Out-of-Network Plan

The member and covered family members may select any licensed dentist anywhere; the amount of payment is the same, regardless of the dentist chosen. You are responsible to your dentist should there be any difference between the non-participating provider schedule of allowances and the dentist's usual and customary charges.

The Plan does not provide for assignment of benefits to your dentist. Upon completion of your dental work, the reimbursement check will be mailed directly to you.

In-Network Plan

When in New York the member and covered dependents may select any participating Healthplex PPO provider. These providers will accept the participating provider schedule of allowances as payment in full. When outside of New York, members and covered dependents will have access to the Careington network which provides thousands of dentists nationwide. Members and covered dependents may have copayments when seeing Careington providers. Visit their website at **healthplex.com** and click on **"Our Dentists"**, then enter **"GG1015A"** in the group number field in the **"Members"** section on the right hand side to review the directory of dentists who participate in the Detectives' Endowment Association retiree dental plan.

The Plan provides for assignment of benefits to your dentist. Upon completion of your dental work, the reimbursement check will be **mailed directly to the participating provider**.

Pre-authorization of Benefits

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, we recommend a description of the procedures to be performed and an estimate of the dentist's charges be filed with Healthplex before the course of treatment is begun.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, Healthplex reserves the right to make a determination of benefits payable.

Proof of Claim

Healthplex reserves the right to accept or to require verification of any alleged fact or assertion pertaining to any claim for dental expense insurance benefits. As a part of the basis for determining benefits payable, Healthplex may require submission of x-rays and other appropriate diagnostic and evaluative materials.

Claim forms may be obtained by calling or writing the Fund Office. After services have been received, return the completed form, signed by both the dentist and the member, to Healthplex.

A claim form should be filed with healthplex within thirty days after completion of the services to which it relates, or within ninety days of the time the services commenced.

General Limitations on Covered Expenses

The contract requires that if alternate methods of treatment exist, payment will not be made for treatment carrying the greater fee, unless that treatment is the only adequate treatment.

Crowns and/or bridgework will only be allowed when these services are used to restore tooth structure or replace missing teeth as covered by the Group Contract.

Reconstruction: Payment will be made toward the cost of procedures necessary to eliminate oral disease and to replace teeth that have been removed subsequent to the effective date of insurance for the covered person. Appliances or restorations necessary to alter vecal dimension, restore occlusion or splint periodontally involved teeth are considered optional and their cost is not payable as a Covered Dental Expense.

Limitations on Orthodontics

Orthodontia - Dependent Children up to age 19. Benefits shall be provided for eligible dependent children consisting of the necessary diagnosis and treatment of class 2 and 3 malocclusions which cause interference with normal functions. Each month of active or passive orthodontic treatment rendered before the commencement of the patient's coverage by the contract reduces the maximum number of months of such treatment allowed under the Contract.

The Fund will not pay towards the cost of any orthodontic appliance inserted when the patient was not covered by contract.

Payments will be made only for treatment rendered by dentists who have had special training to qualify them to render orthodontic treatment, and only for the covered conditions. To receive benefits, the enrollee must have the dental specialist who proposed to perform the service apply to Healthplex for written authorization of the services before orthodontic treatment is started.

Dental Services Not Covered

Payment will not be made for services rendered by other than a duly licensed dentist or by a licensed dental hygienist under the supervision of a dentist; services and appliances not required by accepted standards of dental practice; services for which the patient incurs no dentist's charge; dental surgery or treatment performed for the purpose of improving the patient's appearance (cosmetic dentistry); treatment available without cost under laws enacted by any State legislature or the Congress of the United States (such as Workers' Compensation, Veterans Administration, etc.); service from the dental or medical department of any employer mutual benefit association; labor union, trustee, or other similar person or group; replacement of lost or stolen appliances; plaque control programs; periodontal splinting, duplicate prostheses; implants and attachments thereof; replacement or repair of orthodontic appliances; charges associated with the installation of dentures or fixed bridgework; replacing a tooth lost prior to the effective date of coverage; services rendered for any injury or condition due to war or any act of war; and expenses to the extent of benefits provided under any plan of health or dental insurance provided by the employer or by any group plan other than this one.

Benefits for emergency treatment for relief of pain will not be allowed if the service is rendered along with any other service (excluding x-rays).

If your coverage becomes effective or terminates while treatment is in progress, The Fund will make payment only for services actually performed while its coverage is in effect.

Coordination of Benefits

Coordination of Benefits is the method in which claims are processed when the patient is covered by more than one insurance company. When this occurs, Healthplex will follow the guidelines developed by the National Association of Insurance Commissioners in order to determine the primary and secondary payers. Under C.O.B. rules, both plans may pay up to their maximum amounts as long as the total does not exceed the dentist's fees being charged.

Claims Review Procedure

Inquiries relating to coverage and claims can be made by the subscriber to the Dental Claims Unit. If the Subscriber disagrees with the Unit's disposition of the inquiry, a written request for review may be made within sixty days of notification of the disposition to:

DEA
26 Thomas Street
New York, NY 10007

Expiration of Coverage

Your coverage ceases when your group terminates. Coverage under this program may be continued pursuant to the rules and regulations of COBRA, or you may convert your dental coverage to a regular Direct Payment Contract. The Direct Payment Contract provides all basic benefits.

This brochure contains a general descripon of your dental care program for your use as a convenient reference. All benefits are governed by the provisions of your group's contract.

UFCW
Healthplex is a UNION SHOP

DETECTIVES' ENDOWMENT ASSOCIATION, INC. HEALTH BENEFIT FUND

RETIRED GG1015A

Reimbursement Plan Schedule of Allowances

Administered By

healthplex

333 Earle Ovington Boulevard, Suite 300
Uniondale, NY 11553-3608
healthplex.com

Customer Service
(800) 468-0600

B-3367 Print 11/18 Rev. 11/18

Group Benefit Page

Name of Group: Detectives' Endowment Association
Health Benefit Fund - Retirees

Group Number: GG1015A

Effective Date: January 1, 2019

Plan Number: N/A

Benefit Period: Calendar Year

Reimbursement Plan – Covered services can be rendered by any dentist. To use the plan, members should be treated by the dentist of their choice and submit claims to Healthplex. Payments by the plan are subject to the following terms:

Individual Deductible: $25.00 for Prosthetics

Family Deductible: $25.00 for Prosthetics for each family member

Coinsurance Percentages:

Category I	Diagnostic Services Preventive Services	100% of the maximum allowable amount.
Category II	Basic Restorative Services Endodontic Services Periodontal Services Oral Surgery Services	100% of the maximum allowable amount.
Category III	Major Restorative Services Prosthetic Services	100% of the maximum allowable amount.
Category IV	Orthodontic Services	100% of the maximum allowable amount.

Individual Maximum (Category I, II, III): No Limit per benefit period

Family Maximum (Category I, II, III): No Limit per benefit period

Orthodontic Maximum (Category IV): $1,475.00 Lifetime

Periodontic Maximum: $2,000.00 Lifetime

X-Ray Maximum per person: $30.00 per year

Exclusions and Limitations

Benefits shall not be provided for:

- Hospital administered anesthesia and general anesthesia.
- Any dental procedures which are undertaken primarily for cosmetic reasons.
- Any service or appliance unless required in accordance with accepted standards of dental practice.
- Prosthetic benefits are not covered where sound restorations can be achieved by amalgam or alternative methods.
- Replacements or substitutions of appliances supplied by Plan until five (5) years have elapsed.
- Services or appliances used solely as an adjunct to periodontal care or for some cosmetic purposes.
- Implants and attachments thereof.
- More than two (2) oral examinations and oral prophylaxis (cleaning of teeth) per member per year (once every six months).
- Orthodontia - lost or broken appliance.
- Dentures, crowns, inlays, onlays, bridgework or other appliances or procedures, altering vertical dimension restoring or maintaining occlusion, splinting or replacing tooth structure lost by abrasion or attrition, or treatment of a temporo-madibular joint disturbance.
- A new denture or bridgework if the existing denture or bridgework can be made serviceable.
- Orthodontic services unless for eligible dependent children consisting of the necessary diagnosis and treatment of class 2 and 3 malocclusions with cause interference with normal function with traditional braces.

Non-Participating Provider Schedule of Allowances

These are the amounts that the Fund will reimburse for services listed. You are responsible to your dentist for any additional costs.

Diagnostic & Preventive Services	Reimbursement
Periodic Oral Examination (once every 6 months)	$14.00
*Full Mouth X-Rays (once every 12 months)	25.00
*Single Films (periapical/bitewing)	2.60/3.90
*Bitewing Series	11.70
Panoramic	22.00
Prophylaxis	13.00
Fluoride Treatment (once every 6 months)	13.00
Specialty Consultation	20.00
Emergency Treatment	13.00
Restorative Dentistry	
Amalgam, 1 surface	25.00
Amalgam, 2 surfaces	40.00
Amalgam, 3 surfaces or more	50.00
Composite Filling, 1 surface, Anterior	15.00
Composite Filling, 2 surfaces, Anterior	22.00
Composite Filling, 3 surfaces, Anterior	29.00
Oral Surgery	
Routine Extractions	30.00
Surgical Extractions	60.00
Soft Tissue Impactions	60.00
Bony Impactions (Partial/Full)	112.00/144.00
Aveolectomy, w/extraction per quad	40.00
Root Canal Therapy	
Pulp Capping, Direct	15.00
Root Canal Therapy, Anterior	127.00
Root Canal Therapy, Bicuspid	150.00
Root Canal Therapy, Molar	178.00
Apicoectomy (Anterior)	76.00
Periodontics	
Scaling of Teeth, per quad	35.00
Gingivectomy, per quad	92.00
Osseous Surgery, per quad	178.00
****Prosthetics – Crowns**	
Acrylic w/High Noble Metal Crown	225.00
Porcelain Crown	225.00
Porcelain w/High Noble Metal Crown	225.00
Stainless Steel Crown	50.00
Cast Post	50.00
Recementation, per crown	12.00
****Prosthetics – Fixed Bridges**	
Acrylic w/High Noble Metal Crown or Pontic	197.00
Porcelain w/High Noble Metal Crown or Pontic	197.00
Recementation, bridge	15.00
****Prosthetics – Removable**	
Full Upper or Lower Denture, w/adjustments	250.00
Partial Upper or Lower Denture, cast base	330.00/320.00
Prosthetics Repairs	
Denture Adjustments	10.00
Broken Body/Denture	29.00
Replacement of Broken/Missing Teeth	29.00
Orthodontics – (Dependent Children up to age 19)	
Lifetime Maximum - 24 months	$1,475.00

Orthodontic treatment includes initial insertion and 24 months adjustments for traditional braces.

Dependent Children are covered up to their 19th birthday, or up to their 23rd birthday if a full-time student.

$30.00 Annual Maximum *$25.00 Deductible**

Not all covered services are listed on this schedule. Services not listed will be valued by report.