PROFESSIONAL DENTAL CARE

Local 99 Health & Welfare Fund
Summary of Dental Benefits for Full-Time Employees at BASD
Effective Date: 1/1/2020

Provider Network:
New York & New Jersey: Sele-Dent network of providers
Outside New York & New Jersey: UNICARE network of providers
For assistance locating a participating provider, call Sele-Dent at 800-520-3368

Annual Maximum $1,250.00 individual, **No deductible.**
Ortho Lifetime Max $1,500.00, **Deductible** $100.00, Appliance $210.00, $60.00 monthly (No age limit)

Pre-Authorizations:
Any claims over $300.00 must be pre-authorized.

In Network Coverage:
- Preventive & Diagnostic Dental Procedures are paid at 100% of the network fee schedule.
- Basic and Major Dental Procedures are paid at 80% of the network fee schedule.

Out of Network Coverage:
- Preventive & Diagnostic Dental Procedures are paid at 100% of the Sele-Dent fee schedule*.
- Basic and Major Dental Procedures are paid at 80% of the Sele-Dent fee schedule*
  **Provider may balance bill the member for the difference between their charge and the Sele-Dent fee schedule, along with any applicable coinsurance.*

Benefit Maximums:
- **Examination:** 2 times in a calendar year
- **Prophylaxis:** 2 times in a calendar year
- **Bitewings:** 2 times in a calendar year
- **Full Mouth or Panoramic X-Rays:** Once every 2 years
- **Fluoride:** 2 times in a calendar year, up to age 15
- **Sealants:** No frequency, up to age 15
- **Perio:** Once every 6 months, all four quads same day, no prophy
- **Arrestin:** Once per tooth per calendar year
- **Osseous Surgery:** Once every 6 months
- **Major work:** 3 years replacement on major
- **Missing Tooth:** Covered

Exclusions:
- Implants and Veneers are not covered.
- Coverage is provided to employees only. Dependents are not covered.

Mailing Address:
One Huntington Quadrangle, Suite 1S03
Melville, NY 11747

Toll Free: (800) 520 - 3368
Phone: (516) 887 - 7566
Fax: (516) 887 - 7896

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, CALL 973-735-6464. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https.//www.healthcare.gov/sbc-glossary / or call 973-735-6464 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 In-Network $150 Out-Of-Network Individual $300 Out-of-Network Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/office visit	20% coinsurance	No coverage for hospital based/owned clinics.
	Specialist visit	$10 copay/visit	20% coinsurance	No coverage for hospital based/owned clinics.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Out of Network hospital not covered. Preauthorization is required for CT/PETS scans, MRIs. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.benecard.com	Generic drugs	$3 copay/prescription (retail) $10 copay/prescription (mail order)	Not Covered	Non-prescription OTC drugs not covered. Non-preferred brand name drugs are covered, if medically necessary. (retail and mail order) **Retail**: 14-day supply, limited to 2X per drugs every 6 mos. Mandatory Generic if available. **Mail Order**: 90-day supply **Specialty Drugs**: Preauthorization is required. Not covered at retail. No copay charge if enrolled in diabetic disease management program.
	Preferred brand drugs	$10 copay/prescription (retail) $15 copay/prescription (mail order)	Not Covered	
	Non-preferred brand drugs	$15 copay/prescription (retail & mail order)	Not Covered	
	Specialty drugs	$10 copay/prescription (mail order)	Not Covered	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	No coverage for out-of-network hospitals. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Physician/surgeon fees	No charge	20% coinsurance	Be aware, your network provider might use an out-of-network provider for some services (such as anesthesia). Check with your provider before you get services. Preauthorization is required.
If you need immediate medical attention	Emergency room care	$50 copay / visit	20% coinsurance	Emergency copay is waived if admitted. Emergency medical transportation: $750 limit per occurrence.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$10 copay/visit	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not Covered	120 days limit per occurrence. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Physician/surgeon fees	No charge	20% coinsurance	Be aware, your network provider might use an out-of-network provider for some services (such as anesthesia). Check with your provider before you get services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	Not Covered	**Outpatient services**: 30 visits limit per year. **Inpatient services**: 120 days limit per occurrence. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Inpatient services	No charge	Not Covered	
If you are pregnant	Office visits	$10 copay/ initial visit	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Normal delivery covered up to 48 hours, Cesarean section covered up to 96 hours. Preauthorization is required if stay is beyond 48 / 96 hours. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	Not Covered	

If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	90 visits limit per year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Rehabilitation services	Inpatient / No charge Out-patient / $10 copay / visit	Not Covered	**Inpatient services**: 30 days limit per year. Includes physical therapy, speech therapy, occupational therapy and cardiac rehabilitation. **Outpatient services**: 30 visits limit per year. Includes physical therapy, speech therapy, occupational therapy and cardiac rehabilitation. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered. **Habilitation services**: None
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	No charge	Not Covered	30 days limit per year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Durable medical equipment	No charge	20% coinsurance	Preauthorization is required in excess of $1000 or any rentals. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
	Hospice services	No charge	Not Covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	One exam year.
	Children's glasses	No charge	Charges in excess of $200	One pair of glasses every two years up to $200.
	Children's dental check-up	Not Covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery, Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
- Chiropractic Care, 30 visits limit per year, in-network only. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service or denied as not covered.
- Routine eye care (Adult), one exam limit per year. Eye Glasses limited to $200 every two years.
- Routine Foot Care covered for diabetics only.
- Weight Loss Programs as described in the Federal Preventive Guidelines.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Plan Administrator at 973-735-6464 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 973-735-6464.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see the plan or policy document at www.local99healthandwelfarefund.org

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	$0
Other coinsurance	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12686**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$660
The total Peg would pay is	**$680**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	$0
Other coinsurance	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,601**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$260
The total Joe would pay is	**$560**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	$0
Other coinsurance	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$190
The total Mia would pay is	**$290**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: begin.livongo.com/LOCAL99.

The plan would be responsible for the other costs of these EXAMPLE covered services.

*For more information about limitations and exceptions, see the plan or policy document at www.local99healthandwelfarefund.org

LOCAL 99 Health & Welfare Fund

Alberto Arroyo, Chairperson
Debra Rich, Executive Director

TRUSTEES:
Angela Bialorucki
Martin Canturiano
Cecilia Gomez
Cleveland Jenkins
Kevin McCann
Maricarmen Molina

Date: May 2022

To: All Participants in the Local 99 Health & Welfare Fund and their covered dependents
All COBRA Continuation of Coverage participants and their covered dependents

VISION BENEFITS

Participants in the Local 99 Health and Welfare Fund ("Fund") and their covered dependents have coverage for routine vision services. Services eligible for coverage under the vision benefit include a vision exam and the purchase of frames, lenses and/or contacts. Coverage is limited to a maximum payment amount. Claims with dates of service through May 31, 2022 are subject to a maximum benefit of $200 every two years. Effective June 1, 2022, based on the date of service, the maximum payment will increase to $225 every two years. Coverage details and tips for maximizing this benefit are included below.

Vision Exam – Blue Cross and Blue Shield Participating Provider:
Fund Participants and their covered dependents may visit a participating BCBS ophthalmologist for an annual vision exam. Vision exams performed by a participating BCBS provider are covered at the office visit copay, subject to a limit of one routine exam per year*. If corrective lenses are required, the ophthalmologist will provide the patient with a prescription that can be taken to any optical center. Vision exams provided by participating BCBS providers are processed under the medical plan and not subject to the maximum payment amount available for vision services.

**The annual visit limit does not apply to non-routine optical exams. Non-routine exams may be related to an optical injury or a medical condition such as glaucoma or diabetic retinopathy.*

Vision Exam – Optical Center:
Fund Participants and their covered dependents may obtain a vision exam from any optical center; however, the cost of the exam will be deducted from the maximum vision benefit. Under this option, Fund participants and/or their covered dependents pay for the visit and any related supplies (lenses, frames and/or contacts) and submit receipt to the Fund office for reimbursement*. Upon receipt, the Fund will verify eligibility and benefits and reimburse the Fund participant up to the maximum available vision benefit. Using an optical center for the exam itself will reduce the amount you have to spend on the supplies.

**Retain a copy of the receipt for your records.*

Vision Supplies (Lenses, Frames, and Contacts): Fund participants and their covered dependents may obtain corrective lenses from any provider. For example, this includes freestanding optical centers, such as Visionworks or optical centers located within larger retailers, such as Costco, BJs, and Walmart. Fund participants and/or their covered dependents will pay for the lenses, frames, and/or contacts and submit receipt to our office for reimbursement*. Upon receipt, the Fund will verify eligibility and benefits and reimburse the Fund participant up to the maximum available vision benefit.

**Retain a copy of the receipt for your records.*

Reimbursement Requests: A vision reimbursement form is available but not required. Fund participants and their covered dependents may simply mail, fax, or email receipt to our office at the following address. Make sure the receipt lists the patient's name, service date and an itemization of the services/supplies provided.

Local 99 Health and Welfare Fund
Attention: Tara Carter
703 McCarter Highway
Newark, NJ 07102
Email: tcarter@local99healthfund.org

Alberto Arroyo, Chairperson
Debra Rich, Executive Director

TRUSTEES:
Angela Bialorucki
Martin Canturiano
Cecilia Gomez
Cleveland Jenkins
Kevin McCann
Maricarmen Molina

Vision Reimbursement Form

Instructions: Complete all portions of this form, mail, fax or email it to the address below along with the itemized receipt. Please note: This form is to be used for vision claims only.

Local 99 Health & Welfare Fund
Attention: Tara Carter
703 McCarter Highway
Newark, NJ 07102
Fax#: 973-735-6465
Email: tcarter@local99healthfund.org

Member Name	
Member ID or SSN	
Address	
Daytime Phone Number	
Patient Name ***(if other than the member)***	
Patient Date of Birth	
Patient Relationship to Member	□ Self □ Spouse □ Child

LOCAL 99 HEALTH AND WELFARE FUND
MEDICAL & DENTAL ENROLLMENT FORM
Employer: Bethlehem Area School District

For Employer Use Only:	Employee's Eligibility Date:

ENROLLMENT REASON (CHECK ONE):	☐ NEW HIRE OR NEWLY ELIGIBLE	☐ OPEN ENROLLMENT	☐ QUALIFYING EVENT

EMPLOYEE INFORMATION				
LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**	**SOCIAL SECURITY #**	**DATE OF BIRTH (MM/DD/YYYY)**

GENDER	MARITAL STATUS	DAYTIME/CELL PHONE NUMBER	HOME PHONE NUMBER
☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED		

HOME ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	HIRE DATE

ARE YOU COVERED UNDER MEDICARE, MEDICAID, OR ANOTHER HEALTH INSURANCE CARRIER? ☐ YES (PROVIDE DETAILS BELOW) ☐ NO			
CARRIER NAME		**POLICY NUMBER**	
POLICY HOLDER NAME		**COVERAGE EFFECTIVE DATE**	

PLEASE USE THE CHART BELOW TO INDICATE YOUR BENEFIT SELECTION

COVERAGE TYPE	EMPLOYEE ONLY	FAMILY	NO COVERAGE
Medical & Dental	☐	☐	☐ **I am opting out of coverage under the Local 99 Health & Welfare Fund. I understand that if I do not have Hospital/Medical coverage I may be subject to penalties under the federal individual mandate of the Affordable Care Act.* **I have coverage through the following:** ☐ Spouse ☐ Medicaid ☐ Other _____

Dependents (Complete this section only if you selected Family coverage):

Name of Dependent	Social Security Number	Relationship to Worker	Date of Birth	Gender	Other Health Coverage?	Other Health Carrier Name and Policy Number (if applicable)
				☐ Male ☐ Female	☐ Yes ☐ No	
				☐ Male ☐ Female	☐ Yes ☐ No	
				☐ Male ☐ Female	☐ Yes ☐ No	
				☐ Male ☐ Female	☐ Yes ☐ No	
				☐ Male ☐ Female	☐ Yes ☐ No	
				☐ Male ☐ Female	☐ Yes ☐ No	

Authorization & Certification

By Signing below, I certify that the information I have provided is complete and true to the best of my knowledge.

Employee Signature **Date Signed**