DENTAL BENEFITS PROGRAM
2021

® GCC/IBT 243-C

EASTERN SUFFOLK BOCES
INTRODUCTION

This booklet is divided into four (4) sections in order to provide a ready and understandable reference for your use. The following is a brief outline of each section:

I. **Rules and Regulations** – This section contains the general eligibility requirements necessary for you to participate in the Dental Plan. Beside the rules for becoming eligible, this section contains the rules for continuing to be covered, termination of benefits and definition of dependents.

II. **Schedule of Benefits** – This section contains a summary of the specific benefits available for each participant.

III. **Description of Dental Expense Benefits** – This section describes in detail the protection afforded by the Dental Benefits.

IV. **General Plan Information** – This section explains the claim processing and appeal procedures. It also explains your rights upon termination of coverage, the Plan's Coordination of Benefits policy and third-party liability situations.

I. RULES AND REGULATIONS

INITIAL COVERAGE

Who is eligible for coverage under the Dental Plan?

All active full-time Management, Administrators, Supervisors, Teachers, Teaching Assistants, Teachers' Aides, Adult Nursing Instructors, Sign Language Interpreters and Civil Service Employees.

Should you not be working full-time on the day you would be eligible for benefits, the coverage for both you and your dependents will become effective when you return to full-time work.

Who are eligible dependents?

Your eligible dependents under the Dental Plan are:

a. Your lawful spouse.

b. Your unmarried children to age 19* (or their 25th birthday in case of full-time students enrolled in an accredited educational institution), provided they depend on you for support and maintenance and are not employed on a full-time basis. Proof of enrollment in any such educational institution is required twice a year.

c. The definition of "Children" includes adopted children (including a "proposed adopted child" during any waiting period prior to the finalization of the child's adoption) as well as your own natural children and stepchildren; provided they meet the above requirements in (b) above, and you are legally responsible for their medical expenses. Evidence of this responsibility will be required. Foster children and "Common Law Children" are not eligible for coverage under the Plan.

d. Furthermore, federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, QMCSO's are state orders or administrative orders requiring a parent to provide medical support to a child. For example, in cases of legal separation or divorce.

A QMCSO may require the Plan to make coverage available to your child even though, for income tax purposes or purposes of the Plan, the child is not your legal dependent. In order to qualify as a QMCSO, the Medical Child Support Order must be issued by a court or administrative agency, clearly specify the alternate recipient, reasonably describe the benefits to be provided to such alternate recipient, and clearly state the period to which the order applies.

Upon Plan approval of a QMCSO, a Plan is required to pay benefits directly to the child, or the child's custodial parent or legal guardian, pursuant to the terms of the order. You and the affected child will be notified if an order is received and you may receive a copy of the Plan's procedures for determining the status of a Qualified Medical Child Support Order, if you so request. A child covered under the Plan pursuant to a QMCSO will be treated as an eligible dependent under the Plan.

**A child who reaches age 19, who is physically or mentally incapable of self-support at that time and who is covered under the Plan on the date he/she reaches 19, may be continued to be covered under this Plan, provided your coverage is in force and the child remains incapacitated and meets the requirements in (b) above. Proof of incapacitation must be received by Sele-Dent, Inc within 31 days after the child's 19th birthday.*

BECOMING ELIGIBLE

Each person who is your dependent on the day you become eligible for coverage is eligible on that day. Every other person is eligible on the day that person becomes your dependent.

No new dependent will be recognized for coverage under the Plan until they have been reported to Eastern Suffolk BOCES by the participant. Appropriate documentation of eligibility as a covered dependent (i.e., birth certificate, marriage certificate, etc.) must be sent to Eastern Suffolk BOCES along with the notification. Enroll promptly for the coverage of your dependents. Your dependents will be covered on the day they become eligible. Coverage for dependents will begin:

a. On the day they become eligible, if you enroll for dependent coverage on or before that day

b. On the day you enroll them, if you enroll for dependent coverage within thirty-one days after the day, they are eligible.

If you have eligible dependents who you enroll more than thirty-one days after the date they become eligible, they will have:

a. A three-month waiting period until they are entitled to Type A services, and no Type B services will be covered until six months after the three-month waiting period has expired.

BECOMING COVERED

A person who is eligible for coverage under this plan as an employee may also be eligible as a dependent. In addition, if both you and your spouse are covered under this plan as employees, your children may be covered as dependents of both you and your spouse.

No one will be eligible to be covered as a dependent while in military service. (See termination of Coverage and Military Leave)

TERMINATION OF COVERAGE

When will coverage terminate?

The benefits for yourself and your eligible dependents will terminate as follows:

1. If you cease to be employed by Eastern Suffolk BOCES, your eligibility under the Dental plan terminates at the end of the month in which your employment terminates.
2. If the Plan or benefit is discontinued, your eligibility under the Dental Plan will be terminated as of the effective date of any such service.
3. A dependent's coverage will terminate when he or she is no longer an eligible dependent as defined by the Plan or when your coverage terminates.
4. If a participant takes a leave from employment for service in a designated arm of the Military, he /she can continue coverage under the Plan in accordance with the Uniformed Services of Employment and Re-employment Rights Act of 1994 (USERRA) for up to 18 months of military service. This participant must elect to keep said coverage and must pay the full cost of continuing his/her coverage. If the period of military service is less than 31 days, there will not be a change for this coverage. Additionally, a participant who elects USERRA coverage may not then elect COBRA coverage when USERRA coverage ends.

   Likewise, if a participant elects COBRA continuation coverage during this period, he/she may not then elect USERRA coverage when COBRA ends.

   Upon re-employment after such leave, a participant is entitled to have coverage under the Plan reinstated on the date he/she returns to work without a waiting period.

Should you be activated for military service, contact Eastern Suffolk BOCES.

What will happen to my coverage if I take a leave of absence pursuant to the Family and Medical Leave Act of 1993?
If you work for an employer who has 50 or more employees on each working day of 20 or more work weeks in a current or preceding year, your employer must maintain your dental benefits as if you had continued employment during your leave for a maximum of twelve weeks. You should contact Eastern Suffolk BOCES for details on your coverage during any FMLA leave.

What are my rights after termination of employment?
If your employment terminates for any reason, (except gross misconduct) you will be entitled to apply for COBRA (Continuation of Benefits) as explained on pages 9-10.

What happens if I cannot work due to illness or accident?
If you become disabled and are unable to work due to illness, accident, or Workers' Compensation, coverage will be continued for both you and your eligible dependents, for a period of 12 weeks from the date of your last day worked or until you are able to return to work, whichever occurs first. Eastern Suffolk BOCES reserves the right to require medical evidence of disability.

II. SCHEDULE OF BENEFITS

These benefits will be paid for covered services and supplies furnished by a dentist while you are covered.

In order to receive the benefits listed below, the participant must visit a participating Sele-Dent, Inc. dentist.

If you need the name of a participating dentist, please call Sele-Dent at 1-800-520-3368 or visit our website at www.Sele-dent.com

Sele-Dent has a significant number of participating providers in your area. If you are unable to locate a Sele-Dent participating provider, please call the Sele-Dent office and a knowledgeable, courteous benefit analyst will assist you. Please note, using a participating provider will save you and your family significant out of pocket expenses.

IN-NETWORK BENEFITS

Type A Services	**100%**
Type B Services	**100%**

There is no deductible for In-Network Services.

OUT-OF-NETWORK BENEFITS

Preventative and Diagnostic Services	**100%**
Type A Services	**80%**
Type B Services	**60%**

There is no deductible for Type A or Type B Services Out-of-Network, other than periodontic and orthodontic procedures*.

***Dental deductible for Type B (periodontic and orthodontic services):**

Dental Deductible Per Individual	**$25.00**
Dental Deductible Per Family	**$50.00**

Calendar Year Maximums: Effective 1/1/20 the calendar year maximum to $1,750 per individual per calendar year.

(There is a $500.00 Periodontic Maximum per year.)

Effective July 1, 2021

NEW ORTHODONTIC BENEFIT: A $2,000 Lifetime Orthodontic Maximum. Insertion of braces is paid at $500 and monthly payments of $62.50.

Invisalign will be covered through a dentist only and when treatments are done in an office with monthly or quarterly claim submission. SMILE DIRECT and other mail order trays are NOT covered.

NEW IMPLANT BENEFIT: There is a $1,000 Implant Benefit and ONE PER LIFETIME. $500 will be paid for the placement of the Implant, and $500 will be paid for the restoration with abutment and crown of Implant.

Preventive and Diagnostic Services

- Oral Examinations
- X-Rays
- Prophylaxis (including perio prophylaxis)
- Topical application of stannous fluoride
- Space Maintainers
- Fissure sealants per tooth

Type A Services for Out-Of-Network Benefits – not subject to plan deductible

- Oral Examinations
- X-Rays
- Amalgam Restorations
- Composite Restorations
- Recementing of inlays and crowns
- Pin retention
- Crown repair
- Adjustments and repairs made to dentures

Replacement of teeth or clasps on a denture
Addition of teeth or clasps to a denture
Rebasing, relining or recementing of a denture
Oral surgery
Palliative treatments
Administration of general anesthesia (in conjunction with oral surgery)
Consultations (when performed by a dentist other than the dentists performing the actual services)
Occlusal adjustments

Type B Services for Out-Of-Network Benefits

Gold Restorations
Inlays/On lays
Crowns
Prefabricated crowns
Crown buildups
Posts & Cores
All endodontic procedures
(including pulp caps, pulpotomies, all aspects of root canal therapy, apicoectomy and retrograde fillings)
All dentures
Tissue conditioning
Overdentures
All bridge crowns, bridge pontics, and cast metal retainers

*Orthodontic services – $25.00 deductible individual, $50 deductible family
*All periodontic procedures (excluding perio prophylaxis) – $25.00 deductible individual, $50 deductible family

III. DESCRIPTION OF DENTAL EXPENSE BENEFITS

Important Benefit Information

An expense will be incurred on the date the service is **performed** or the supply is **furnished**, not on the date the bill is received.

If, during the course of treatment, a patient is transferred from one dentist to another, or if more than one dentist renders service on one dental procedure, the benefits will be determined as though one dentist had furnished all treatment. However, each dentist rendering treatment is required to submit their own claim form.

Expenses Not Eligible Under Dental Coverage

The Plan does **not** cover:

1. Charges for procedures performed solely for cosmetic purposes, except for treatment of injury sustained in an accident occurring while the covered person is covered, and not excluded under any of the other listed exclusions.
2. Charge for services or supplies which are not medically indicated or reasonably necessary.
3. Charges for services rendered or supplies furnished by other than a dentist.
4. Charges in excess of the Fair and Reasonable charges in the area.
5. Expenses for services and supplies to the extent they are provided for under (a) any other plan for which any employer or union shall have paid any part of the cost or made or allowed collections, or (b) any government plan or law under which the individual is or could be covered.
6. Charges for the services and supplies (a) received in a U.S. Government hospital, (b) furnished elsewhere by or for the U.S. Government or (c) received in any governmental hospital or for other government-furnished care, unless the individual would have to pay the charges if not covered.
7. Expenses due to an act of war, (either declared or undeclared) occurring while the individual is covered.
8. Charges that fall under the parameter of any motor vehicle policy, whether or not such policy is required by law, including but not limited to “No Fault” Coverage.

9. Services rendered to you or a covered dependent by any of the following relatives:
    a. Spouse
    b. Parent(s) or parent(s) in-law
    c. Child(ren)
    d. Brother(s) or brother(s) in-law
    e. Sister(s) or sister(s) in law
    f. Grandparent(s)
10. Not covered for these items:
    a. Surgical Implants
    b. Retention appliances and visits
    c. Oral hygiene, dietary, plaque control and other educational programs
    d. Duplicate prosthetic appliances
    e. Porcelain veneered crowns or pontics placed on molars
    f. Temporary services
    g. Dental care for congenitally missing teeth
11. Due to loss or theft of dentures, bridges or appliances. Which a covered person would not legally have to pay if there were no coverage

IV. GENERAL PLAN INFORMATION

CLAIM PROCEDURES

1. When you know it is necessary for you to be treated by a dentist, simply instruct the dentist to provide a Universal Claim form. You complete the members portion of the claim form, and the dentist completes the rest. It is important that the members Social Security number be included on the form.
2. The completed original of the form should then be returned, by the member or the dentist, to; **Sele-Dent, Inc., One Huntington Quadrangle, Suite 1C12, Melville, NY 11747, Attn: Dental Claim Department**, for determination of eligibility and benefit authorization.
3. When the work is completed, the dentist will send the form to the claim administration office at Sele-Dent, Inc.

For all services, payment of the claim will be made directly to you, unless you have assigned the payment to the dentist, by completing the assignment section at the bottom of the claim form.

CLAIM APPEAL AND PROCEDURES

If your claim benefits are denied, in whole or in part, for any reason, the Plan will send you written notice of such denial. The notice will include the specific reason or reasons for the denial. If a denial takes place, you may appeal, in writing, to Sele-Dent, Inc. **within 60 days** after you receive the denial notice.

Your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL SELE-DENT'S DENIAL OF BENEFITS FOR ____________________DATED__________________." If this statement is not included, then Sele-Dent, Inc. may not understand that you are making an appeal as opposed to a general inquiry. You will be notified in writing of the results.

Sele-Dent's decision on your appeal will be made promptly and will not ordinarily be made more than sixty (60) days after the Plan received your written appeal, unless special circumstances require an extension of time for processing. In that case, a decision shall be rendered as soon as possible, but not later than 120 days after your appeal is received. Sele-Dent's decision on review will be in writing and will include specific reasons for the decision. The final decision will be that of Eastern Suffolk BOCES and shall be binding.

Sele-Dent is HIPAA compliant and protects and secures your Protected Health Information (PHI) and all sensitive information through physical and electronic safeguards.

PLAN INTERPRETATIONS AND DETERMINATIONS

Not withstanding any other provisions of this Plan, Eastern Suffolk BOCES is responsible for interpreting the Plan and for making determinations under the Plan. In order to carry this responsibility, Eastern Suffolk BOCES shall have exclusive authority and discretion:

- To determine whether an individual is eligible for any benefits under the Plan.
- To determine the amount of benefits, if any, an individual is entitled to from the Plan.
- To determine or find facts that are relevant to any claim for benefits from the Plan.
- To interpret all the Plan's provisions.
- To interpret all the provisions of the Summary Plan Description.
- To interpret the provision of any collective bargaining agreement or written participation agreement involving or impacting the Plan.
- To interpret the provisions of the Trust Agreement governing the operation of the Plan.
- To interpret all the provisions of any other document or instrument involving or impacting the Plan.
- To interpret all the terms used in this Plan and all the other previously mentioned agreements, documents, and instruments.
- To amend, modify, or discontinue all or part of the Plan whenever, in their sole and absolute discretion, conditions so warrant.

Cooperation

Every claimant will furnish to Sele-Dent, Inc. all such information in writing, as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. Failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of benefits. Eastern Suffolk BOCES will be sole judge of the standard of proof required in any case, and they may, from time to time, adopt such formulas, methods and procedures as they consider advisable.

Mailing Address of Claimant

If a claimant fails to inform Eastern Suffolk BOCES, of a change of address and Sele-Dent. Is unable to communicate with the claimant at the address last recorded by Sele-Dent, Inc. and a letter sent by first class mail to such claimant is returned, any payments due the claimant will be held without interest until payment can be successfully made.

Recovery of Payment

Sele-Dent, Inc. has the right to recover any overpayment or payment made in error to you or to a third party on your behalf, or any benefit payments made in reliance on any false or fraudulent statement, information or proof submitted. Such a recovery may be made by reducing

other benefit payments made to you or on your behalf, by commencing a legal action or by such other methods as the Trustees, in their sole and absolute discretion, determine to be appropriate.

Occasionally, a third party may be liable for your dental expense. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your dental bills. The rules in this section govern how this Plan pays all benefits in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there are questions of third-party liability, many months pass before the third party actually pays. These rules permit this Plan to pay your covered expenses and provide any other benefits to which you are entitled until your dispute with the third party is resolved.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, or that the Third Party settles the claim which gave rise to the injuries without admission of guilt, this Plan must be reimbursed for the relevant benefits it has advanced to you out of any recovery whatsoever that you receive that is, in any way, related to the event which caused you to incur the medical expenses.

COORDINATION WITH OTHER DENTAL PLANS

In the event a covered person under the Dental Plan is covered under another Dental plan provided through the auspices of any employer or educational institution, there will be a “coordination of benefits” regarding reimbursement by this Dental Plan.

This coordination will apply where an expense is incurred for a covered event, under this Dental Plan, which also is covered under the other plan. A determination will be made as to which plan is the “first” plan and which plan is the “second” plan. The method determining which is “first” is based on the following rules:

If the Dental Plan is the first such plan, it will pay it’s benefits as if there were no other such plan. If the Dental Plan is the second plan, it will pay it’s benefits as if there was no other plan except that this plan will pay no greater part of a charge covered by the Dental Plan and other plan(s) than that which when added to the part(s) payable by the other plans equal 100% of such charge.

1. A Plan covering a person as an employee will pay benefits first. A Plan covering a person as a dependent will pay second.
2. If a dependent child is covered by both parents’ Plans, the primary plan is the Plan which covers the child of the parent whose date of birth, excluding the year, occurs earlier in a calendar year. The secondary plan is the Plan which covers the child of the parent whose date of birth, excluding the year, occurs later in a calendar year. If a Plan containing the “birth date” rule is coordinated with a plan containing the gender-based rule and as a result, the Plans do not agree on the order to pay benefits, the gender-based rule will determine the order.

3. When the parents are divorced or legally separated the order is:
    a. The policy of the parent with custody pays first. The policy of the parent without custody pays second.
    b. If the parent with custody has remarried, the order is:
        i. The Plan of the parent with custody.
        ii. The Plan of the stepparent (custodial).
        iii. The Plan of the parent without custody.

However, if there is a court decree which specifically states the parent responsible for the child's dental care expenses, the Plan of that parent will pay first. That court order will supersede any order given above.

CONTINUATION OF COVERAGE (SELF PAY) AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (herein after COBRA) provides that you can continue dental care coverage for yourself and eligible dependents, if applicable, under certain circumstances where coverage would otherwise end (called "qualifying events"). This section outlines your rights and obligations with respect to continuation of the dental benefits provided under the Plan.

You have the right to choose continuation coverage if you lose your coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of a participant and you are covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group dental coverage under the Plan for any of the following three (3) reasons:

- The death of your spouse.
- Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with a contributing employer.
- Divorce from your spouse.

Dependent children of a participant covered under the Plan shall have the right to choose continuation of coverage if coverage under the Plan is lost for any of the following four (4) reasons:

- The death of the participant.

- The termination of the participating parent's employment (for reasons other than gross misconduct) or a reduction in the parent's hours of employment with a contributing employer.
- Parent's divorce.
- The dependent ceases to be a "dependent child" under the terms of the Plan.

A child born or placed for adoption with a participant during the period of the participant's continuation coverage is also eligible for COBRA coverage. Once the newborn or adopted child is enrolled for COBRA coverage, he/she will be treated like all other COBRA "qualified beneficiaries".

Under the law, the participant or eligible spouse, if applicable, must inform the Plan Administrator of a divorce within sixty (60) days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later.

When the Plan Administrator is notified of one of these events, you will be notified, in writing, that you have the right to choose COBRA coverage. Under the law, you or your eligible dependent, if applicable, must inform the Plan Administrator in writing that you want COBRA coverage within sixty (60) days of the latter:

- The date you or your eligible dependent ordinarily would have lost coverage because of one of the events described above.
- The date you receive notice of your right to elect continuation coverage.

If you choose COBRA coverage, you are entitled to coverage that is identical to the coverage being provided under the Plan to similarly situated participants (or their eligible dependents). If you lost group dental coverage because of a termination of employment or a reduction in hours, you can continue coverage for up to eighteen (18) months. In the case of other qualifying events, qualified dependents can continue COBRA for up to thirty-six (36) months.

An 18 month period of COBRA coverage may be extended for up to eleven (11) months (for a total of twenty nine (29) months of COBRA coverage) if the qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of the participant's termination or reduction of hours. The individual must notify the Plan Administrator within sixty (60) days of the determination (and within the initial eighteen (18) month COBRA period).

The eleven (11) month extension also will apply if the qualified beneficiary becomes disabled at any time within the first sixty (60) days of his/her initial eighteen (18) month period of continuation coverage, provided that the Plan Administrator is timely notified of the disability determination, as described above.

The twenty-nine (29) month extension is also available to a disabled qualified beneficiary's nondisabled family members who are entitled to COBRA coverage.

Additional qualifying events may occur while continuation coverage is in effect. Such events may extend an eighteen (18) month period of COBRA coverage to up to a total of thirty-six (36) months, but in no event will coverage extend beyond thirty-six (36) months.

The law also provides that your COBRA coverage may end before the expiration of the 18, 29, or 36-month period for any of the following five (5) reasons:

- The Plan no longer provides group dental coverage.
- The payment for your continuation coverage is not timely paid.
- The individual becomes covered under another group dental plan (as a participant or otherwise) that;
  - i. Does not contain a pre-existing condition, exclusion or limitation
  - ii. Contains a pre-existing condition exclusion or limitation but does not apply to the individual because he/she has at least twelve (12) months of creditable coverage (without a sixty-three (63) day, break in coverage) that counts toward the exclusion or limitation.
- Coverage has been extended for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

In order to continue coverage under the Plan, you must pay the cost of the COBRA coverage. There is an administration charge for COBRA coverage.

COBRA coverage is subject to your eligibility for coverage under the Plan. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible. Once your COBRA coverage terminates for any reason, it cannot be reinstated.

If you have any questions about COBRA continuation coverage, please contact the Plan Administrator at 1-800-520-DENTAL