Other Endodontic/Periradicular Services

Pulpotomy, deciduous teeth only
(1 per tooth per lifetime) ..... $ 65.00
Apicoectomy, 1st root *(1 per lifetime)* $200.00
Apicoectomy, each additional root $100.00
(General Anesthesia/IV sedation covered with Apicoectomy)
Retrograde filling, per root, in conjunction with apicoectomy *(1 per lifetime)* ..... $ 75.00

PERIODONTICS

Gingivectomy and Osseous surgery will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. The treatment plan must be accompanied by periodontal charting for osseous surgery and gingivectomy. Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance will be made on a quadrant or sextant basis. Periodontic benefits are not usually paid for procedures performed on patients under 19 years of age. Exceptions can be made based on documented medical necessity.

Gingivectomy or gingivoplasty per quadrant
(1 per 5 years) $325.00
Osseous surgery, per quadrant
(1 per 5 years) $625.00
Periodontal scaling and root planning,
per quadrant *(2 times per calendar year, limited to 2 quadrants per visit)* .....$ 38.00
Periodontal maintenance procedure
(2 per calendar year, either prophylaxis ***or*** *periodontal maintenance procedure)* .....$ 70.00

PROSTHODONTICS (REMOVABLE)

A benefit will be paid for a permanent denture replacing an interim denture after 6 months but no longer than 12 months from the date the interim denture was inserted. The Plan will pay for no other installation within the next 5 year period. Benefits are payable upon insertion. Allowance includes post delivery care, relines and adjustments for 6 months.

Complete Dentures *(1 per 5 years)*

Full upper or lower denture (permanent) $750.00
Full upper or lower denture, implant/abutment supported $750.00
Full upper or lower denture (interim) $220.00

Partial Dentures *(1 per 5 years)*

Partial upper or lower denture, permanent $750.00
Partial upper or lower denture, implant/abutment supported $750.00
Unilateral partial denture, permanent $400.00
Partial upper or lower denture, interim
(anterior teeth only) $220.00

Repairs to Full/Complete Dentures

Repair broken complete denture base .....$ 100.00
Replace missing or broken teeth
(limited to 4 per calendar year) .....$ 60.00

Repairs to Partial Dentures

Repair resin denture base .....$ 90.00
Repair cast framework ..... $ 90.00
Repair, replace or add clasp to existing partial
(limited to 4 per calendar year) ..... $ 65.00
Replace or add tooth to existing partial
(limited to 4 per calendar year) ..... $ 60.00

Rebase Full Denture - *(1 per 2 years)*

Rebase (full denture only) maxillary or mandibular $200.00

Reline of Dentures *(1 per 2 years)*

Reline full denture $180.00
Reline partial denture $180.00

PROSTHODONTICS (FIXED)

All fixed bridge units will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion of the fixed bridge.

Pontics *(1 per 5 years)*

Cast metal, full $400.00
Porcelain fused to metal $550.00
Porcelain/Ceramic $550.00
Resin fused to metal $375.00

Abutments (Fixed Bridge Retainers) Crowns

(1 per 5 years)
3/4 Cast metal $430.00
Cast metal, full $600.00
Implant/abutment supported, cast metal $600.00
Porcelain fused to metal $725.00
Implant/abutment supported, porc fused to metal $725.00
Porcelain/Ceramic $725.00
Implant/abutment supported, porcelain/ceramic $725.00
Resin fused to metal $425.00
Retainer for Maryland-type bridge $275.00

Recement Bridge ..... $ 60.00

ORAL SURGERY

Extractions *(1 per tooth per lifetime)*

Extract coronal remnants, primary tooth ..... $ 90.00
Erupted tooth or exposed root $110.00
Surgical removal $170.00
Soft tissue impaction $225.00
Partial bony impaction $300.00
Full bony impaction $350.00
Surgical removal of residual roots $170.00

Other Oral Surgical Procedures

Biopsy of oral tissue, hard or soft (tissue removal) $ 90.00
Alveoloplasty, per quadrant *(1 per lifetime)* $150.00
Removal of odontogenic cyst or tumor $100.00
Removal of exostosis or torus, per site $200.00
Incision and drainage, intraoral ..... $ 75.00
(1 per calendar year) (General anesthesia/IV sedation not covered with this procedure.)
Frenulectomy $175.00
Excision of lesion *(1 per 12 months)* $100.00

ORTHODONTICS

Orthodontic appliances must be in place before age 19 for employees and unmarried dependent children enrolled/eligible in the plan..

If a cosmetic upgrade (ex. invisalign® or clear brackets) is chosen and treatment is provided by a participating provider, the member may be responsible for a one time cosmetic upgrade fee, to be discussed prior to treatment.

Limited/Interceptive/Appliance Therapy
(Once per lifetime, prior to comprehensive treatment and not an integral part of comprehensive treatment. Additional appliances and office visits are the responsibility of the member.) $500.00
Comprehensive orthodontic treatment, appliance insertion *(once per lifetime)* $600.00
Periodic orthodontic treatment visit
(A benefit is provided for 24 completed active monthly treatment visits per life. Treatment visits beyond 24 months are the responsibility of the member, at the EBF allowance rate, when treatment is provided by a participating provider.) $75.00
Passive Treatment (for cases started after 01/01/14)
(one treatment benefit per lifetime) $300.00

ADJUNCTIVE GENERAL SERVICES

General anesthesia/deep sedation
(per covered oral surgery visit) $200.00
or
Intravenous sedation
(per covered oral surgery visit) $200.00
Palliative (emergency) treatment of dental pain *(2 per calendar year)* .....$ 37.00

Exclusions And Limitations

- There is a coverage for replacement of an existing crown, partial or full removable denture or replacement of fixed bridgework by a new denture or bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if the Plan is furnished satisfactory evidence that: (a) The existing denture or bridgework was inserted at least **five** years prior to its replacement and that the existing denture or bridgework cannot be made serviceable by a dentist or (b) In the case of a crown, that at least **five** years has elapsed since the crown was inserted.

In addition to the exclusions and limitations as stated in the CSEA Horizon Dental Plan Schedule of Allowances and those listed above, this Plan does **not** cover:

- charges for surgical implants.
- charges for any type of service or appliance not described in schedule of allowances.
- treatment by other than a licensed dentist or dental hygienist acting within the scope of licensure.
- services and supplies that are primarily cosmetic in nature.
- replacement of a **lost** or stolen prosthetic appliance.
- duplicate prosthetic appliances or services.
- dentures, crowns, inlays, bridgework or appliances to change or maintain vertical dimension.
- precision or other elaborate attachments or features for dentures, bridgework or any other dental appliances.
- any service rendered or appliance inserted before the eligibility date or after the termination date under this Plan.
- splinting.
- treatment covered by Workers' Compensation or similar law.
- charges for expenses which are reimbursable through "no-fault" automobile insurance.
- any claim or appeal that is submitted after a period that exceeds one year from the calendar year in which dental services were rendered..
- temporary dental services which will be considered an integral part of the final dental service rather than a separate service.

Coordination of Benefits

Since it is not intended that the patient receive greater benefits than the actual expenses covered, the amount of benefits payable under the CSEA Horizon Dental Plan will take into account any coverage the employee (or eligible dependent) has under other group plans. In other words, the benefits under the CSEA Horizon Dental Plan will be coordinated with the benefits of the other group plans.

NOTE: An employee may not be covered both as an employee and as a dependent of an employee. If both parents are Fund members, coverage for children may not be claimed under both parents.

Birthday Rule

Coordination of benefits regulations state that the primary payer of benefits for dependent children is determined by the parent who has the earlier date by month and day, without regard to the year of birth.

CSEA EMPLOYEE BENEFIT FUND

Danny Donohue, Chairman
One Lear Jet Lane, Suite 1
Latham, NY 12110-2395

1-800-323-2732

(Telephone Device For The Deaf)

TDD # 1-800-532-3833

www.cseaebf.com

7/14

HORIZON

DENTAL PLAN

CSEA EMPLOYEE BENEFIT FUND

SUMMARY PLAN DESCRIPTION

GENERAL INFORMATION

Enrollment

Coverage under the Plans offered by the CSEA Employee Benefit Fund is not automatic. You must first enroll yourself and your dependents in the Fund. There is one enrollment form which enrolls you in the Plan(s) negotiated for you. If you have not already done so, you can obtain an enrollment form by calling the Fund at **1-800-323-2732.** You can also visit **www.cseaebf.com** to use the "enroll online" option. You can also download an enrollment form from the website for later submission.

Enrollment in the plan does not vest any right in the covered employee except the right to receive benefits under the plan only so long as payments are being received by the Fund on behalf of the employee. Return the completed enrollment form and any additional information required by the Fund.

WHO IS ELIGIBLE

Full-Time Employee

- If you are a full-time employee in a CSEA represented bargaining unit that has negotiated with your employer for Fund coverage.

Part-Time Or Seasonal Employee

- If your collective bargaining agreement includes coverage for certain part-time and seasonal employees.

NOTE: An employee may not be covered both as an employee and as a dependent of an employee. If both parents are Fund members, coverage for children may not be claimed under both parents.

Dependents

- If your collective bargaining agreement includes dependent coverage, your dependents become eligible at the same time you do.
- You must notify the Fund promptly of changes in dependent status to ensure that new dependents receive the appropriate coverage and to avoid responsibility for charges incurred by an individual after he or she has ceased to be your dependent.

Dependents Include:

Spouse

- Your spouse. This includes a person of the same sex to whom the covered employee was married in a jurisdiction permitting same sex marriages. A spouse can be removed upon entry into a legal separation. If you become divorced, **you must** remove your ex-spouse upon the finalization of divorce.

Domestic Partner

- Domestic partner coverage may be offered by your employer. Please contact your employer for additional information.

Children

- Your unmarried children, including stepchildren who permanently reside with you and legally adopted children under the age of 19.
- Your legal ward under the age of 19 who permanently resides with you pursuant to a court order awarding legal guardianship to you.
- Any child or ward described above, regardless of age, who is incapable of self support by reason of mental or physical disability, provided he or she became so disabled prior to reaching the age of 19.
- Any child or ward described above under the age of 25 who is a full time student (minimum of 12 undergraduate or 6 graduate credit hours) enrolled in a regionally accredited college or university and working toward a Bachelor's Degree (e.g., B.A. or B.S.), Master's Degree (e.g., M.A. or M.S.) or Associate's Degree (e.g., A.A. or A.S.). Technical courses of short duration do not qualify, even if a diploma is awarded. The Fund requires that current proof of student status be provided annually (letter or statement from the college's Registrar's Office or completion of Student Status Form available from the Fund).

NOTE: This form is used only to update/validate the CSEA EBF dependent student eligibility file. Your Health Insurance carrier may require different or additional evidence of dependent student enrollment. We suggest that you obtain a letter of student enrollment from the school registrar to avoid delays in processing health insurance claims for your child.

C.O.B.R.A.

- If you become ineligible for Fund coverage because of retirement, termination, layoff, leave without pay or reduction in hours, you may have certain rights to continue Plan coverage through C.O.B.R.A. Under these and certain additional circumstances, your spouse and/or dependent(s) may have rights to continue coverage through C.O.B.R.A. as well.
- Before your payroll status changes, ask your employer for details about continuing coverage through C.O.B.R.A.

Appeal Procedure

- If you feel that you did not receive full benefits, you may appeal to the Fund. Send a letter to the Fund explaining why you feel you did not get the full amount to which you were entitled. Include copies of any supporting documentation.
- All appeals must be submitted within 60 days of the determination being appealed.
- This procedure is not designed to cover services clearly not covered by the Plans.

CSEA EMPLOYEE BENEFIT FUND WEBSITE

Find the most up to date information on your dental benefits by visiting our website at **www.cseaebf.com**

Save valuable time by printing dental plan information, provider listings and EBF forms.

HORIZON DENTAL PLAN

How To Use This Plan

- You may use any licensed dentist for dental care.
- The Fund contracts with participating dental offices to accept the fee schedule as payment in full for covered dental services.
- If you would like to view our Directory of Dental Care Providers, you can request a copy by calling us at **800-323-2732** or go to our website **www.cseaebf.com.**
- Specialists within participating general practices may have the right to bill members for the difference between the specialist's customary charge and the allowance which the CSEA Employee Benefit Fund pays under the Horizon Dental Plan. The Specialist must inform the Fund and the member that he/she will not be accepting the plan allowance as payment in full and must provide proof of specialty status to the Fund.
- If you choose a non-participating dentist, and are charged more than the amount listed under the schedule of allowances, you must pay the difference. (See schedule of allowances.)
- The Fund does not recommend that you use any particular dentist, either participating or non-participating.
- A universal American Dental Association (ADA) claim form, available through your dental provider, or a CSEA claim form, which may be obtained from the Benefit Fund or downloaded from our website, **www.cseaebf.com** must be used to submit for completed services. Electronic claims are also accepted.

Submit all dental claim forms to:
CSEA EMPLOYEE BENEFIT FUND
P.O. Box 489 • Latham, NY 12110-0489

Maximum Benefit – Dental Plan

- There is a $2850.00 a year maximum on dental benefits.
- $2850.00 a year of covered dental benefits is available for each member and dependent.
- For year 2014 and on, there is no annual maximum for children under the age of 19.
- This maximum is on a calendar-year basis (January through December).
- Under this maximum, we are assuming liability for up to the first $2850.00 of covered dental work per year. This maximum does not apply to orthodontics.
- We encourage those about to undergo extensive dental treatment to discuss those plans with the dentist beforehand. There are often less expensive alternatives available which will provide high quality dental care.

Pre-Authorization of Benefits

- Whenever the estimated cost of a recommended dental treatment exceeds $500.00, we advise the submission of a preauthorization before the work begins.
- Use a dental claim form for this submission, and include the related x-rays.
- After review, the Benefit Fund will notify the member and the dentist of the benefits payable based upon the treatment plan.
- In determining the amount of benefits payable, consideration will be given to alternate procedures that will accomplish a professionally acceptable result.
- If the member and the dentist agree to a more expensive method of treatment than that pre-authorized by the Benefit Fund, the amount exceeding the pre-authorization will not be paid by the Fund even if it would otherwise be a covered service.
- If you have work done for over $500.00 without submitting a pre-authorization first, your claim will be reviewed under the alternate treatment provision.
- We strongly recommend that whenever you are discussing your treatment plan with your dentist, you clearly understand what is being proposed. If we recommend alternate benefits, you should also discuss this with your dentist.

A pre-authorization is not a guarantee of benefits. Payment is always subject to eligibility at the time of service.

CSEA EBF HORIZON DENTAL PLAN SCHEDULE OF ALLOWANCES COVERED SERVICES

DIAGNOSTIC SERVICES

Clinical Oral Evaluation (Examination)

Evaluation – periodic, comprehensive or detailed *(2 evaluations per calendar year)* ..... $ 37.00
Evaluation – limited *(2 per calendar year)* ..... $ 37.00

Dental Radiographs

Intraoral complete series, including bitewings *(1 per 3 years)* ..... $ 80.00
or
Panoramic *(1 per 3 years)* ..... $ 80.00
There is a 3 year limitation for complete series and/or panoramic radiographs. Periapical and bitewing x-rays are not covered if performed during the same 12 month period as complete series. Periapical x-rays are not covered during the same 12 month period as a panoramic film.
Periapical x-rays, per film *(Maximum 10 per 12 month period)* ..... $ 8.00
Bitewing x-ray, per film *(Maximum 4 per 12 month period)* ..... $ 8.00
Intraoral occlusal film *(2/3 years)* ..... $ 25.00

PREVENTIVE SERVICES

Dental prophylaxis, adult-12 yrs and over *(2 per calendar year)* ..... $ 70.00
Dental prophylaxis, child-under age 12 *(2 per calendar year)* ..... $ 55.00
Fluoride, under age 19 *(2 per calendar year)* ..... $ 18.00
Sealants, under age 19, per tooth *covered on bicuspids and molars in the permanent dentition. (1 per 3 years)* ..... $ 25.00
Space maintainers, under age 19 *(1 per 3 years)*
Unilateral space maintainer ..... $ 75.00
Bilateral space maintainer $150.00

RESTORATIVE - FILLINGS

Amalgam Restorations - *(1 per surface per tooth per 12 month period) Includes tooth preparation, all adhesives, liners and bases and polishing to restore a tooth to proper form and function.*

PERMANENT OR PRIMARY TEETH

Amalgam-one surface ..... $ 90.00
Amalgam-two surface ..... $ 110.00
Amalgam-three surfaces $140.00
Amalgam-four or more surfaces $140.00

Resin-Based Composite Restorations

(1 per surface per tooth per 12 month period) Includes tooth preparation, acid etching, adhesives, liners, bases, curing and the broad category of material called resin-based composites.

Permanent or Primary teeth (Anterior or Posterior)

Resin-based one surface ..... $ 95.00
Resin-based two surfaces $130.00
Resin-based three surfaces $160.00
Resin-based four or more surfaces, or involving incisal angle $160.00

RESTORATIVE - CROWNS AND INLAYS/ONLAYS

These services are limited to permanent teeth, as scheduled. Crowns and inlays are covered for the restoration of teeth which as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite material. All crown work will be professionally reviewed for necessity and appropriateness of the planned treatment, taking into account the exclusions and limitations of the Plan. Benefits are payable upon insertion.

Crowns - *(1 per 5 years)*

Resin *(permanent, anterior teeth only)* $160.00
Resin fused to metal $425.00
Porcelain/Ceramic $725.00
Implant/abutment supported, porc/ceram $725.00
Porcelain fused to metal $725.00
Implant/abutment supported, porc fused to metal $725.00
Full cast metal $600.00
Implant/abutment supported, full cast metal $600.00
3/4 cast metal $430.00

Inlays/Onlays - *(1 per 5 years)*

Inlay/onlay, one surface $250.00
Inlay/onlay, two surfaces $370.00
Inlay/onlay, three or more surfaces $382.00

Other Restorative Services

Recement crown ..... $ 30.00
Stainless Steel crowns, deciduous teeth *(1 per 3 years)* ..... $ 75.00
Pin retention, per tooth *(1 per 12 month period)* ..... $ 20.00
Post and core, cast or prefabricated, per tooth *(1 per 5 years)* $155.00

ENDODONTICS

Root Canal Therapy *(1 per tooth per lifetime)*

Benefits for root canal therapy are limited to permanent teeth and are payable upon completion.

Root canal therapy, anterior $375.00
Root canal therapy, bicuspid $475.00
Root canal therapy, molar $600.00