Law Enforcement Health Benefits, Inc.

Dental & Vision Member Benefits

215-364-3529

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Member Dental Benefits

Members will continue to be **COVERED** as long as they are in **ACTIVE STATUS**. **BENEFITS** will **TERMINATE** due to a **Resignation, Dismissal**, or **ALL Leave of Absences, except for Family Medical Leave of Absence & Military Leave of Absence (Post 911) War on Terrorism.**
RETIRED Police Officers and their eligible dependents as determined by the September 2010 Healthcare Reform Act will be provided coverage for their current contractual five years plus additional time derived from converting accumulated sick time.

DEPENDENTS ELIGIBLE FOR ENROLLMENT

Your legal spouse and all biological or adopted children under 26 years of age are eligible for enrollment. LEHB requires a copy of the birth certificate or adoption papers listing the covered member's first and last name. A dependent child's benefits will terminate the last day of the month of their 26th Birthday.
A child, who is physically or mentally incapable of self-support prior to attaining age 19, may be continued under the plan while remaining incapacitated, subject to your own coverage continuing in effect. A letter of verification (Independence Blue Cross disability form) is required on an annual basis from the dependent's physician.

DENTAL BENEFITS

Selecting a dentist:

- Member may select any dentist to provide services; however, using a LEHB Dental Network Provider will minimize member out of pocket expenses.
- If a member selects a participating LEHB dentist listed in our provider book, the member will enjoy the highest level of dental benefits at the lowest possible cost.
- Members will receive an explanation of benefits form (EOB) which will indicate:
    - When member is eligible for next routine dental exam
    - Balance remaining in annual dental cap (January-December)
- If member is unclear if eligible for routine dental exam, please call (215) 364-3529.
- Confirmation number is not required to process and pay claims.

Non-participating dentist:

- If member selects to have dental services rendered by a non-participating dentist, not listed in the LEHB provider book, the member could incur out of pocket expenses.
- LEHB will reimburse the member, upon receipt of proper documentation, 75% of the LEHB allowable rate for that specific service. The member should understand that a non-participating dentist is allowed to collect the full charged amount from the member.
  - Example; Member receives dental services from a non-participating dentist. The non-participating dentist charges $100.00. The LEHB allowable rate for that service paid to a participating dentist is $75.00 and accepted as payment in full.
- This means when LEHB receives the proper documentation from the member using a non-participating dentist LEHB will then process the member reimbursement at 75% of the $75.00 allowable rate, which is $56.25. The member would then incur $43.75 out of pocket expense for one specific service rendered by a non-participating dentist.

Participating Dentist:

Members using participating LEHB dentists will have no office visit copay and no out of pocket deductibles, as long as you do not exceed your annual maximum dental allowance.

If a medical specialist provides dental care such as an oral surgeon then the services are covered by Blue Cross and the member will incur a $25.00 copay per visit.

Member copay applies if porcelain crowns are requested on molars.

- A $75.00 member copay is required if the member request porcelain crowns on molar teeth (12). Copay would apply for each molar. There will be no copay if the normal crowns are used.

Office visits and Prophylaxis

- Not more than once in any period of six consecutive months
- Not within 90 days of Periodontal maintenance and Scalings

Scalings

- Not more than once in 5 years.
- Not within 90 days of Prophylaxis or Periodontal maintenance.

Periodontal Maintenance

- Not within 90 days of Prophylaxis or Scalings.

Fluoride Treatment

- For unmarried eligible dependent children under age 19, but not more than once in any period of six consecutive months.

Sealants

- Molar teeth only for unmarried eligible dependent children under age 17 and payable one time.

X-rays

- Additional films (up to 12) once every 4 years
- Intra-oral occlusal view
    - Once every 12 months
- Bitewing films
    - Every 12 months
- Panoramic survey
    - Once every 4 years

Adjustments to Dentures

- Covered six months after insertion
    - Not more than one reline or rebasing in any period of 36 consecutive months
- Replacement of an existing partial or full denture or bridge by a new bridge (Only if satisfactory evidence is presented that the existing denture or bridge is at least 5 years old, and the existing denture or bridge is not serviceable and cannot be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services, which are necessary to render such appliance serviceable.)
- Replacement of crowns, inlays and onlays (only if satisfactory evidence is presented that it is at least 5 years old and is not serviceable and cannot be made serviceable.)

Pre-authorization is required for all major dental services over $275.00 and services listed below:

- All major dental claims $275.00 and over must be pre-certified.
- Properly mounted x-rays must accompany these claims.
- Doctor must submit treatment plan with pre-operative x-rays
- Pre-authorization required for periodontics over $100.00
- Services requiring pre-authorization:
    - All major treatment plans of $275.00 or more
    - Prosthetic crowns, bridges, dentures
    - Periodontics over $100.00
        - Dr. must submit treatment plan with pre-operative x-rays and/or charting for periodontal work.
        - **Periodontics costing over $100.00 require pre-authorization.**
        - If a pre-authorization is not obtained by the treating dentist prior to treatment, the claim will be rejected and the LEHB member will be held harmless.
    - Orthodontics—**ONLY COVERED UP TO DAY OF 19TH BIRTHDAY**
        - FIRST PHASE NOT COVERED
    - Endodontics may be performed without pre-authorization; however, pre-op and post-op x-rays must accompany claims for payment.
    - Extractions of six or more teeth except for emergencies.

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ANNUAL MAXIMUM DENTAL ALLOWANCE

The yearly maximum dental allowance payable by the LEHB Dental Fund is $4,000.00 per year per covered person for all allowable procedures with the exceptions of orthodontics. Your annual allowance will correspond to the calendar year, beginning January 1st and ending December 31st.

- Your LEHB Dental Explanation of Benefits will notify member of annual dollars used.

Orthodontics (braces) (Unmarried eligible dependent children up to 18 years of age ONLY)

- Orthodontics require pre-authorization
- No copay or deducible would be incurred when using a LEHB participating orthodontist.
- Maximum allowable payment is $3,000.00 when selecting a participating LEHB orthodontist, which will be accepted as payment in full by participating LEHB orthodontist.
- This does not include Phase I treatment which is the responsibility of the member. A financial agreement should be signed by the member with the treating orthodontist before Phase I treatment is started.
- Phase I treatment is not covered for all orthodontic cases. Please discuss possible alternative treatments with your doctor or seek a second opinion before agreeing to Phase I treatment.
- If you select a non-participating orthodontist, the LEHB Dental Fund (upon receipt of proper documentation) will reimburse the member $2,400.00 and the member will be responsible for any balance billed by the non-participating orthodontist.
- Orthodontic benefits are paid over the (normal) two year period. If, for some reason, the unmarried eligible dependent is terminated with the LEHB Dental Fund, the orthodontic payments will be terminated and you will be responsible for the balance due at time of treatment.

Extractions

- Pre-authorization required for extraction of six (6) or more teeth (except for emergencies)
- Note: Properly mounted x-rays must accompany all pre-authorization services

Implants

- Pre-authorizations for Implants are highly recommended. Implant Abutment and Crown NOT covered.

Implants may be partially covered in lieu of bridge. Please call LEHB (215) 364-3529 for terms and conditions of coverage and your financial responsibility.

Member Vision Benefits

Members will continue to be **COVERED** as long as they are in **ACTIVE STATUS**. **BENEFITS** will **TERMINATE** due to a **Resignation, Dismissal**, or **ALL Leave of Absences, except for Family Medical Leave of Absence & Military Leave of Absence (Post 911) War on Terrorism.**

RETIRED Police Officers and Unmarried Eligible Dependents are COVERED for FIVE (5) YEARS plus any additional years converted from sick time.

DEPENDENTS ELIGIBLE FOR ENROLLMENT

Your legal spouse and all biological or adopted children under 26 years of age are eligible for enrollment. LEHB requires a copy of the birth certificate or adoption papers listing the covered member's first and last name. A dependent child's benefits will terminate the last day of the month of their 26th Birthday.

A child, who is physically or mentally incapable of self-support prior to attaining age 19, may be continued under the plan while remaining incapacitated, subject to your own coverage continuing in effect. A letter of verification (Independence Blue Cross disability form) is required on an annual basis from the dependent's physician.

VISION BENEFITS

The LEHB Vision Fund helps promote good eyesight for you and your family. It also aims to minimize the development of more severe vision problems, which could lead to blindness and/or other long-term deficiencies. The LEHB Vision Fund strongly urges you and your family to maintain routine vision check-ups.

- Members will receive an explanation of benefits form (EOB) which will indicate when a patient is eligible for next routine eye exam.
- If member is unclear if eligible for routine eye exam please call (215) 364-3529
- Confirmation number is not required to process and pay claims
- Member should only use vision providers who post frame cost on frames.

FREE CHOICE OF VISION CARE PROVIDERS

By selecting a LEHB participating vision provider you minimize your out of pocket expense and are guaranteed to receive the highest level of care by maximizing the vision benefits.

We have an available list of participating vision providers either on (www.lehb.org). The participating providers have agreed to accept the LEHB vision payment as payment in full for a complete eye examination and a pair of basic eyeglasses. Extra charges may apply if designer frames, contact lenses, and/or special spectacle lens options are selected. Out of Network vision providers will be reimbursed 75% of allowed rate.

NON-PARTICIPATING EYE DOCTORS.

- If member elects to have vision services rendered by a non-participating provider, not listed in the LEHB provider directory, the member could incur out of pocket expenses.
- LEHB will reimburse the member, upon receipt of proper documentation, 75%

of the LEHB allowable rate for that specific service. The member should understand that a non-participating provider is allowed to collect the full charged amount from the member.

- Example: Member receives services from a non-participating provider. The non-participating provider charges $100.00. The LEHB allowable rate for that service paid to a participating provider is $75.00 and accepted as payment in full.

- This means when LEHB receives the proper documentation from the member using a non-participating provider, LEHB will then process the member reimbursement at 75% of the $75.00 allowable rate, which is $56.25. The member would then incur $43.75 out of pocket expense for one specific service rendered by a non-participating dentist.

FREQUENCY OF BENEFITS

All eligible employees, spouses' and unmarried eligible dependent children are eligible for the following vision benefits:

- Vision Exam
  - Optometrist: $50.00
  - Ophthalmologist: $57.00
  - Once every 12 months
  - Each exam shall consist of but not be limited to:
    1. A complete history of patient
    2. External examination of the eyes and adnexa, papillary reflexes, cover test ocular motilities, convergence near point
    3. Ophthalmoscopy
    4. Biomicroscopy
    5. Tonometry
    6. Refraction
    7. Stereopsis testing
       - Color vision testing

VISION FEE SCHEDULE----SERVICE MAXIMUM ALLOWANCE

Frames (prescription required) —once every 12 months from date of eligible

- Wholesale cost $50.00
- **Participating provider must supply a minimum of 100 frames that will be completely covered by allowance.**

Lenses—once every 12 months from date of eligible

- Single vision $40.00
- Bifocal $50.00
- Trifocal $60.00*
- Progressive $100.00*
- Lenticular $100.00 (with prior approval)

submitted with lab bill

Contacts—once every 12 months in lieu of frames and lenses from date of

eligible

- LEHB will reimburse provider
  - Contact lenses $100.00
  - Therapeutic Contacts $175.00 (with prior approval)

Participating providers agree to charge a maximum of no more than $50.00 for standard 2-week disposable soft contact lenses; i.e. the eligible member or dependent should not be charged more than $50.00 towards their contact lens and exam fee total fee.

$50.00 Exam fee paid for by LEHB
$100.00 Contact lens fee paid for by LEHB
$50.00 From member
$200.00 Global contact lens fee

The global contact lens fee (eye examination, contact lens fitting, 4 boxes of contact lenses, care kit, and 6 months follow-up care) should not exceed $200.00 for a standard 2-week modality soft contact lens.

Lens Options

- Polycarbonates $15.00 paid by LEHB

VISION PLAN EXCLUSIONS

NO PORTION of the materials of related fees will be paid under this plan for the following:

- Field Vision Test
- Medical or Surgical treatment for the eyes
- Repair Charges
- Retinal Photography
- Replacement of scratched, lost or broken lenses or frames
- Sunglasses

The following lenses or lens options are not covered under your vision plan. You are urged to discuss the costs of these items prior to making your selection, since you are responsible for full payment directly to the provider.

- Plain Lenses (non-prescription)
- Anti-reflective lenses or coating
- Polarized lenses
- Mirror coated lenses
- Ultra violet coating
- Faceted edging
- Oversized lenses 58 eye size and above or E.D. 64mm/over
- Tinting
- Scratch coating
- Photochromic lenses
- Hi-index thin lenses

IMPORTANT NOTE:

Glasses and/or contact lenses will not be funded unless the prescription is a **.50 DIOPTER OR GREATER** in any one field, sphere, cylinder or both.

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