SUMMARY PLAN DESCRIPTION

HORIZON DENTAL PLAN



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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. Upon receipt of notice of your eligibility, we will send you a welcome letter which includes an enrollment form. Please complete and return the form to the CSEA EBF. If you need another form, you can call **1-800-323-2732** to request one or visit **www.cseaebf.com** to download a form from our website. When you visit the website, you can register for our Member Portal which will allow you to view plan information, make enrollment changes and submit requested documentation.

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.

SUBMIT ALL ENROLLMENT FORMS TO: CSEA Employee Benefit Fund P.O. Box 516 Latham, NY 12110-0516

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. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are Fund members, coverage for children cannot be claimed under both.

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 children, stepchildren and legally adopted children, under the age of 26 whether residing with you or not and regardless of marital status and/or student status.
- Your legal ward under the age of 26 who permanently resides with you pursuant to a court order awarding legal guardianship/ custody 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 26.

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.

CSEA EMPLOYEE BENEFIT FUND WEBSITE

- Find the most up to date information on your dental benefits by visiting our website at www.cseaebf.com where you can register for our Member Portal.
- Save valuable time by viewing 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 whether payment is made by you or the Fund.
- If you would like to view our current Directory of Dental Care Providers, visit our website at www.cseaebf.com.
- Specialists within participating general practices 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 provider, and are charged more than the amount listed under the Schedule of Allowances you must pay the difference.
- A universal American Dental Association (ADA) claim form, available through your dental provider, or a CSEA form which can be obtained from our website at www.cseaebf.com must be used to submit for completed services. Electronic claims are also accepted.
- The Fund does not recommend that you use any particular dentist, either participating or non-participating.

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 \$3,000 annual maximum dental benefit for each covered member and dependent. This maximum is on a calendarvear basis (January through December).
- There is no annual maximum for children under the age of 19, per the Affordable Care Act guidelines.
- Under this maximum, the Benefit Fund is assuming liability for up to the first \$3,000 of covered dental work per year. This maximum does not apply to orthodontics, implant body placement, implant abutments, prophylaxis or oral evaluations.
- 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.

Appeal Procedure

 If you feel that you did not receive full benefits, you may appeal to the Fund. Please call customer service at **1-800-323-2732** and request a dental claim appeal form which can be emailed or mailed to you. Include copies of supporting documentation.

- ALL appeals must be submitted within 60 days of the claim being appealed.
- Please note the appeal process could take up to 4-6 weeks.
- This appeal procedure is not designed to cover services not covered by the Plans

Pre-Authorization of Benefits

- Whenever the estimated cost of a recommended dental treatment exceeds \$500, 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 we recommend alternate benefits, you should also discuss this with your dentist.
- For Example: If your dentist submitted a
 preauthorization for a crown which would cost
 \$900 and after professional review a restoration
 for \$225 would give an acceptable result,
 the Benefit Fund would pay only \$225. If the
 member decided to have the crown, he or she
 would pay the difference of \$675 (\$900-\$225).

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 FOR COVERED SERVICES

DIAGNOSTIC SERVICES		
CONSULTATION (1 per calendar year)	\$1	40.00
Clinical Oral Evaluation (Examination) (3 evaluations per calendar year, outside al maximum)	nn	ual
Periodic, detailed, limited, oral child		
evaluation	Ś	66.00
Comprehensive oral and periodontal	•	
evaluation	\$	70.00
Dental Radiographs		
Intraoral complete series, including		
bitewings (1 per 3 years)	\$1	43.00
or		
Panoramic (1 per 3 years)	\$1	43.00
There is a 3 year limitation for complete se	rie	es
and/or panoramic radiographs. Periapical		
bitewing x-rays are not covered if performe		
the same 12 month period as a complete s		
Periapical x-rays are not covered within the		
12 month period as a panoramic image.		
Periapical x-ray, each image		
(Maximum 10 per calendar year)	Ś	27.00
Bitewing x-rays (Maximum 4 per calendar		
One	-	
Two	•	
Three	•	
Four		
Occlusal image (2 per 3 years)	•	
Cephalometric image	•	
(1 per calendar year)	\$1	55.00
Cone beam CT images (limited, mandibul		
maxillary or both jaws) (1 per 5 years)		
	-	
TESTS AND LABORATORY EXAMINATIONS	s	
Pulp vitality test (1 per tooth per	_	
calendar year)	Ś	45.00
outendar year)	Υ	10.00
PREVENTIVE SERVICES		
Prophylaxis (Adult and Child) 3 per calend	daı	year,
outside maximum		
Dental prophylaxis, adult-12 yrs		
and over	\$1	00.00
Dental prophylaxis, child-under age 12		
Fluoride (2 per calendar year)	\$	37.00

Sealants, child-under age 19, per tooth

covered on bicuspids and molars in the permanent dentition only (1 per 3 years)......\$ 53.00

Space maintainers, child-under age 19

(1 per tooth per lifetime)

Unilateral space maintainer	\$148.00
Rilateral space maintainer	\$208.00

RESTORATIVE - FILLINGS

Amalgam Restorations

(1 per each 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	\$142.00
Amalgam-two surfaces	\$167.00
Amalgam-three surfaces	\$205.00
Amalgam-four or more surfaces	\$205.00

Resin-Based Composite Restorations

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

Resin based, two surfaces	\$195.00
Resin based, three surfaces	\$225.00
Resin based, four or more surfaces or	
involving incisal angle	\$225.00

PERMANENT OR PRIMARY TEETH (Posterior)

Resin based, one surface	\$167.00	
Resin based, two surfaces	\$200.00	
Resin based, three surfaces	\$240.00	
Resin based, four or more surfaces or		
involving incisal angle	\$240.00	

RESTORATIVE: CROWNS & INLAYS/ONLAYS

- Crowns and inlays/onlays are covered for the restoration of permanent teeth which, as the result of extensive decay or fracture, cannot be restored with an amalgam or resin-based composite filling.
- The treatment plan must be accompanied by radiographs and will be professionally reviewed for necessity and appropriateness of the planned treatment taking into account the exclusions and limitations of the Plan.
- · Any type of crown restoration that has been in

place for 12 months is considered permanent and subject to the frequency limitation.

- Benefits are payable upon insertion of the crown or inlay/onlay.
- Pre-op radiographs are required for the review of this procedure.

Crowns (1 per tooth per 5 years)	
Resin (permanent, anterior teeth only)	\$170.00
Resin fused to metal	\$440.00
Porcelain/Ceramic	
Porcelain fused to metal	\$900.00
3/4 cast metal	\$550.00
Full cast metal	\$710.00
Implant/Abutment Supported Crowns	
(1 per implant per 10 years)	
Implant/abutment supported,	
porc/ceramic	\$900.00
Implant/abutment supported,	
porc fused to metal	\$900.00
Implant/abutment supported,	
full cast metal	\$710.00
Inlays/Onlays (1 per tooth per 5 years)	
Inlay/onlay, one surface	\$250.00
Inlay/onlay, two surfaces	
Inlay/onlay, three or more surfaces	
	Q002.00
Other Restorative Services	
Recement crown, implant crown	
(1 per crown per calendar year)	\$ 80.00
Stainless steel crowns, deciduous	4 07 00
teeth only (1 per tooth per 3 years)	\$ 87.00
Core buildup, including pins	A 00.00
(1 per tooth per lifetime)	\$ 82.00
Pin retention, per tooth	¢ 22.00
(1 per calendar year)	\$ 33.00
Post and core, cast or prefabricated, per tooth (1 per 5 years)	¢100.00
per tootii (1 per 5 years)	\$ 160.00
ENDODONTICS	
Root Canal Therapy (1 per tooth per life	time)
Benefits for root canal therapy are limite	
permanent teeth and are payable upon c	
	•
Root canal therapy, anterior	
Root canal therapy, bicuspid	
Root canal therapy, molar	. \$1,0/0.00
Other Endodontic/Periradicular Service	es
Pulpotomy, deciduous teeth only	
(1 per tooth per lifetime)	\$100.00

Apicoectomy, 1st root (1 per tooth per	lifetime)
Anterior	\$670.00
Bicuspid	\$730.00
Molar	\$770.00
Apicoectomy, each additional root	\$340.00
(General Anesthesia/IV Sedation cover	ed with
Apicoectomy)	
Retrograde filling, per root, in conjunc	ction with

apicoectomy (1 per tooth per lifetime) \$200.00

PERIODONTICS

Gingivectomy, Osseous Surgery and Bone Replacement Graft 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 x-rays and periodontal charting. Benefits will be paid for only the most comprehensive surgical procedure necessary in each site. The allowance for gingivectomy and osseous surgery 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. There is a frequency limit of 2 bone grafts per year. Covered bone grafts include D4263, D6104 and D7953.

Gingivectomy or gingivoplasty, per quadrant		
(1 per 5 years)	\$425.00	
Osseous surgery, per quadrant		
(1 per 5 years)	\$800.00	
Bone replacement graft, per tooth (D4	263)	
(2 per calendar year)	\$300.00	
Periodontal scaling and root planing,		
per quadrant (2 per calendar year)	\$140.00	
Periodontal maintenance procedure		
3 per calendar year (outside annual max	cimum),	
either prophylaxis or D4346 or D4910	\$100.00	

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. If a permanent denture is not inserted prior to 12 months, the interim denture will be considered a permanent denture. This plan will pay for no other installation within the next 5 or 10 year period. Benefits are payable only upon insertion of denture. Allowance includes

post-delivery care, relines and adjustments for 6 months.

Complete Dentures (1 per 5 years) Full upper or lower denture, permanent \$950.00 Full upper or lower denture, interim \$275.00
Partial Dentures (1 per 5 years) Partial upper or lower denture,
permanent\$950.00
Unilateral partial upper or lower denture, permanent\$410.00 Interim partial dentures, upper or
lower, anterior teeth only\$275.00
Implant/Abutment Supported Dentures (1 per 10 years)
Implant/abutment supported full upper or lower denture, permanent\$1,125.00 Implant/abutment supported partial
upper or lower denture, permanent \$1,125.00
Repairs to Full/Complete Dentures Replace missing or broken teeth (limited to 4 per calendar year)\$ 70.00
Repairs to Partial Dentures
Repair, replace or add clasp to existing partial
denture (limited to 4 per calendar year)\$ 70.00
Replace or add tooth to existing partial denture
(limited to 4 per calendar year)\$ 70.00
Rebase Full Denture (1 per 2 years) Rebase - upper or lower\$251.00
Reline of Dentures - upper or lower (1 per 2 years) Reline full denture
Other Removable Prosthetic Services
Precision Attachments
Covered precision attachments include D5862, D6950
and D6192. One per tooth position per 5 or 10 years,
depending on denture frequency. 2 per calendar year.
D5862\$380.00

PROSTHODONTICS (FIXED)

Services are limited to permanent teeth replacement.

The treatment plan must be accompanied by radiographs and 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 unit per 5 or 10 years)	
Cast metal	\$600.00
Porcelain fused to metal	
Porcelain/Ceramic	
Resin fused to metal	
	•
Abutment Crowns for Fixed Bridge Retain	ners
(1 per tooth per 5 years)	
3/4 Cast metal	
Full Cast metal	•
Porcelain fused to metal	
Porcelain/Ceramic	
Resin fused to metal	
Retainer for Maryland-type bridge	.\$385.00
Implant/Abutment Supported Crowns for	Fixed
Bridge Retainers (1 per implant per 10 yea	
including pontics part of implant fixed bridge	
Implant/abutment supported, cast metal.	
Implant/abutment supported,	•
porc fused to metal	.\$900.00
Implant/abutment supported,	
porcelain/ceramic	.\$900.00
Other Fixed Partial Denture Services	
Recement bridge, implant bridge (1 per bridge per calendar year)	¢ 00 00
(1 per bridge per caleridar year)	.\$ 90.00
Other Removable Prosthetic Services	
Precision Attachments	
Covered precision attachments include D58	62, D6950
and D6192. One per tooth position per 5 or 1	0 years,
depending on denture frequency. 2 per caler	ndar year.
D6950	.\$380.00
ORAL SURGERY	
Extractions (1 per tooth per lifetime)	
Extract coronal remnants, primary tooth.	
Erupted tooth or exposed root	.\$165.00
Surgical removal	
Soft tissue impaction	.\$345.00
Partial bony impaction	.\$455.00
Full bony impaction	.\$560.00

Other Oral Surgical Procedures

Surgical Placement of Implant Body (D6010:

1 per tooth position per 10 years)

 Post-op Radiographs are required for the payment of this procedure. Benefits are payable upon insertion.

Surgical removal of residual roots.....\$205.00

 An allowance will be provided for the surgical placement of the Implant Body. The plan will not pay for a replacement within the next 10 year period.

- A provider either participating or nonparticipating will be permitted to charge their customary fee for the implant body procedure and accept the \$1,075 per implant benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the surgical implant body will be outside of the member's annual plan maximum.
- A tooth or teeth currently having a prosthetic (denture, partial denture, crown, inlay-onlay) placed within the last 5 years and is/are being replaced by a covered Implant/Abutment Supported Prosthetic would be subject to the 5 year replacement rule.
- Implant/Abutment Supported Prosthetics-(Removable Dentures, Fixed Dentures, Fixed Partial Dentures/Retainers & Single Crowns) will be subject to a 10 year replacement rule.

Supporting Structures (1 per tooth position per 10 years/2 per calendar year)

Prefabricated Abutment (D6056)	\$350.00
Custom Abutment (D6057)	\$350.00
Semi-precision Abutment (D6191)	\$350.00

- A provider either participating or non-participating will be permitted to charge their customary fee for the implant abutment and accept the \$350 per implant abutment benefit as an allowance against such fee. If treatment is provided by a participating provider, the member may be responsible for a balance, to be discussed prior to treatment.
- The allowance for the implant abutments will be outside of the member's annual plan maximum.

Bone Graft at time of implant placement

There is a frequency limit of 2 bone grafts per year.
Covered bone grafts include D4263, D6104 and
D7953. (1 per implant position per 10 years /
2 per calendar year: D6104)\$395.00

Surgical access of an unerupted tooth

(1 per tooth per lifetime)......\$275.00

Biopsy of oral tissue, hard or soft

(tissue removal)......\$195.00

Alveoplasty in conjunction with

extractions, per quadrant (1 per lifetime) ..\$205.00

Alveoplasty not in conjunction with

extractions, per quadrant (1 per 5 years)..\$205.00

Removal of odontogenic cyst or tumor.....\$230.00

Removal of exostosis or torus, per site\$300.00
Incision and drainage, intraoral\$150.00
(1 per tooth per calendar year, General anesthesia /
IV sedation not covered with this procedure)
Frenulectomy (3 per lifetime)\$285.00
Excision of lesion (1 per calendar year)\$230.00
Bone replacement graft for ridge preservation
(1 per tooth per lifetime / 2 per
calendar year: D7953)\$300.00
Precision Attachments
Covered precision attachments include D5862, D6950
and D6192. One per tooth position per 5 or 10 years,
depending on denture frequency. 2 per calendar year.
D6192\$380.00
ORTHODONTICS
This plan does not cover adult orthodontics. Provided
for employees under the age of 19 and unmarried
dependent children enrolled in the plan. Orthodontic
appliances must be in place before age 19.
Limited orthodontic treatment\$515.00
(once per lifetime, prior to and not in the same
month as comprehensive treatment. Additional
appliances and office visits are the responsibility of
the member.)
Comprehensive orthodontic treatment,
appliance insertion (once per lifetime) \$1,050.00
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.)\$170.00
Passive treatment (one treatment benefit per
lifetime following comprehensive treatment,
includes retainers)\$400.00
ADJUNCTIVE GENERAL SERVICES
General anesthesia/deep sedation -each 15 minute
increment with a maximum benefit of \$410.00
(per covered oral surgery visit)\$205.00
or
Intravenous sedation -each 15 minute increment
with a maximum benefit of \$410.00
(per covered oral surgery visit)\$205.00
Palliative (emergency) treatment of dental pain
(2 per calendar year)\$ 85.00

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 or
 - (c) The existing implant supported crown, bridge or denture was inserted at least **ten** years prior to it's replacement and that the existing implant supported crown, bridgework or denture cannot be made serviceable by a dentist.

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 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
- any service rendered or appliance inserted before the eligibility date or after the termination date under this Plan

- · splinting
- mini implants
- 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 are determined by the Employee Benefit Fund to be 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. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are Fund members, coverage for children may not be claimed under both.

Birthday Rule

Coordination of benefits regulation states that the primary payer of benefits for dependent children is determined by the parent who has the earlier birth date by month and day, without regard to year of birth (other determining factors may apply).

YOUR UNION. YOUR BENEFITS.

\$3,000 Annual Max

NO COPAYS, DEDUCTIBLES, OR WAITING PERIODS!



3 Cleanings / Exams per year outside the annual max.

Dependents Covered Until the Age of 26 regardless of student or marital status.





Orthodontic Coverage for dependent children up to age 19.

Allowances are accepted at any licensed provider. Participating providers accept allowances as full payment.





\$1,075 Dental Implant
Allowance (up to two per year)
outside the annual max.



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