CASEBP

CATSKILL AREA SCHOOLS EMPLOYEE BENEFIT PLAN

SERVICES	MID-LEVEL PLAN	HIGH-LEVEL PLAN
Exams		
Initial Oral Exam	100% of NDAS	100% of NDAS
Periodic Exam	100% of NDAS	100% of NDAS
X-Rays		
X-rays-routine (two sets in any twelve-month period)	100% of NDAS	100% of NDAS
X-rays-non-routine (as needed)	100% of NDAS	100% of NDAS
Panoramic x-ray (one every 36 months)	100% of NDAS	100% of NDAS
Periodontal Cleaning-two per calendar year	100% of NDAS	100% of NDAS
Cleaning (Prophylaxis)-two per calendar year		
Child	100% of NDAS	100% of NDAS
Adult	100% of NDAS	100% of NDAS
Fluoride (two per Plan year)	100% of NDAS	100% of NDAS
Restorations (Fillings)	80% of NDAS	100% of NDAS
Crowns	80% of NDAS	80% of NDAS
Bridges	80% of NDAS	80% of NDAS
Dental Implants	Not Covered	80% of NDAS
Pulp Capping (Direct)	80% of NDAS	100% of NDAS
Root Canals	80% of NDAS	100% of NDAS
Dentures	80% of NDAS	80% of NDAS
Oral Surgery	80% of NDAS	100% of NDAS
Extractions	80% of NDAS	100% of NDAS
Palliative Emergency	80% of NDAS	100% of NDAS
Space Maintainers	80% of NDAS	100% of NDAS
Inlay Restorations	80% of NDAS	100% of NDAS
Surgical Extraction	80% of NDAS	100% of NDAS
Periodontal Services		
Alveoplasty/Extract	80% of NDAS	100% of NDAS
Gingival Scaling	80% of NDAS	100% of NDAS
Gigivectomy	80% of NDAS	100% of NDAS
Osseous Surgery	80% of NDAS	100% of NDAS
Orthodontic Benefits	Paid at 50% to a lifetime maximum of $4,400.00 (up to age 19)	Paid at 75% to a lifetime maximum of $4,400.00 (any age)
Calendar Year Maximum	None	$4,290.00
Dependents	Age 26	Age 26

If you expect a single dental treatment to cost more than $600.00, you must obtain a pre-treatment estimate from your Professional Provider before the treatment begins.

CASEBP

CATSKILL AREA SCHOOLS EMPLOYEE BENEFIT PLAN

THIS IS NOT A FULL BENEFIT COMPARISON BUT A GENERAL OVERVIEW OF THE PLANS OFFERED AT CASEBP AND THE CURRENT PLAN. FULL BREAKDOWN OF COVERAGE CAN BE FOUND IN THE CASEBP PLAN DOCUMENTS, AND

https://www.oncboces.org/DentalPlanDocuments.aspx.

THIS IS NOT A GUARANTEE OF BENEFITS OR REIMBURSEMENT. CLAIMS ARE PROCESSED ON THE DATE RECEIVED AND ACCORDING TO THE PLAN GUIDELINES.

Mid-Level Plan has no annual maximum for non-orthodontic care. Charges are paid at the 50th percentile of the National Dental Advisory Service (NDAS), 80th percentile of NDAS for the High-Level Plan.

*CASEBP premiums are effective as of July 1st, 2023.

	Mid-Level	High-Level
Annual Premium		
Individual	$587	$780
Two-Person	$1,284	$1,551
Family	$1,284	$2,395

Check if your dentist/dental practice participates with Ameritas

https://dentalnetwork.ameritas.com/

Classic = mid-level plan Plus = high-level plan

CASEBP
DENTAL PLAN

MEMBERSHIP APPLICATION

ALL INFORMATION MUST BE PROVIDED. PLEASE TYPE OR PRINT IN INK.

PLEASE INDICATE: NEW ADDITION__X__ EXISTING SUBSCRIBER_____ TERMINATION_____

LAST NAME	FIRST	INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	C/O		COUNTY
CITY	STATE	ZIP CODE	PHONE #
SEX __MALE __FEMALE	DATE OF BIRTH MO DAY YR	MARITAL STATUS __SINGLE __MARRIED	MARRIAGE DATE MO DAY YR
NAME OF EMPLOYER Middleburgh Central School			EMPLOYMENT DATE
ADDRESS OF EMPLOYER 291 Main Street Middleburgh, NY 12122		FEDERAL MEDICARE CLAIM NUMBER: __MEDICARE PART A EFFEC. DATE_____ __MEDICARE PART B EFFEC. DATE_____	

Check desired coverage: __INDIVIDUAL __2-PERSON __FAMILY

__HIGH-LEVEL PLAN __MID-LEVEL PLAN

LIST BELOW ALL ELIGIBLE DEPENDENTS IN ORDER OF AGE
PLEASE NOTE: INCOMPLETE INFORMATION COULD RESULT IN CLAIM DENIALS

LAST NAME	FIRST	DATE OF BIRTH MO DAY YR	RELATIONSHIP (HUSBAND, WIFE, SON, OR DAUGHTER)	SOCIAL SECURITY #	IS MEMBER DISABLED

On the effective date of this contract, do you or your spouse have coverage through another **MEDICAL HEALTH PLAN**?
__Yes __No **If yes**, indicate Carrier_____
Name of Policyholder_____
Individual Contract_____ Family Contract_____

On the effective date of this contract, do you or your spouse have coverage through another **DENTAL PLAN**?
__Yes __No **If yes**, indicate Carrier_____
Name of Policyholder_____
Individual Contract_____ Family Contract_____

The above information is true and correct to the best of my knowledge. If any information pertaining to this application changes, I will notify my employer immediately.

SIGNATURE_____ DATE_____

EMPLOYER STATEMENT: Work Status: ___Full-time ___Part-time ___On Leave ___Retired (date) _____

Date of Employment: _____ Dental Effective Date: 7/1/2023 Termination Date: _____

Employer Representative: _____ Date: _____

Middleburgh CENTRAL SCHOOL DISTRICT

Ameritas

AUTHORIZATION FOR VOLUNTARY DEDUCTION
DENTAL INSURANCE
2023/2024 SCHOOL YEAR

Check Desired Plan:

☐ Mid-Level (Classic) Plan

☐ High-Level (Plus) Plan

Check Desired Coverage:

☐ Individual ☐ Family

☐ 2 Person

I, _____ hereby authorize

(Please print Employee Name)

Middleburgh Central School District to deduct the following:

$_____ from my dental reimbursement account for my dental insurance premiums.

$_____ from my paycheck for my dental insurance premiums in the 2023/2024 school year. I understand that this amount will be divided equally over 20 pay periods.

In the event that my employment ends for any reason, any remaining balance due will be deducted from my final paycheck. If there is not a final paycheck, I agree to reimburse Middleburgh Central School District for the premiums paid on my behalf.

_____ _____

Employee Signature Date

To find a participating Dentist, please visit:
https://dentalnetwork.ameritas.com/

2023/2024 Dental Insurance Rates

Cost per Year (12 month, July 1 - June 30)			
Plan/Coverage	Individual	2 Person	Family
Mid-Level	$ 588	$ 1,284	$ 1,284
High-Level	$ 780	$ 1,548	$ 2,400