner dies; or
2. Your spouse's/domestic partner's hours of employment are reduced; or
3. Your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct; or
4. Your spouse/domestic partner becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse or the domestic partnership ends.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Fund because any one of the following qualifying events happens;

1. The parent employee dies; or
2. The parent employee's hours of employment are reduced; or
3. The parent employee's employment ends for any reason other than his or her gross misconduct; or
4. The parent employee becomes enrolled in Medicare (Part A, Part B, or both); or
5. The parents become divorced or legally separated or the do mestic partnership ends; or
6. The child stops being eligible for coverage under the Fund as a "dependent child."

Sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Fund and that bankruptcy results in the loss of coverage of any retired employee covered under the Fund, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse/domestic partner, surviving spouse/domestic partner and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Fund.

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of employee or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Fund Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse, termination of domestic partnership or a dependent child's losing eligibility for coverage as a dependent child), YOU must notify the Fund Administrator. The Fund requires you to notify the Fund Administra-

tor within 60 days after the qualifying event occurs. You must send this notice to the Fund Administrator. In the event of death, a copy of the death certificate must be provided. In the event of divorce, you must send a copy of the divorce judgment. In the event of legal separation, you must send a copy of the Court Order of Separation. In the event of termination of the domestic partnership, you must provide the Fund with written evidence of same.

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event or on the date that Fund coverage would otherwise have been lost, if later.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, termination of domestic partnership or a dependent child losing eligibility as a dependent child, COBRA continuation lasts for up to 36 months.

When the qualifying event is the end of employment (including retirement) or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

1. <u>Disability Extension of 18 month Period of Continuation Coverage:</u>

If you or anyone in your family covered under the Fund is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, and you notify the Fund Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Fund Administrator is notified of the Social Security Administrator's determination before the end of the 18-month period of COBRA continuation coverage. This notice should be send to the Fund Administrator.

2. <u>Second Qualifying Event Extension of 18-month Period Continuation Coverage</u>

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse/domestic partner and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse/domestic partner and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated, or the domestic partnership is terminated. The extension is also available to a dependent child when that child stops being eligible under the Fund as a dependent child. **In all of these cases, you must make sure that the Fund Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Administrator.** In the event of death, a

PROSTHODONTICS - FIXED

Code	Procedure	Freq Limit	GP Allw	Spec Allw
6700	***Fixed Partial Denture Retainers-Crowns***			
Includes temporary coverage, occlusal adjustment and tissue preparation. A claim is deemed payable upon permanent insertion of bridges.				
6710 *	Crown-resin (laboratory)	1/5	150	
6720	Crown-resin w/high noble metal	1/5	500	
6721	Crown-resin w/pred.-base metal	1/5	500	
6722	Crown-resin w/noble metal	1/5	500	
6740	Crown-porcelain/ceramic	1/5	500	
6750	Crown-porcelain fused to high noble metal	1/5	500	
6751	Crown-porcelain fused to pred.-base metal	1/5	500	
6752	Crown-porcelain fused to noble metal	1/5	500	
6780	Crown-3/4 cast high noble metal	1/5	500	
6790	Crown-full cast high noble metal	1/5	500	
6791	Crown-full cast pred.-base metal	1/5	500	
6792	Crown-full cast noble metal	1/5	500	
6900	***Other Fixed Prosthetics***			
6930	Recement fixed partial denture	1/1	35	
6940	Stress breaker	1/5	110	
6950	Precision attachment/crown	1/5	125	
6980	Fixed partial denture repair-by report	1/5	75	

* Effective 1/1/2007

PROSTHODONTICS - FIXED				
Code	**Procedure**	**Freq Limit**	**GP Allw**	**Spec Allw**
	Fixed Partial Denture Retainers-Inlays/Onlays			
6545	Retainer-cast metal	1/5	165	
6548 *	Porcelain/ceramics retainer	1/5	165	
6600 *	Inlay—porcelain/ceramic, two surfaces	1/5	252	
6601 *	Inlay—porcelain/ceramic, 3 more surfaces	1/5	350	
6602 *	Inlay– high noble metal, two surfaces	1/5	160	
6603 *	Inlay—high noble metal, 3 more surfaces	1/5	388	
6604 *	Inlay– base metal, two surfaces	1/5	150	
6605 *	Inlay—base metal, 3 more surfaces	1/5	313	
6606 *	Inlay—noble metal, two surfaces	1/5	155	
6607 *	Inlay—cast noble metal, 3 more surfaces	1/5	360	
6608 *	Onlay—porcelain/ceramic, two surfaces	1/5	250	
6609 *	Onlay—porcelain/ceramic, 3 or more surfaces	1/5	344	
6610 *	Onlay—high noble metal, two surfaces	1/5	380	
6611 *	Onlay—high noble metal, 3 or more surfaces	1/5	410	
6612 *	Onlay—base metal, two surfaces	1/5	150	
6613 *	Onlay—base metal, 3 or more surfaces	1/5	315	
6614 *	Onlay—noble metal, two surfaces	1/5	155	
6615 *	Onlay—cast noble metal, 3 or more surfaces	1/5	360	

* Effective 1/1/2007

copy of the death certificate must be provided. In the event of divorce, you must send a copy of the divorce judgment. In the event of legal separation, you must send a copy of the Court Order of Separation. In the event of termination of the domestic partnership, you must provide the Fund with written evidence of same.

If you have any Questions

If you have any questions about your COBRA continuation coverage, you should contact the Fund Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep the Fund Informed of Address Changes

In order to protect your family's benefits, you should keep the Fund Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Fund Administrator.

COORDINATION WITH OTHER DENTAL, OPTICAL AND BENEFIT PLANS

These plans have been designed to help you meet the cost of dental, optical and other needs. Since it is not intended that you receive greater benefits than the actual expenses incurred, the amount of benefits payable under this plan will take into account any coverage you, your spouse/domestic partner, or dependents have under other group plans. That means, the benefits under this plan will be coordinated with the benefits of other group plans that your family may have.

A spouse/domestic partner or child will not be covered for any benefits from this Benefit Fund if, for any reason, they choose not to or neglect to enroll in their employer's or other available group coverage plan, provided the coverage was available at no cost to them.

It is important for you to remember the following points.

1. This Benefit Fund assumes first responsibility within the limits of our plans for all the **member's** covered benefits.
2. If your spouse/domestic partner is covered by a group coverage plan, that plan has first responsibility for your spouse's/domestic partner's benefit claims. This means that the **spouse's/domestic partner's** plan must pay all the spouse's/domestic partner's expenses incurred up to the limit of the schedule in that plan.
3. If the plan covering your spouse/domestic partner does not provide coverage to pay all of the expenses incurred and all of the primary plan's requirements have been met, the Fund will provide the difference of such expenses and the incurred cost within the limits of its coverage. You cannot collect from the Fund and under your spouse's/domestic partner's plan in excess of fees charged.
4. For **dependent children** of parents not separated or divorced,

the plan of the parent whose **month and day** of birth falls earlier in the calendar year pays first, and the plan of the parent whose date of birth falls later in the calendar year will pay second ("birthday rule"). The word "birthday" refers only to month and day, not the year in which the parent was born.

5. If two or more plans cover a person as a **dependent child of separated or divorced parents**, the benefits are determined in the following order:
   a) First, the plan of the parent with custody of the child;
   b) Then, the plan of the spouse/domestic partner of the parent with the custody of the child; and
   c) Finally, the plan of the parent not having custody of the child.
   d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity is aware such a decree exists.

6. Where husband and wife/domestic partners are both members of the Benefit Fund, the same coordination of benefits apply.

If you have any doubt about coverage for you, your spouse, your domestic partner and/or your dependent children, please contact the Fund office.

CLAIMING YOUR BENEFITS

Review Your Enrollment

Review the contents of this booklet thoroughly. Locate which benefit applies to your needs and provides the best coverage for you. After you are certain that the benefit is due you, check to see that all anticipated claims fall within the allowable claim-time limit; that is, within one year of the calendar year in which the services are rendered. Follow directions for submitting claims.

Claim Forms

Follow all instructions contained on the claim forms. All forms or correspondence received by the Fund must contain the following information:

Name of member; and

Address of member; and

Telephone number(s) of member; and

Social Security Number of member.

An incomplete form will be returned causing a delay in your benefit payment. The Fund reserves the right to request that you place your original signature and the current date on all claim forms. **The Fund cannot ac-**

PROSTHODONTICS - FIXED

Code	Procedure	Freq Limit	GP Allw	Spec Allw
6065 *	Implant supported porcelain/ceramic crown	1/L	500	
6066 *	Implant support metal crown-high noble metal	1/L	500	
6067 *	Implant supported metal crown	1/L	500	
	Fixed Partial Denture, Implant Supported			
6068 *	Abutment supported retainer-porcelain/ceramic	1/L	500	
6069 *	Abutment retainer-porcelain fused-high noblemetal	1/L	500	
6070 *	Abutment retainer-porcelain-predom. based metal	1/L	500	
6071 *	Abutment retainer-porcelain-fused to noble metal	1/L	500	
6072 *	Abutment retainer for cast metal-high noble metal	1/L	500	
6073 *	Abutment retainer for cast metal –base metal	1/L	500	
6074 *	Abutment retainer for cast metal –noble metal	1/L	500	
6075 *	Implant supported retainer for ceramic FPD	1/L	500	
6076 *	Implant supported retainer for ceramic FPD	1/L	500	
6077 *	Implant supported retainer for cast metal	1/L	500	
6200	**Bridge Pontics**			
No coverage for a fixed bridge where there are missing teeth on both sides of the same jaw. An alternative benefit of a partial denture will be allowed. A claim is deemed payable upon permanent insertion of bridges.				
6210	Pontic-cast high noble metal	1/5	500	
6211	Pontic-cast pred. base metal	1/5	500	
6212	Pontic-cast noble metal	1/5	500	
6214	Pontic-Titanium	1/5	500	
6240	Pontic-porcelain fused to high noble metal	1/5	500	
6241	Pontic-porcelain fused to pred. base metal	1/5	500	
6242	Pontic-porcelain fused to noble metal	1/5	500	
6245	Pontic-porcelain/ceramic	1/5	500	
6250	Pontic-resin high noble metal	1/5	500	
6251	Pontic-resin w/pred. base metal	1/5	500	
6252	Pontic-resin w/noble metal	1/5	500	

* Effective 1/1/2007

PROSTHODONTICS - FIXED				
Code	**Procedure**	**Freq Limit**	**GP Allw**	**Spec Allw**
6000	***Implant Services***			
Pre-approval, pre-operative and post-operative implant x-rays required. Implant related prosthetics must be submitted for pre-approval before treatment begins. Failure to obtain preauthorization will result in the denial of benefits. Once the implant related prosthetic has been placed, no other benefit will be allowed for the tooth. The Fund is not responsible for any costs associated with implant services other than what is contained in this section. **Participating providers are NOT required to accept the plan's fees as payment in full for any implant procedures.** All covered implant crowns are abutment/implant supported. A claim is deemed payable upon permanent insertion of implant related procedures. **All implants are benefitted once in a lifetime.**				
	Surgical Services			
Pre-approval & pre-operative x-rays required.				
6010 **	Surgical placement of implant body: endosteal implant. Includes second stage surgery & placement of healing cap	1/L	500	
6040 **	Surgical placement: eposteal implant. This may be arch or unilateral appliance	1/L	500	
6050 **	Surgical placement: transosteal implant	1/L	500	
	Implant Supported Prosthetics			
6052 *	Implant/abutment supported removable upper denture for completely edentulous arch	1/5	500	
6053 *	Implant/abutment supported removable lower denture for completely edentulous arch	1/5	500	
6058 *	Abutment supported porcelain/ceramic crown	1/L	500	
6059 *	Abutment supported metal crown-high noble metal	1/L	500	
6060 *	Abutment metal crown-predom-base metal	1/L	500	
6061 *	Abutment-metal crown-noble metal	1/L	500	
6062 *	Abutment-cast metal crown-high noble metal	1/L	500	
6063 *	Abutment-cast metal-predom. based metal	1/L	500	
6064 *	Abutment-cast metal crown-noble metal	1/L	500	
	* Effective 1/1/2007			
	** Effective 1/1/2008			

cept photocopied optical, hearing aid, tax and legal vouchers. The Fund does accept photocopied dental and prescription reimbursement claim forms.

Payment

The processes for payment of benefits vary. Payments shall be made either to the member directly or to the provider of the particular service. Specifics are provided according to each benefit.

For dental benefits a claim is deemed payable: upon permanent insertion of crowns, bridges (fixed & removable) and dentures; for RCT's & apicoectomy's, upon review of completion x-rays; for extractions, on the day teeth are extracted; and for orthodontia, when the teeth are banded and for each month of adjustment(s).

Payment will not be made for any benefit that is claimed after a period that exceeds one year from the calendar year in which services were rendered. For example, services performed in 2006 must be claimed no later than December 31, 2007. You must be eligible for benefits on such payment events.

RIGHT TO RECOUP BENEFIT PAYMENTS MADE IN ERROR OR TO SUSPEND BENEFITS COVERAGE

The Benefit Fund periodically audits payments made. If for any reason the Fund discovers a discrepancy that results in a request for a refund, any failure to comply may place your future benefits in jeopardy.

The Fund has the right to recoup overpayments that were caused by an error in the processing of a claim or if additional information comes to the attention of the Fund after the claim has been paid, for you or an otherwise ineligible dependent. The Fund may bill you for overpayments made and/or it may also reduce future benefit payments to offset the overpaid amounts. Furthermore, the Fund has the right to suspend one or more benefits if you have received overpayment or have in any way abused the Fund's benefit program.

AMENDMENT AND TERMINATION OF BENEFITS

The benefits provided by the Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees in their sole and absolute discretion. The Board of Trustees adopts rules and regulations for the payment of benefits. All provisions of this booklet are subject to such rules and regulations and to the Trust Agreement, which established the Fund and governs its operations.

Your coverage and your dependents' coverage will stop on the earliest of the following dates:

- When the Fund is terminated; or
- When you are no longer eligible; or
- When there is non-payment; or
- When the Employer ceases to make contributions on your behalf to the Fund

Your dependents' coverage will also terminate when they are no longer

eligible dependents. Member benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits. The Trustees may expand, modify or cancel the benefits for members and dependents; change eligibility requirements or the amount of the self-pay premiums; and otherwise exercise their prudent discretion at any time without legal right or recourse by a member or any other person.

RIGHT TO APPEAL

The benefits provided by this Fund may be changed by the Board of Trustees at any time, in their sole and absolute discretion. The Board of Trustees adopts rules and regulations for the payment of benefits. All provisions of this booklet are subject to such rules and regulations and to the Trust Agreement, which established and governs the Fund operations.

All rules are uniformly applied by the Fund office. The action of the Fund office is subject only to review by the Board of Trustees. A member or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees within 180 days of the determination being appealed:

Board of Trustees
Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Suite D
Bohemia, New York 11716

The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final and conclusive and binding on all persons.

BENEFITS PAYABLE ON BEHALF OF DECEASED MEMBER

With respect to any benefits payable to a deceased member upon the date of death or with respect to death benefits payable by virtue of the death of the member where the member's designated beneficiary has predeceased the member and a successor has not been designated, or where the member has not designated a beneficiary, then these benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The covered member's:

A. Surviving spouse/domestic partner, or

B. If no surviving spouse/domestic partner, to the surviving children equally; or

C. If no surviving children, to the covered member's estate.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered member or dependent is injured through the acts or omissions of a third party, the Fund shall be entitled, to the extent it pays out benefits, to reimbursement from the covered member or dependent from any recovery obtained from the responsible third party (including Worker's Compensation cases). Alternatively, the Fund shall be subrogated, unless other-

PROSTHODONTICS - REMOVABLE

Code	Procedure	Freq Limit	GP Allw	Spec Allw
5650	Add tooth to existing partial (to replace extracted tooth)	1/L	60	
5660	Add clasp to existing partial (when abutment tooth is extracted)	1/L	60	
5700	***Denture Relining***			
5730	Reline complete upper-chairside	1/3	85	
5731	Reline complete lower-chairside	1/3	85	
5740	Reline partial upper-chairside	1/3	85	
5741	Reline partial lower-chairside	1/3	85	
5750	Reline complete upper-laboratory	1/3	130	
5751	Reline complete lower-laboratory	1/3	130	
5760	Reline partial upper-laboratory	1/3	130	
5761	Reline partial lower-laboratory	1/3	130	
5800	***Other Removable Prosthetic Service***			
5820	Interim partial upper	1/5	150	
5821	Interim partial lower	1/5	150	
5850	Tissue conditioning-upper (by report)	1/3	45	
5851	Tissue conditioning-lower (by report)	1/3	45	
5860	Overdenture complete (by report)	1/5	440	
5861	Overdenture partial (by report)	1/5	400	

PROSTHODONTICS - REMOVABLE				
Code	**Procedure**	**Freq Limit**	**GP Allw**	**Spec Allw**
Pre-operative x-rays may be required. Fee allowance includes conventional clasps, rests, and prosthetic teeth. Also included is routine post-delivery care and adjustments for a 6 month period following insertion. Relines are included in the fee allowance for a 12 month period following insertion. If a tooth is extracted on which a root canal has been performed and/or a crown has been placed within 1 year of treatment, the fee paid for the root canal and/or crown will be deducted from the bridge or denture, fixed or removable. A claim is deemed payable upon permanent insertion of dentures.				
5110	Complete denture-upper	1/5	440	
5120	Complete denture-lower	1/5	440	
5130	Immediate denture-upper	1/5	500	
5140	Immediate denture-lower	1/5	500	
5200	***Partial Dentures***			
5211	Partial denture-upper-resin base	1/5	255	
5212	Partial denture-lower-resin base	1/5	255	
5213	Partial denture-upper-cast metal w/resin	1/5	400	
5214	Partial denture-lower-cast metal w/resin	1/5	400	
5400	***Adjustments to Dentures***			
5410	Adjust complete denture-upper	1/1	20	
5411	Adjust complete denture-lower	1/1	20	
5421	Adjust partial denture-upper	1/1	20	
5422	Adjust partial denture-lower	1/1	20	
5500	***Repairs to Complete Dentures***			
5510	Repair broken complete denture base	1/1	40	
5520	Repair missing/broken teeth (max 4)	1/1	40	
5600	***Repairs to Partial Dentures***			
5610	Repair resin denture base	1/1	40	
5620	Repair cast framework	1/1	40	
5630	Repair or replace broken clasp-1st clap	1/1	60	
5640	Repair broken teeth-per tooth (max 4)	1/1	40	

wise prohibited by law, to all rights of recovery that the covered member or dependent may have against such third party arising out of its acts or omissions that caused the injury. Subrogation means that the Fund becomes substituted in the injured person's place to pursue a claim recovery against the third party. Fund benefits will be provided only on the condition that the covered member or dependent agrees in writing:

1. To reimburse the Fund to the extent of benefits paid out of any monies recovered from such third party, whether by judgment, settlement or otherwise; and
2. To provide the Fund with an assignment of proceeds to the extent of benefits paid out by the Fund on the claim and to cooperate and assist the Fund in seeking recovery. The assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services; and
3. To take all reasonable steps to effect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement or subrogation and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

BENEFITS

Retiree Benefits

What are the Benefits

Effective March 1, 2007, the Fund is pleased to offer two plans of retiree benefits: the "basic" no-cost plan, which consists of reduced dental benefits, and optical and hearing aid benefits equivalent to those enjoyed by the active Fund members. The schedule of coverage is the same as that for active participants of the Fund except that the dental benefits are subject to an annual maximum of $500 per individual and $750 per family.

The second option is a three-tiered, self-pay retiree plan of benefits, as follows:

1. The **Premium Plan** offers eligible retirees the opportunity to continue coverage at the level of benefits available to active members for:
   - Dental (includes a maximum of $2,250 per person for general dentistry, a separate maximum of $2,000 for periodontal procedures, as well as lifetime benefits of $1,995 for orthodontic benefits and a separate lifetime maximum benefit of $2000 for implants);
   - Hearing aid; and
   - Optical Benefits.
2. The **Premium Plus Plan** offers the same benefits listed above, "plus":

- Prescription drug co-payment reimbursements benefit.

3. The **Platinum Plan** offers the benefits listed in items 1 and 2 above, "plus":
   - Tax Preparation; and
   - Legal Services benefits.

Who is eligible

Retirees who at the time of retirement were active members of the Fund or have at least ten (10) years accumulated participation with the Fund as a result of a contributing employer making such contributions.

For those retirees who initially retired on or after January 1, 1985, you must be in receipt of a monthly pension from either the New York State Retirement System or a related organization (as defined by the Fund).

For all retirees to be eligible for Fund benefits, you must satisfy at least one of the following conditions:

1. You initially left employment with Suffolk County or a contributing employer on or after age 55 and had 10 years of employment with either employer; or
2. You are currently age 55 or older and had 20 years of employment with Suffolk County or a contributing employer and have maintained continued coverage with the Fund by self-paying from the date of separation from the employer through to the age of 55; or
3. You are in receipt of a disability retirement benefit from either the New York State Retirement System or the retirement system in which a contributing employer participates.

Dependent coverage

Dependents of eligible retirees are covered for benefits and are defined the same as for active employees on page 5.

Limitations

Coverage is not extended to dependents of deceased retiree members. However, upon the death of the retired member, the dependent may choose to continue coverage under COBRA. The Fund office must be contacted within 60 days of the death for the qualified beneficiary/ dependent to be eligible for continuation of coverage.

Payment will not be made for any benefit that is claimed after a period that exceeds one year from the calendar year in which services were rendered. Services rendered in 2006, for example, must be claimed no later than December 31, 2007.

It is the responsibility of the retiree to inform the Fund of his or her eligibility for coverage. In a case of late notification, payment will be made only for claims submitted in the calendar year in which services

PERIODONTICS

Code	Procedure	Freq Limit	GP Allw	Spec Allw
	PRIOR APPROVAL REQUIRED FOR ALL SURGICAL PERIODONTAL PROCEDURES			
	The Fund reserves the right to have all periodontal services reviewed at any time. Specialist fees allowed only when specialist has performed the service.			
4000	***Surgical Services***			
	Curettage and/or gingivectomy are not considered as separate services when performed during osseous surgery.			
4210	Gingivectomy/gingivoplasty-per quad	1/4	120	195
4211	Gingivectomy/gingivoplasty 1-3 teeth	1/4	90	155
4240	Gingival flap proc.-per quad (incl. rt. planing)	1/4	300	450
4241 *	Gingival flap proc. 1-3 teeth	1/4	225	335
4260	Osseous surgery-per quad (incl. flap & closure)	1/4	300	450
4261 *	Osseous surgery 1-3 teeth	1/4	225	335
4270	Pedicle soft tissue graft	1/4	150	190
4271	Free soft tissue graft incl. Donor site	1/4	150	190
4300	***Non-surgical Periodontal Services***			
	No benefit when performed on same date as surgical procedures, or when performed on same date as prophylaxis.			
4341	Periodontal scaling & root planing-per quad Maximum 2 quads on same date. Maximum 1 UL, UR, LL, or LR in any 6 month period.	1/6M	40	60
4342 *	Periodontal scaling & root planning 1-3 teeth Maximum 2 quads on same date. Maximum 1 UL, UR, LL, or LR in any 6 month period.	1/6M	30	45
4910	Periodontal maintenance procedures No benefit within 3 months of any other periodontal therapy. Maximum of 1 in any 3 month period.	4/1	50	65

* Effective 1/1/2007

ENDODONTICS				
Code	**Procedure**	**Freq Limit**	**GP Allw**	**Spec Allw**
3400	**Periapical Services**			
A claim is deemed payable upon review of completion x-rays for an apicoectomy.				
3410	Apicoectomy/periradicular surgery-anterior	1/L	234	360
3421	Apicoectomy/periradicular surgery-1st root-bicuspid	1/L	304	468
3425	Apicoectomy/periradicular surgery-1st root-molar	1/L	351	540
3426	Apicoectomy/periradicular surgery-add'l root	1/L	117	180
3430	Retrograde filling-per root	1/L	40	65
3450	Root Amputation	I/L	90	140
3920	Hemisection-incl. Root removal	1/L	134	206

were rendered.

How to obtain the Retiree Plan Benefits

To elect any of the plans above, you must complete and return the enrollment form to the Benefit Fund office within sixty (60) days of the date of your retirement. This is the only opportunity you will have to obtain this coverage. You will not be given another opportunity to buy the self-pay enhanced coverage.

If you do not elect to enroll in any of the self-pay plans within the 60 day period, your active level of benefits coverage will cease and you will only receive the limited benefits available via the "basic" no-cost retiree plan (dental—up to $500 per person per year, maximum $750 per family per year; optical and hearing aid) and will NEVER AGAIN be given the opportunity to enroll in one of these enhanced plans in the future.

Retirees who opt for coverage in either the Premium or the Premium Plus Plans will be provided yearly opportunities to move up to a greater coverage. Retirees who do not opt for any of these plans will automatically be maintained in the no-cost, basic plan. Once this occurs, you may NEVER AGAIN opt to purchase any of the "premium" plans.

To be covered under any of the plans noted above, you must enroll and emit payments for a full fiscal year (March 1 through February 28). Payment frequency is limited to quarterly, semi-annual or annually. If you opt to pay semi-annually or annually, your self-pay premium will be discounted by either 5% (for a semi-annual payment) or 10% (for an annual payment).

If you are enrolled and the Fund does not receive your self-pay premium payment to continue benefits, your coverage will cease and you will NOT be entitled in the future to resume participation in any retiree plan offered by the Benefit Fund, including the no-cost "basic" plan. All benefits will cease.

Eligibility for dependents is based on the coverage you choose during the applicable enrollment period. If you elect individual coverage, you will not be entitled to elect dependent coverage at a later date, unless you add a dependent to your family because of a life event (e.g., you get married). You may not enroll a dependent at a later date who was eligible for enrollment at the time of your initial enrollment. In addition, should you subsequently drop a dependent, that dependent may never be re-enrolled by you.

Prescription Drug Co-Payment Benefit

Who is eligible

Member and eligible dependents as defined by the Fund.

What is the Benefit

Once annually, the Fund reimburses a member the out-of-pocket costs that have been paid on behalf of eligible family members within the calendar year for drugs prescribed by a medical doctor, osteopath or

dentist. A licensed pharmacist must dispense prescriptions.

Effective January 1, 2006, for prescriptions filed in 2005 through December 31, 2008 for those members for whom the Fund received a one-time lump contribution equivalent on a per capita basis to that received on behalf of AME members the annual maximum to be reimbursed per family is $350. The maximum allowable co-payment is $20.

For all other members, the annual maximum to be reimbursed per family is $300. The maximum allowable co-payment is $10.

All rules and regulations governing your basic health plan's prescription drug plan apply to your Fund coverage of this benefit.

Claims for prescription drug copayments can only be filed **ONCE** annually per family. Submit only after you have accumulated the applicable annual maximum for co-payment costs. If you do not meet the maximum total prior to the end of the year, submit your claim for whatever the amount is below that figure after the last day of that calendar year. Any claim paid by the Fund will **NOT** be reconsidered at a later date.

Covered expenses
Any prescription drugs which are covered under your basic health plan's prescription drug plan.

Exclusions
Any prescriptions not covered as determined by your basic health plan's prescription drug plan.

Claims not submitted prior to December 31st of the current year for the previous year's expenses will not be eligible for reimbursement. Example: Claims for 2006 may be claimed only up to 12/31/2007.

Limitations
The Fund will not pay prescription costs incurred by members in excess of the applicable co-payment. If you use a non-participating pharmacy, you will be required to pay the full cost of the prescription to the pharmacy. The Fund will only reimburse the co-payment amount that the plan would have paid if you used a participating pharmacy.

Duplicate or supplemental claims will not be honored.

Claiming
Obtain a Prescription Drug claim form from your payroll representative or download it from the Fund's website, www.scmebf.org. Complete instructions for filing are included on the back of the claim form. Proof of payment must be attached. Individual copies of your receipts must be accompanied by Schedule A (obtained from your payroll representative or the Fund's website).

Pharmacy Printout Filings
Complete the claim form for all persons covered under the Fund.

ENDODONTICS

Code	Procedure	Freq Limit	GP Allw	Spec Allw
3100	***Pulp Capping***			
	Verification of need and pre-operative x-rays required. Considered for benefits only when extent of involvement can be seen radiographically. Temporary restoration included in fee for direct pulp cap.			
3110	Pulp cap-direct	1/1	18	
3120	Pulp cap– indirect	1/1	13	
3200	***Pulpotomy***			
3220	Therapeutic pulpotomy—Primary teeth only	1/L	43	
3221 *	Pulpodebridement—Adult teeth	1/L	43	
3300	***Endodontic Therapy***			
	Pre and post-operative x-rays required. Fee allowance includes treatment plan, clinical procedures and follow-up care. Re-treatment allowed only under special circumstances that can be adequately documented. A claim is deemed payable upon review of completion x-rays for root canals.			
3310	Root canal-1 canal	1/L	280	432
3320	Root canal-2 canals	1/L	327	504
3330	Root canal-3 or more canals	1/L	374	576
3331	Root canal obstruction-non-surgical access	1/L		300
3332	Unrestorable tooth Incomplete root canal	1/L	95	140
3346	Root canal retreatment—anterior teeth	1/L	340	532
3347	Root canal retreatment-bicuspid	1/L	387	604
3348	Root canal retreatment-molar	1/L	434	676
3351 *	Apexification—1st visit	1/L	75	110
3352 *	Apexification—2nd visit	1/L	45	70
3353 *	Apexification—3rd and final visit	1/L	45	70

* Effective 1/1/2007

Code	Procedure	Freq Limit	GP Allw	Spec Allw
2900	***Other Restorative Services***			
2910	Recement inlays/onlay or partial restoration	1/1	25	
2920	Recement crowns (not covered within 12 months of insertion)	1/1	30	
2930	Prefab stainless steel crown-primary tooth	1/L	120	
2931	Prefab stainless steel crown-permanent tooth	1/5	120	
2950	Core buildup, including pins	1/5	90	
	Considered for benefits only when necessitated by loss of tooth structure that has left an inadequate foundation to support a crown restoration.			
2951	Pin retention-in addition to restoration	1/1	15	
2952	Cast post and core	1/5	110	
2954	Prefab post and core	1/5	110	
2970	Temporary crown (fractured tooth-anterior) Limited to special circumstances that can be adequately documented	1/L	80	
2980	Crown repair (by report)	1/5	50	

Prescriptions for the member, spouse/domestic partner, and covered children must be on the same form. Identify each family member and attach all printouts for that person, including the total of each one. Do this for each individual for whom you are submitting. Please complete all required areas of information.

Remember to sign and date the bottom of the form.

Health Plan's Printout

Complete all required areas of information on the claim form and attach the health plan's printout you receive annually from your basic health plan's prescription benefit manager. All the information necessary on the claim form is contained on your printout.

Individual Receipts

Individual copies of receipts **will not** be accepted as proof of payment unless the pharmacy utilized **can not** produce a printout. **Schedule A must be attached to the completed claim form when submitting copies of individual receipts.** Complete Schedule A as follows:

a) List prescription copayments in date order by patient.
b) Attach clear COPIES of individual receipts. (ORIGINAL receipts will be returned to you along with your claim form, resulting in a delayed reimbursement.)
c) Copy receipts in the same order listed on Schedule A and indicate the corresponding line number from the claim form.
d) Altered receipts will be disallowed unless signed by the pharmacist.

Optical

Who is eligible

Members and eligible dependents, as defined by the Fund, are entitled to an optical benefit once every calendar year.

What are the Benefits

Covered members and their eligible dependents can receive optical benefits either through a non-participating provider of their choice or through Participating Optical Centers.

(1) Participating Optical Centers

The optical allowance of up to $80 once every calendar year may be used at a Participating Optical Center selected by the Fund. The Centers agree to provide the services listed on the following page for the allowance.

When you use a panel practitioner and select from this collection, the Fund voucher will be accepted as payment in full. Reimbursement from the Fund will be made directly to the provider.

The Fund has also arranged discounted fees for certain services, which are listed on the following page.

Covered Optical Services

EYE EXAMINATION - Including glaucoma testing for patients over 35;

FRAMES - Any frame in the store with a retail value of up to $140.

LENSES - All ranges of prescription lenses to be of first quality impact-resistant glass or plastic, standard or oversized. Polycarbonate lenses for children who have not reached their 13th birthday.

LENS TYPES - Single, Bifocal (including generic invisible or blended), Multifocal, Progressive (Silor Super/Progressive Elegance or equivalent), Daily, Extended and Disposable Contacts ($80 maximum allowance for contact lenses). Cosmetically tinted contacts are not included in coverage.

LENS TREATMENT - Cosmetic and sun tinting, scratch resistance and UV protection.

Optical Fee Schedule

Eye Exam	$20
With or Without exam, prescription lenses and frames*	$80
With or Without exam, Standard Daily Wear Contacts*	$80
With or Without exam, Extended Wear Contacts*	$80
Contacts, Disposable*	$80

* If the patient has exhausted the exam portion of their annual optical benefit, the reimbursement will be limited to the remaining portion of the benefit.

Member Payment/Surcharges

The Participating Fund optical providers have also agreed to the following set fees, which are the patient's responsibility. Frames selected inside the plan frames, that have a retail value over $140, will have a $140 allowance subtracted from the retail value of the frame. (Example: Frame retail value is $200, less the plan allowance of $140 =$60 + tax payable by the member)

Progressive (Varilux or Equal)	$75.00
Ultra Thin Lenses (Hi-Index)	$60.00
Progressive Photosensitive Lenses (Generic or Equivalent)	$110.00
Anti-Reflective Coating	$30.00
Contacts, Disposable*	Balance after $ 80 Fund Payment
Sun-sensitized Plastic Single Vision Lenses (Including Transitions)	$40.00
Sun-sensitized Plastic Bifocal lenses (Flat Top 28 – Including Transitions)	$60.00

* You may not be denied your choice of disposable contact lenses if you choose not to agree to purchase further disposable lenses from the participating provider or the provider's recommended disposable lens supplier.

Code	Procedure	Freq Limit	GP Allw	Spec Allw
2700	***Crowns***			
Pre-operative x-rays required. Crowns will be considered only when teeth cannot be restored with direct restorative materials (amalgam or composite). Includes tissue preparation, occlusal adjustment, temporary protective coverage and local anesthesia. A claim is deemed payable upon permanent insertion of crowns.				
2720	Crown-resin w/high noble metal	1/5	500	
2721	Crown-resin w/pred.-base metal	1/5	500	
2722	Crown-resin w/noble metal	1/5	500	
2740	Crown-porcelain/ceramic substrate	1/5	500	
2750	Crown-porcelain fused to high noble metal	1/5	500	
2751	Crown-porcelain fused to pred.-base metal	1/5	500	
2752	Crown-porcelain fused to noble metal	1/5	500	
2780 *	3/4 Crown—High Noble	1/5	500	
2781 *	3/4 Crown—Based Metal	1/5	500	
2782 *	3/4 Crown-Noble	1/5	500	
2783 *	3/4 Crown-Porcelain	1/5	500	
2790	Crown-full cast high noble metal	1/5	500	
2791	Crown-full cast pred.-base metal	1/5	500	
2792 *	Crown-full cast noble metal	1/5	500	
2794 *	Crown—Full Titanium	1/5	500	

* Effective 1/1/2007

Code	Procedure	Freq Limit	GP Allw	Spec Allw
2500	***Inlay/Onlay Restorations***			
Coverage restricted to either inlay or onlay. Inlay/Onlay restorations will be considered only when tooth cannot be restored with direct restorative material (amalgam or composite).				
2520	Inlay-metallic, 2 surfaces	1/5	195	
2530	Inlay-metallic, 3 or more surfaces	1/5	240	
2542	Onlay-metallic, 2 surfaces	1/5	245	
2543	Onlay-metallic, 3 or more surfaces	1/5	290	
2620	Inlay-porcelain/ceramic, 2 surfaces	1/5	210	
2630	Inlay-porcelain/ceramic, 3 or more surfaces	1/5	250	
2642	Onlay-porcelain/ceramic, 2 surfaces	1/5	260	
2643	Onlay-porcelain/ceramic, 3 or more surfaces	1/5	300	

Limitations

An additional fee may be charged for contact lenses, photosensitive lenses, hi-index and anti-reflective coating. For a fashion frame that is part of the program where the retail price exceeds $140, the optical provider agrees that $140 will be deducted from the retail price. Supplies for disposable lenses are not covered. The comprehensive examination fee is limited to $20.

(2) Optical Services - Non-participating

The Fund will pay up to $80 per eligible person for specified optical services provided by any licensed optometrist, optician or physician* of your choice in accordance with the fee schedule. The fee schedule provides for a **maximum allowable amount for each service,** which may be claimed once in a calendar year for a total of $80. **If an eye examination is provided by a physician for which you are covered by your medical plan, then you must submit an itemized receipt marked "paid", showing the co-payment amount with the voucher when submitted to the Fund for payment of up to $20. Your available benefit for lenses and frames will be limited to the remaining portion of your allowance. If you utilize the services of a physician for the exam, and then an optical center for the lenses and frames, you must insure that the voucher submitted by the center does not assert a claim for the exam. The Fund will only reimburse up to $20 for one exam.*

How to receive the benefit

An optical voucher must be obtained from the Fund prior to receiving optical services. Allow a minimum of 10 days prior to your appointment for receipt of your voucher from the Fund. Submit the voucher directly to the provider of services if you utilize a participating optical center.

- The Fund has arranged with participating optical providers a set fee schedule for certain services which represent a greatly reduced cost to the member.
- If you are using a provider of your choice, send your completed voucher along with a paid itemized bill directly to the Fund. Reimbursement will be made directly to you.

The Benefit Fund does not cover VDT glasses or non-prescription glasses/sunglasses.

Unused optical benefits in any calendar year may not be carried over for use in subsequent calendar years

Bereavement Benefit

Who is Eligible

Designated beneficiaries of active members only.

What is the benefit

A death benefit in the amount of $10,000 payable to the beneficiary or beneficiaries named in writing by the member and filed with the Fund office. If no beneficiary is named, or if a named beneficiary is not living at the time of the member's death, payment will be made to the member's estate. If the active employee is over 70 years of age at time of death, the benefit is re-

duced to $5,000.

Limitations

Covered members are those as defined by the Fund in an active payroll status only, with the exception of those members on a leave of absence of up to one year due to extended illness, maternity or a job-related injury resulting in Worker's Compensation status. Retired members or members on COBRA are not eligible for this benefit.

Claiming

Submit a certified copy of the death certificate to the Fund office along with the member's social security number.

In those cases where no beneficiary has been named or the named beneficiary predeceased the member, copies of Letters of Administration or Letters Testamentary from the Surrogate Court must also be submitted.

Designating a Beneficiary

Designation of Beneficiary Forms are available from your payroll representative or the Fund office. If you wish to update information, complete another form and submit it to the Fund office. This information will supersede the original form.

Survivors Benefit

Who is eligible

Active member, spouse or eligible domestic partner.

What is the benefit

The Fund will pay $1000 upon the death of either the member, the member's spouse or the member's eligible domestic partner. With regards to the member, the member can designate an eligible beneficiary of his/her choice.

Limitations

Covered members are those as defined by the Fund and include members on a leave of absence of up to one year due to extended illness, maternity, or a job-related injury resulting in Worker's Compensation status. Retired members, their spouse/domestic partners or eligible domestic partners and those on COBRA are not eligible for this benefit.

The member will be the beneficiary upon the death of his or her spouse. The member's spouse will be the beneficiary upon the death of a member, unless a signed form naming another beneficiary is on file with the employee's payroll office. Payment will be made to the designated beneficiary of single members.

Claiming

Submit a certified copy of the death certificate to the Fund office along with the member's social security number and designation of beneficiary form.

Designating a Beneficiary

Designation of Beneficiary Forms for the Survivors Benefit are available from the Fund or your payroll representative. If you wish to update information, complete another form and submit it to the Fund office. This infor-

RESTORATIVE SERVICES

Code	Procedure	Freq Limit	GP Allw	Spec Allw
	Allowance is made for only one restoration per tooth surface regardless of the number of combinations of restorations placed in the same tooth; i.e., an MO and DO placed on the same tooth is considered to be an MOD. The maximum allowable per tooth is the allowance for a 3 or more surface filling. No benefit is available for a filling replaced within 12 months of placement.			
2100	***Amalgam Restorations (including bases & polishing)***			
2140 *	Amalgam-1 surface, permanent/primary	1/1	40	
2150 *	Amalgam-2 surfaces, permanent/primary	1/1	50	
2160 *	Amalgam-3 or more surfaces, permanent/ primary	1/1	60	
2300	***Resin Based Composite Restorations***			
2330	Composite-1 surface, anterior	1/1	50	
2331	Composite-2 surfaces, anterior	1/1	65	
2332	Composite-3 surfaces, anterior	1/1	80	
2335	Composite-4 or more surfaces or involving incisal angle - anterior. ***Must include surfaces DI or MI to receive full benefits.***	1/1	90	
2391 *	Composite-1 surface, posterior- permanent	1/1	50	
2392 *	Composite-2 surfaces, posterior- permanent	1/1	65	
2393 *	Composite-3 or more surfaces, posterior- permanent	1/1	85	

* Effective 1/1/2007

PREVENTIVE SERVICES				
Code	**Procedure**	**Freq Limit**	**GP Allw**	**Spec Allw**
1100	***Dental Prophylaxis (cleaning)***			
1110	Dental prophylaxis-adult (13 and older)	2/C	39	
1120	Dental prophylaxis-child (12 and under)	2/C	34	
1200	***Fluoride Treatments (ages 3 through 12)***			
1203	Topical application of fluoride-child	2/C	14	
1300	***Other Preventive services***			
1351	Sealant - Per tooth (12 and under) -includes the application of sealants only to permanent molar teeth with occlusal surfaces intact, no caries, and with no previous restorations-initial application only	1/L	20	
1500	***Space Maintenance (passive appliances)***			
(12 and under) Prior approval required-limited to initial appliance and includes all necessary adjustments				
1510	Space Maintainer-fixed, unilateral	1/L	100	
1515	Space Maintainer-fixed, bilateral	1/L	140	
1550	Re-cementation of space maintainer	1/1	24	

mation will supersede the original form. Only the member may designate a beneficiary of the Survivors Benefit.

Hearing Aid Benefit

Who is eligible

Member and eligible dependents as defined by the Fund.

What is the Benefit

Upon the recommendation of a physician or audiologist, up to $400 will be paid by the Fund once every 36 months towards the cost of a hearing aid, including charges for its fitting.

Limitations

The Fund does not pay for any repairs to hearing aids, any non-durable equipment such as replacement batteries, nor any appliances or expenses not recommended or approved by a physician or audiologist. Benefits payable under Worker's Compensation, Medicaid or any other Government plan are not covered. This benefit is secondary to any benefit for hearing aids payable by you or your eligible dependents' basic health plan.

Claiming

Obtain a Hearing Aid claim form from the Fund office or request one from the Fund's website, www.scmebf.org. If your basic health plan currently covers this benefit, you must submit your expenses to that entity first and the Fund second. When submitting to the Fund you must enclose a copy of the explanation of benefits payment issued by your basic health plan in order for the Fund to adjudicate your claim. A bill for the hearing aid must also be attached. The claim will be subject to verification.

Dental Benefits

Who Is Eligible

Member and eligible dependents as defined by the Fund.

What is the Benefit

Members and their dependents are eligible for reimbursement for dental expenses in accordance with the Fund's established Schedule of Dental Benefits.

Limitations

Each active covered individual is subject to annual maximums of $2,250 for general dentistry, $2,000 for periodontal treatment and a separate lifetime maximum benefit of $2000 for implants (codes 6010, 6040 and 6050). These implant benefits (codes 6010, 6040, and 6050) do not count towards the annual maximum benefit for general dentistry or periodontal treatment. However, all other implant related services do count towards the general dentistry annual maximum benefit .
Adolescent and adult orthodontics are limited to a $1,995 lifetime maximum.

Retired members and their dependents, who remain in the basic level (no-cost) retiree plan, are limited to an annual maximum of $750 per family, with any one person not exceeding more than $500 for all dental services.

Claiming

Request a claim form from the Fund office, your payroll representative, dentist's office or download it from the Fund's website, www.scmebf.org. All sections must be completed.

If the procedure or series of treatments is covered and is expected to exceed $1,000**,** your dentist must file your claim form with the Fund as a Predetermination Request before treatment is commenced. Please be certain that the predetermination has been reviewed by the Fund before any treatment is begun. Payment for such treatment may not be made without this review.

In both cases, after any dental treatment is concluded, have your dentist complete the claim form or complete the reviewed predetermined claim form and return it to the Fund office. According to the Fund's policies, payment will be made to either you or your dentist.

It is important that you remember that an incomplete claim form will be returned to you for more information, which may cause a delay in your benefit payment. Be sure that all claim forms are completed and all of the necessary information has been included before filing. This is your statement that the services have been completed as described.

Never sign a blank claim form certifying that services have been received.

The Fund reserves the right to request and receive any additional information it deems necessary to properly make a determination on the claim.

Pre-determination Of Dental Benefits

Your Benefit Fund dental program has a Predetermination of Benefits feature for treatments that exceed $1,000. Your dentist is required to fill out a Predetermination Request and submit it with a properly mounted set of x-ray films and any other pertinent documentation for review by the Fund. Most dentists are familiar with this process. The predetermination process assures that both you and the dentist will know in advance what services are covered and what the Benefit Fund will pay. Predetermination is not intended to interfere with your dentist's professional judgment or to delay your receiving dental care. Rather, this process permits review of the proposed treatment in advance and allows for resolution of any questions before, rather than after, the work has been done.

Predetermination allowances are payable only after the following conditions are applied.

1) The claimant must be eligible for benefits when the described services are incurred. In the case of termination from the Fund, an expense is incurred when the service is performed, except in cases of:

DENTAL FEE SCHEDULE

Code	Procedure	* Freq Limit	GP Allw	Spec Allw
	DIAGNOSTIC SERVICES			
0100	***Clinical Oral Examinations***			
	Either 2 periodic exams (0120) or 1 periodic exam and 1 new patient exam general practitioner (0150) will be benefited in any calendar year.			
0120	Periodic oral exam	2/C	25	
0140	Limited oral exam/problem focused /emergency	1/C	30	
0150	Comprehensive oral exam/new patient	1/C	35	
0160	Extensive oral exam/new patient/specialist	1/C		25
0200	***Radiographs***			
0210	Complete series w/bitewings (10 or more)	1/3	45	
0220	Periapical/1st film	4/1	5	
0230	Periapical-each additional film	0 *	5	
0240	Intraoral occlusal film	2/3	10	
0270	Bitewing-single film	2/1	7	
0272	Bitewing-2 films	2/1	10	
0274	Bitewing-4 films	2/1	18	
0290	Posterior-anterior or lateral skull & facial film	1/1	18	20
0330	Panoramic-with or without additional films	1/3	35	
0340	Cephalometric Film	1/1	18	
0350	Oral Facial Films (orthodontist only)	1/L		20
0400	***Tests and Laboratory Examinations***			
	Verification of need required for payment			
0460	Pulp vitality test	1/1	15	
0470	Diagnostic Cast—Upper and /or lower	1/L	30	

* Effective 1/1/2007

FREQUENCY LIMIT ABBREVIATIONS

0	**No Frequency Limit**
1/C	**Once in a calendar year**
2/C	**Two times per calendar year**
1/6M	**Once per six months**
1/1	**Once per twelve months**
2/1	**Two times per twelve months**
4/1	**Four treatments per twelve months**
1/3	**Once per 36 months**
2/3	**Two times per 36 months**
1/4	**Once per 48 months**
1/5	**Once per 60 months**
1/L	**Once per patient lifetime**
6/L	**Six times per patient lifetime**
12/L	**Twelve times per patient lifetime**
18/L	**Eighteen times per patient lifetime**
24/L	**Twenty four times per patient lifetime**

Benefits listed under Spec Allw will be available when services are provided by Board Eligible or Board Certified specialists**.**

- Dentures, or fixed bridgework - when the final impression is taken;
- Crown work - when preparation of the tooth is begun;
- Root canal therapy - when root canal treatment is completed.

2) So long as there has not been a change in the plan of benefits prior to performance of the service that would thus vary the allowance indicated.
3) So long as the total benefit payments for all treatment of a patient in any benefit period does not exceed plan maximums.
4) The allowances may be reduced by Coordination of Benefits, if applicable, for each patient.

The Benefit Fund shall have the right to request that a member or his/her dependent undergo an oral examination by a dentist provided and paid for by the Fund to verify treatment recommended in a Predetermination review, or following treatment to determine the extent of services rendered. This requirement applies where clarifying information can only be obtained in this way. Failure to comply will result in forfeiture of benefits.

A pre-authorization issued by the Fund is valid for 12 months from the date of issue. (Example: issued 4/1/06 - approval expires on 3/31/07)

Periodic Review of Treatment

The Fund reserves the right to request dental patients be examined to assure that in all cases proper care, procedures and costs have been assigned. It periodically reviews prescribed courses of treatment in individual cases to determine whether the Alternate Benefit Provision should be authorized and payments limited accordingly.

Alternate Benefit Provision

If an alternate benefit can be provided, giving consideration to professionally acceptable alternate procedures, services or courses of treatment, the Fund will determine the amount of benefits payable that would accomplish the desired results. (The attending dentist and the patient may proceed with the original treatment plan regardless of the Fund's benefit determination.)

For example, a payment for a crown will not be allowed if an acceptable professional result can be obtained by placing a filling in the tooth. A payment will be made as if a filling was placed in the tooth that received the crown. Upon presentation of documentation satisfactory to the Fund that the tooth can only be restored by a crown, payment will be made for a crown.

The Fund retains the right to limit the number of payments to be made for dental services in circumstances that, in the Fund's sole judgment, require such limitation.

Participating Dental Program

The Fund has made arrangements with many local dentists who have agreed to accept the fees listed in this booklet as payment in full. However, this does not apply to implant services, ADA code series 6000 (see page 44 – 45). Should you decide to use one of the participating dentists, no charges will be made for any of the eligible dental services listed and payments will be made directly from the Fund to your dentist. Frequency limits and general exclusions remain the same no matter which dentist (participating or otherwise) you choose.

Participating dentists may charge you for services not listed in the Schedule of Dental Benefits, but such services should be infrequently encountered, if at all.

Please refer to the list of participating dentists for those offices accepting the Fund plan. Dentists who specialize in orthodontia, periodontia, endodontia or oral surgery are listed separately from general dentists. This list will be revised from time to time by the Fund so check with the Fund office to verify the status of the provider you have chosen.

Special Orthodontia Panel

The Fund has recently made arrangements with a separately enrolled panel of orthodontists who have agreed to limit their fee charged for a standard 24-month active orthodontia case to $2,995. The Fund will remit payment of up to $595 for the diagnostic and appliance insertion and up to $100 per month for 14 months, for a total payment from the Fund of $1,995 for the standard 24-month case, the current lifetime maximum for orthodontia. The balance of $1,000 is the **minimum** amount payable by the member ($50 per month for the 1st visit through the 20th visit) if one of these special orthodontia panelists is utilized for the standard 24-month case. If a special orthodontia panelist is utilized for a non standard (more than 24-months) case, the monthly fee will not exceed $100. The Fund's obligation, however, remains a maximum of $1,995.

Maximum Amount Payable

The maximum amount payable for each individual for the listed dental services will be $2,250 in any calendar year, exclusive of orthodontia or periodontia services, which have separate maximums of $2,000 in any calendar year for periodontia, either $1,995 in a lifetime for either adolescent or adult orthodontia.

Retirees who remain enrolled in the basic (no-cost) plan, have an all-inclusive annual maximum of $750 per family, with any one person not exceeding more than $500 for all dental services.

General Limitation of Covered Expenses

Covered dental expenses will not include and no payments will be made for, expenses incurred for the performance of any dental service not provided for in this schedule. In special instances, the Fund Trustees may agree to accept certain expenses as covered dental expenses. To submit the expenses to the Fund for consideration, the dental service should be identified in terms of the American Dental Association Uni-

Claim Form Essentials

Claim forms are processed more promptly when they are complete and accurate. The Fund's claims department constantly sees common omissions that result in delayed payment. The Fund strives to get you your payment as quickly as possible and you can help by using the checklist provided below.

- ☐ Is the member's social security number (not the patient's) correctly entered on the dental claim form?
- ☐ Does the claim form include the name of the dentist providing the service, his/her current Tax ID number and his/her signature?
- ☐ Did you use nicknames on the claim form? Unless the name is recognizable as one of the names on file with the Fund, chances are it will result in a returned claim.
- ☐ Is the patient's date of birth listed? Two members of the same family with the same name cannot be identified without it.
- ☐ Is each service listed separately on the form? Does it show the date of service, the proper ADA code, the tooth number (if applicable) and the charge for the specific dental procedure?
- ☐ Is there more than one patient on one claim form? Are there several patients' forms attached together? Only one claim form per patient can be processed and it's possible that several forms attached together can be missed. If you're attaching multiple claims, make sure you indicate it on the first claim.
- ☐ Did you attach a copy of the Explanation of Benefits (EOB) with the claim? If the Fund is not primary, you need this before the claim can be processed. Make sure all information is visible, including reasons why the primary carrier denied the service.
- ☐ If the service was pre-approved, is the approval form included? Without the approval form, the claim will be denied for not having been submitted for pre-approval.
- ☐ Did you check with your dentist prior to scheduling your appointment to make sure that you have met the frequency limits for the services that are to be provided?
- ☐ Is your family's enrollment up-to-date? Student verification, handicap status and new dependents must all be current before payment can be made.
- ☐ Did your dentist include additional information that might be helpful in making a favorable determination?

☐

SCHEDULE OF DENTAL FEES

form Code of Dental Procedures and Nomenclature (codes for covered services listed in the following schedule) and by narrative description. If expenses incurred for a dental service not expressly provided for in this Schedule are accepted by the Fund, the covered dental expense for that dental service will be determined while remaining consistent with those listed in this Schedule and will be conclusive and binding. In any event, expenses incurred for instruction for plaque control, oral hygiene instruction, bite registrations or for dental services that do not have uniform professional endorsement will not be accepted by the Benefit Fund as covered dental expenses.

A temporary dental service will be considered an integral part of the final dental service rather than a separate service. The Fund will not absorb or be responsible for any fees or charges that are owed by a member that exceed the benefits herein.

As a guide to members in their utilization of the Dental Benefit Plan, the following list specifies but does not limit the particular and general exclusions from the plan.

Payment will not be made for any expenses incurred:

1. For any services, supplies or treatment not prescribed by a legally qualified dentist or physician;
2. For services rendered prior to the patient becoming eligible for benefits;
3. For services completed after termination of coverage;
4. For any dental or surgical procedure performed solely or substantially for cosmetic reasons or to correct congenital or developmental malformations;
5. For procedures, restorations or appliances performed or fabricated solely for cosmetic purposes or to increase vertical dimension, to restore occlusion or to restore tooth structure lost by attrition or abrasion;
6. For replacement of an existing crown, inlay, onlay, fixed bridge or complete or partial removable denture until five years have elapsed from the date the service was originally completed and only if the crown, inlay, onlay, fixed bridge or complete or partial removable denture being replaced is unsatisfactory and cannot be made satisfactory;
7. For multiple abutting of teeth for prosthetic purposes when the additional teeth are free of decay and functionally sound or for prosthetic appliances, fixed or removable, placed for the purpose of periodontal splinting;
8. For charges for temporary crowns (unless tooth is fractured, and only on anterior teeth) or for temporary dental services which will be considered an integral part of the overall dental

service rather than a separate service;

9. For dental service performed by a dentist in which the Fund experiences an instance of unsatisfactory documentation or recording of services that is deemed detrimental to the Fund or the patient;
10. All periodontal treatment must be reviewed and approved for benefits prior to treatment. The most inclusive periodontal service includes all related services performed on the same date in the same area and payment will be made for the all-inclusive service only. For osseous surgery (ADA code 4260) and gingivectomy (ADA code 4210) performed on the same date, payment will be made for the all-inclusive osseous surgery;
11. For any benefit that is claimed after a period that exceeds one year from the calendar year in which dental services were rendered;
12. For replacement of a lost, stolen or missing appliance or prosthetic device or the fabrication of a spare appliance or device;
13. For dental supplies or services rendered for injuries or conditions compensable under Worker's Compensation, Employer's Liability laws or "no fault" automobile insurance laws; dental services provided by a Federal or State or Provincial government agency, i.e., Veteran's Administration Hospital or provided without cost to the covered individual by any municipality, county or political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable eligible dental benefits contained in this plan;
14. For dental supplies or services furnished by or for the United States Government or any local governmental agency or where reimbursement is made elsewhere;
15. For services where a charge is not incurred or payment is not required;
16. For dental services or supplies not listed or not consistent with the Schedule of Dental Benefits, unless the Fund reviews the services and accepts the expenses as Covered Dental Expenses. The Covered Dental Expense for such services will be determined by the Fund and will be consistent with those listed in the Schedule;
17. For treatment of disturbances of the temporomandibular joint or myofacial pain;
18. For treatment that does not meet currently accepted standards of dental procedures or treatments that are experimental in nature;

19. For adult orthodontic services provided when there is a cosmetic purpose and no severe malocclusion exists and/or functional problems exist. Interceptive and comprehensive orthodontic treatment for eligible dependent children 18 years of age and under will be a covered service, with supporting documentation showing need for service;
20. For analgesics (such as nitrous oxide) or other euphoric or prescription drugs; local anesthesia or drugs that desensitize teeth;
21. For any charges for broken appointments or completion of claim forms;
22. For any charges for hospitalization, including hospital visits, laboratory tests and/or laboratory examinations; all other services and treatments not specifically listed, as included in the Benefit Fund's dental plan.
23. No coverage for a fixed bridge where there are missing teeth on both sides of the same jaw. An alternative benefit of a partial denture will be allowed.

NOTE: Further information is available upon request. If you have any questions regarding the coverage, benefits or exclusions, please contact the Fund Office at (631) 319-4099.