CATSKILL AREA SCHOOLS EMPLOYEE BENEFITS

HIGH-LEVEL DENTAL PLAN

PRE-TREATMENT ESTIMATES

IMPORTANT NOTICE: 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. The Provider's report must include an estimate of charges, as well as copies of x-rays, photographs, and models, if appropriate. This report can be emailed to the third-party claim administrator at Group@Ameritas.com. The Third-Party Claim Administrator will review the material submitted, taking into consideration possible alternative courses of treatment, and then you and the Provider will be notified of what the Plan will pay on your behalf for the proposed treatment. For any questions, please contact the CASEBP office at 1-607-588-8917 or 1-800-962-6294

Pre-treatment calculations reflect maximums at the time the pre-treatment is processed and are valid for 90 days. Benefits paid prior to services being rendered may affect your reimbursement.

Treatment decisions are different from payment decisions. The Plan makes payment decisions only. It is the Professional Provider who is responsible for determining whether the treatment should be rendered, regardless of whether the charges are totally or partially included in or excluded from coverage under this plan. The Plan does not select, endorse, or credential any medical or dental provider and takes no responsibility for the proper or improper performance of any Professional Provider.

SECTION 1
INTRODUCTION

Your Employer is providing dental benefits to you through the self-funded Otsego-Northern Catskill BOCES Dental Consortium, which is referred to in this booklet as the "Plan." This booklet is your plan document and summary plan description. It provides information on your Plan benefits and your responsibilities to provide information to the Plan for the proper administration of your dental claims. Any apparent conflict between this document and any other publication or presentation involving this Plan will be resolved by reference to this Plan document.

Plan Administrator – The Plan Administrator is the Deputy Superintendent of ONC BOCES located at 2020 Jump Brook Road, Grand Gorge, NY 12434. Phone: 607-588-6291.

Administrator – The Plan is administered by the CASEBP Plan Coordinator, PO Box 383, Grand Gorge, NY 12434. Phone: 607-588-8917 or 800-962-6294.

Third-Party Claims Administrator - Ameritas, PO Box 82520, Lincoln, NE 68501-2520**.** Phone: 800-487-5553.

Governing Body – The governing body of the Catskill Area Schools Dental Plans is the Board of Trustees of the Catskill Area Schools Employee Benefit Plan.

Plan Effective Date – The effective date of this Plan is July 1, 2000.

Plan Year – The Plan Year begins on July 1st and ends on June 30th.

Plan Year Maximum Payments - The maximum amount the Plan will pay for all Covered Services (except orthodontic treatment) for any Covered Person in one Plan Year is reviewed and revised at the beginning of every Plan Year. Benefits may be paid again to the yearly maximum amount beginning in the next Plan Year. For orthodontic treatment, there is a separate *lifetime maximum* payment per Covered Person's lifetime, which is also reviewed and revised at the beginning of every Plan Year.

SECTION 2
DEFINITIONS

Throughout this booklet, certain words and phrases may be capitalized. Those terms are defined in this section.

ALLOWABLE/COVERED EXPENSE – means the maximum amount we will pay for the services or supplies covered under this Plan. The Allowable Expense for Covered Services performed by a Professional Provider will not exceed the 80th percentile of the National Dental Advisory Service (NDAS) Pricing Program figures, which are updated annually, or any discounted rates negotiated by the Plan with the Professional Provider. The fact that a Professional Provider recommends a service or device does not necessarily make it a Covered Expense, even though it may not be specifically excluded.

CHARGE – means the amount the Professional Provider bills for a service or supply. Charges are incurred on the date the service or supply is provided to you. In the case of dentures or fixed bridges, the date incurred is the date the impression is taken. In the case of crown work, the date incurred is the date the tooth preparation begins. In the case of root canal therapy, the date incurred is the date preparation of the tooth begins.

COVERED SERVICES/ COVERED EXPENSES – means those services for which the Plan will make payment.

COVERED PERSON – means an Employee, Retiree and/or an Employee's or Retiree's Dependent who is eligible to receive benefits under this Plan.

EMPLOYEE – means a person who meets an Employer's requirements for eligibility under the Plan. Employers may have different eligibility requirements, so check with your Employer Plan Representative for specific eligibility information.

EMPLOYER – means one of the school or BOCES districts participating in the Plan.

EMPLOYER PLAN REPRESENTATIVE – means the individual at the participating Employer school district who provides information to Employees on behalf of this Plan and provides information to this Plan on behalf of Employees.

MEDICALLY NECESSARY – means those treatments, procedures, drugs, or supplies (services) required to diagnose or treat a Covered Person's dental or medical condition, as determined in accordance with accepted dental or medical practices and standards. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the Service does not make it Medically Necessary or mean that the Plan must provide coverage for it. The Plan will determine whether care is or was Medically Necessary. We will base our decision in part on a review of your medical/dental records. We will also evaluate medical/dental opinions we receive. This could include the medical opinion of a professional society, peer review committee, or other groups of dentists or physicians.

In determining if a Service is Medically Necessary, we will also consider the following:

- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care, or treatment;
- The opinion of the attending Professional Providers (which have credence but do not overrule contrary opinions); and
- Any other relevant information brought to our attention.

Services will be deemed Medically Necessary only if:

- They are appropriate and consistent with the diagnosis and treatment of your dental/medical condition;
- They are required for the direct care and treatment or management of that condition;
- If not provided, your condition would be adversely affected;
- They are provided in accordance with community standards of good medical practice;
- They are not primarily for the convenience of you, your family, the Professional Provider or another provider;
- They are the most appropriate services and rendered in the most efficient and economical way and at the most economical level of care which can safely be provided to you; and
- They are provided only for the period necessary for effective diagnosis and treatment of your condition;
- You fully comply with the medical or dental regime established by your Professional Provider.

PROFESSIONAL PROVIDER – means an individual licensed to practice dentistry and/or to perform oral surgery, and other health care professionals who are licensed to provide the services covered under this Plan, in accordance with the license requirements in the State in which they practice. The Provider must bill the Plan for his services to be reimbursed by the Plan.

SPOUSE - means a person to whom you are legally married.

SECTION 3
ELIGIBILITY AND ENROLLMENT INFORMATION

Who is Eligible? Employees, Retirees, and their dependents may be eligible for coverage under this Plan. An Employee may select individual coverage for themself only, a two-person plan for themself and one Dependent, or family coverage that includes the Employee, their Spouse, and any eligible dependents.

A Retiree may select only individual coverage for themself and individual coverage for their spouse. See Section 3, Eligibility and Enrollment Information, "Retiree Eligibility" for details.

Employee Eligibility. The Plan has established certain minimum eligibility requirements for Employees. However, your Employer may adopt more restrictive eligibility requirements within certain limits. Contact your Employer Plan representative for Employer-specific eligibility requirements. Minimum eligibility requirements are as follows:

(1) the Employee must have been hired for an anticipated period of at least three months; and
(2) The Employee must work a regularly scheduled work week of 20 or more hours and be paid a minimum annual salary of at least $2,000.00.

Employees may enroll for either two-person, individual, or family coverage at the time of hire. If an Employee's spouse works for another Employer member of this Plan, the Employee and Spouse may each elect individual coverage, or one may elect family coverage.

Retiree Eligibility. If an Employer offers retiree dental benefits, the Employee must purchase either (1) an individual policy or (2) two individual policies (for themself and their spouse) at the time of retirement. If they have Dependents (eligible children) when they retire, they may retain family coverage until the children are no longer eligible as Dependents. At that time, they must drop family coverage and purchase either one individual policy covering themself or two individual policies covering themselves and their spouse.

> Employees who waive coverage for *any reason* at the time of retirement generally may not elect coverage later. Check with your Employer to verify their policy on this issue because your contract may provide alternative benefits. To maintain your coverage in this Plan after retirement, it must be elected at the time of retirement. If you elect not to cover your spouse at the time of retirement, you may not obtain coverage for any spouse or dependent later.

Vested Status and Retiree Coverage. If an Employee terminates their employment with a participating Employer before retirement age, they may be eligible to continue coverage under the Plan while in "vested" status, and then into retirement. However, to be eligible, the Employee must have (1) satisfied the minimum requirements established by law for vesting their retirement allowance and (2) meet the minimum requirements for continuation of health coverage into retirement at the time of employment termination (except for age). These requirements may not be satisfied while the Employee is in vested status or after the Employee's retirement allowance begins. In addition, an Employer who offers coverage to its retirees may require that the Employee be within five years of retirement at the time they vest.

Vestees must pay the full cost of coverage. After a vestee becomes eligible to receive their retirement allowance, they will be required only to pay the retiree's share of the cost. If there is any interruption in coverage during vested status (such as for failure to remit payment for coverage), the vestee may lose their retirement continuation coverage. Check with your Employer for their policy in this regard.

Coverage for Survivors of Employees or Retirees. If an Employee or Retiree dies while covered for benefits under this Plan, the surviving Dependents are entitled to continue coverage for three months

beyond the last month for which contributions were made on the Employee/Retiree's behalf. This coverage is provided at no cost to the survivors (the school district will make the Employee/Retiree's contribution). COBRA continuation rights will begin after the expiration of survivor benefits.

Once COBRA has been exhausted, the surviving Dependents will be eligible to continue coverage under the Plan *if the deceased Employee/Retiree had at least 10 years of service prior to their death.* The spouse will remain eligible for coverage until they remarry, provided they pay the full cost of coverage. Dependent children will remain eligible for as long as they would have been eligible had their Employee/Retiree parent lived.

Dependent Eligibility. If you have family coverage, the following members of your family may also be covered as Dependents:

(1) Your spouse, unless you are divorced or your marriage has been annulled.
(2) Your biological children, step-children, adopted or pre-adoptive* children, and eligible foster children (those who are placed with the employee by an authorized agency or order of a court of competent jurisdiction), regardless of marital status, financial dependence, residence or student status. Eligibility ends when the child reaches their 26th birthday. (Only the employee's child is eligible, not the child's spouse or children).
(3) Any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness, or developmental disability as defined in the New York Mental Hygiene Law. The condition must have occurred before the child reached the age at which coverage would otherwise terminate. The child's disability must be certified by a physician within 31 days after they reach the age at which coverage would have terminated for coverage to continue under the Plan. The Plan has the right to check whether a child is and continues to qualify under this paragraph. We have the right to request and are furnished with such proof as may be needed to determine eligibility status of a person covered under this Plan.
(4) A child who lives with an Employee on a temporary basis, such as an exchange student or a foster child, is not eligible for benefits.

The Plan has the right to request and be furnished with any proof we need to determine whether a dependent is and remains eligible to receive benefits under this Plan.

Coverage for Disabled Employees. Employees who become Totally Disabled due to illness or injury and who remain Totally Disabled for a continuous period of three months will be eligible to continue coverage under the Plan for up to one year. To be eligible for a waiver of premium during that time, the Disabled Employee must be on authorized leave without pay and not be receiving income through salary, sick leave accruals, or retirement allowance. The Employee must apply for a waiver of premium and keep coverage in effect by paying premiums prior to their application for a waiver. A waiver of the premium may continue for up to 12 months but will terminate if any of the following events occurs: the Employee returns to the payroll; the Employee terminates employment; the Employee (or Dependent) dies; the Employee's disability ceases; or the Employee retires.

****** IMPORTANT! YOU MUST NOTIFY YOUR EMPLOYER PLAN REPRESENTATIVE OF ANY CHANGE IN CIRCUMSTANCES THAT MIGHT AFFECT ELIGIBILITY OF YOUR SPOUSE OR OTHER DEPENDENTS. OTHERWISE, YOU MAY BE RESPONSIBLE TO PAY ANY CLAIMS THAT WERE PAID IN ERROR ON BEHALF OF YOUR INELIGIBLE DEPENDENT.**

When Coverage Begins.

Employees. A new Employee's effective date of coverage is established by their Employer. Coverage may begin on the first day of employment or later. Check with your Employer's Plan Representative regarding your effective date of coverage under the Plan.

Dependents (other than newborns). Employees may elect two-person or family coverage when (1) they acquire a spouse or child who meets the definition of Dependent, or (2) they wish to enroll a previously eligible but un-enrolled spouse or child who meets the definition of Dependent.

An Employee must apply for two-person or family coverage within 30 days after their coverage becomes effective, or the date they acquire a Dependent, in order for coverage to become effective on the first day of the month following application. Otherwise, the coverage will not begin until the first day of the third month following application. In some cases, coverage may begin on the date of marriage, or the date the Employee acquires a Dependent child. Application for first day coverage must be made in advance.

Newborn Coverage. If an Employee has family coverage, their newborn Dependent child will automatically become eligible as a Dependent on the date of their birth. However, the newborn's eligibility for coverage will terminate 30 days after birth unless the Claims Administrator has received enrollment materials by that date.

If the Employee does *not* have family coverage at the time of the infant's birth, the infant will still be covered if the Employee elects Dependent dental coverage, effective as of the first day of the month in which the child was born, and they submit enrollment materials (which are received by the Claims Administrator) no later than 30 days after the birth. The contribution payment must be received by the Claims Administrator on or before the 30th day of the month following the month in which the birth occurs.

Note that to be eligible for any prosthetic or orthodontic benefits, the Covered Person must have been enrolled in the Plan for a period of at least 12 Consecutive months prior to the date coverage is requested.

When Coverage Ends.

Employees. Your coverage as an Employee under this Plan ends at 11:59:59 pm on the day in which the first of the following events occurs:

(1) The day your employment ends; or
(2) The day your status as an eligible Employee ends; or
(3) The last day of the month immediately preceding the month in which you, or your Employer on your behalf, made any required contribution; or
(4) The day your Employer stops participating in the Plan or otherwise terminates your coverage; or
(5) The day the Plan terminates.

Dependents. Your coverage as a Dependent ends at 11:59:59 pm on the day in which the first of the following events occurs (except as provided in any extension of coverage provision):

(1) The day the Employee's coverage under the Plan ends; or
(2) The day the Employee ceases to be in a class of Employees eligible for Dependent coverage; or
(3) The last day of the month immediately preceding the month in which the Employee, or the Employer on behalf of the Employee and covered Dependent, made any required contribution; or
(4) The day Dependent coverage is canceled; or

(5) The day you no longer qualify as a Dependent (or Student Dependent) under the Plan; or
(6) The date of the Employee's death (unless you are entitled to survivor benefits); or
(7) The day the Plan terminates.

Retirees. Your coverage as a Retiree and your spouse or Dependent's coverage will end when the first of the following events occurs, (except as provided in any extension of coverage provision; see "Coverage of Survivors of Employees or Retirees" section above):

(1) The Retiree or the former Employer fails to timely pay the applicable cost of the Retiree's coverage; or
(2) The Plan terminates; or
(3) The Dependent coverage terminates under the Plan; or
(4) The Retiree dies.

SECTION 4
COBRA CONTINUATION COVERAGE

Federal statutes require the Plan to offer special health benefit continuation rights to certain Covered Persons, if coverage is lost due to certain specified occurrences. This law is commonly known as COBRA. The events that will give the Covered Person the option to choose this COBRA continuation coverage are known as "qualifying events." A "qualified beneficiary" is the person eligible for coverage due to a qualifying event. The "Claims Administrator" in the Plan is the Catskill Area Schools Dental Plan.

Qualifying Events. If you are an Employee, you will become a qualified beneficiary under the Plan if you lose coverage because either of the following events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you become a qualified beneficiary if you lose coverage because any of the following events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than their gross misconduct; or
(4) You become divorced or legally separated from your spouse.

Dependent children will become qualified beneficiaries if they lose coverage because any of the following events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than their gross misconduct;
(4) The parents become divorced or legally separated; or
(5) The child no longer meets the definition of Dependent under the Plan.

When is COBRA Coverage Available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Claims Administrator has been notified that the qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the *Employer* must notify the Claims Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events. For the other qualifying events (divorce or legal separation of the Employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), *you must notify* your Employer Plan Representative within 60 days after the qualifying event occurs, and your Employer Plan Representative will notify the Claims Administrator. If you fail to notify the Plan representative within 60 days of the event, COBRA coverage is automatically waived.

How is COBRA Coverage Provided? Once the Claims Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Length of COBRA Coverage. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, divorce or (in some cases) legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage is extended to 18 months. Sometimes, there are multiple qualifying events, so that if you have any questions about the length of COBRA coverage, please contact your Employer Plan Representative.

Early Termination of COBRA Coverage. The maximum period of COBRA coverage may be shortened, and coverage terminated early for any of the following reasons:

(1) the Employer ceases to provide any group dental coverage to any Employee (including successor plans);
(2) the qualified beneficiary fails to make timely payment of their required contribution for coverage;
(3) the qualified beneficiary becomes covered, after the date of COBRA election, under another group dental plan maintained by another Employer that does not exclude or limit coverage for a qualified beneficiary's pre-existing medical condition.

Cost of COBRA Coverage. Employees and other Covered Persons who elect to continue benefits through COBRA will pay 102% of the combined Employee/Employer contribution. The initial payment must be received by the 45th day after the COBRA election. Subsequent payments must be made in advance and no less frequently than quarterly.

SECTION 5
PREVENTIVE DENTAL SERVICES
SCHEDULE OF BENEFITS AND LIMITATIONS

PREVENTIVE DENTAL SERVICES BENEFITS. The Plan covers the following services when they are Medically Necessary and appropriate. Payment is 100% of the Allowable Expenses (as defined in Section 2).

SCHEDULE OF PREVENTIVE DENTAL BENEFITS AND LIMITATIONS	
Type of Service:	**The Plan Pays:**
ORAL EVALUATIONS	100% of Allowable Expenses for two routine dental evaluations each calendar year. Additional evaluations may be covered if there is a diagnosis that requires additional evaluation.
CLEANING (PROPHYLAXIS)	100% of Allowable Expenses for two routine cleanings and two periodontal cleanings (four quadrants each) in each calendar year.
FLOURIDE APPLICATION	100% of Allowable Expenses for two topical applications of fluoride in each Plan year.
X-RAYS	100% of Allowable Expenses for one full mouth x-ray or panorex x-ray in any 36 month period. Bitewing x-rays are also covered to a maximum of two sets in any 12-month period. X-rays are also covered if needed to diagnose or treat a specific condition requiring treatment.
TESTS AND LABORATORY EXAMINATIONS	100% of Allowable Expenses for bacteriologic culture, pulp vitality, and other miscellaneous laboratory tests required in connection with examinations.
SEALANTS	100% of Allowable Expenses for topical application of sealant for a covered Dependent under 19 years of age. Treatment is limited to one per tooth in any 36-month consecutive period. There is no benefit for oral hygiene, dietary or plaque control programs or treatments.

SECTION 6
BASIC DENTAL SERVICES
SCHEDULE OF BENEFITS AND LIMITATIONS

The Plan covers the following services when they are Medically Necessary and appropriate. Payment under the Plan is 100% of the Allowable Expense (as defined in Section 2). **A pre-estimate must be provided if an individual charge is expected to be over $600.00.**

SCHEDULE OF BASIC DENTAL BENEFITS AND LIMITATIONS	
Type of Service:	**The Plan Pays:**
EXTRACTIONS	100% of Allowable Expenses for simple or surgical tooth extractions, including anesthesia, suturing, and routine post-op care.
RESTORATIONS (FILLINGS)	100% of Allowable Expenses for single and multiple surfaces and pin-retained restorations of the teeth with amalgam, silicate, acrylic, or plastic material.
ORAL SURGERY	100% of Allowable Expenses for oral surgery, such as incision and drainage of abscess; removal of odontogenic cyst or tumor; local anesthesia and routine post-operative care; and biopsy of oral tissue. Benefits include Medically Necessary general anesthesia administered by a Professional Provider when included in the primary procedure performed on the same day.
SPACE MAINTAINERS	100% of Allowable Expenses for replacement of prematurely lost or extracted teeth, as well as the necessary modification of a space maintainer if required due to a related change in the condition of the mouth. There is no benefit for the replacement of a lost, missing, or stolen space maintainer.
EMERGENCY TREATMENT	100% of Allowable Expenses for emergency dental procedures that are necessary to temporarily relieve acute pain, discomfort, or distress, but that does not affect a definite cure.
ENDODONTICS	100% of Allowable Expenses for treatment of disease of the dental pulp, including root canals.
PERIODONTICS	100% of Allowable Expenses for treatment of diseases of gums and tissues of the mouth, including gingivitis.
ANESTHESIA	100% of Allowable Expenses for anesthesia charges that are not included in the primary procedure.

SECTION 7
MAJOR DENTAL SERVICES
BENEFITS AND LIMITATIONS

The Plan covers the following services (1., 2. and 3.) when they are Medically Necessary and appropriate. Payment under the Plan is 80% of Allowable Expenses (as defined in Section 2). **A pre-treatment estimate of an individual charge over $600 must be submitted before the above procedures can be performed.**

1. Inlays, Onlays, Gold Restorations and Crowns. Benefits are provided for procedures to restore diseased or accidentally broken teeth by applying crowns; inlays (gold fillings); onlays (covering the top of the tooth); and gold foil or cast. These procedures are covered only when the tooth cannot be restored by conventional methods such as amalgam, composites, etc.

2. Prosthetic Services, Dentures and Bridges. The Plan pays for the construction, placement, insertion, and repair of natural teeth by artificial devices, including bridgework and dentures, when the treatment is Medically Necessary and appropriate. Benefits are also provided for the installation of fixed bridgework (including inlays and crowns as abutments) and placement of full or partial dentures when Medically Necessary and appropriate.

Replacement of an existing or partial or full removable denture or fixed bridgework by a new denture will only be covered under the following conditions:

1. the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was placed;

2. the existing denture or bridgework cannot be made serviceable, at least five years has elapsed before its replacement, and you have been covered under this Plan for at least two years; or

3. the existing denture is an immediate temporary denture that cannot be made permanent, and replacement by a permanent denture takes place within 12 months following the date of initial placement of the immediate temporary denture.

After your bridgework or dentures have been installed for at least six months, benefits are provided for their repair or re-cementing, with certain limitations. Repairs include tissue conditioners, relining, and rebasing. Only one relining or rebasing is covered during any 36-month consecutive period. Relining or rebasing for temporary dentures is not covered if the temporaries are immediately replaced.

3. Dental Implants. The Plan pays for the surgical placement of dental implants (endosteal, subperiosteal/eposteal, transosteal, prefabricated, and custom implant abutments), bone augmentation, implant repair, and implant maintenance when the treatment is Medically Necessary and appropriate to restore teeth lost due to dental caries or abscess.

A pre-treatment estimate of an individual charge over $600 must be submitted before the above services can be provided.

SECTION 8
ORTHODONTIC TREATMENT
BENEFITS AND LIMITATIONS

What is Covered? WHEN PRIOR APPROVAL IS OBTAINED, the Plan pays **75% of Allowable Expenses** for orthodontic treatment when it is considered Medically Necessary and appropriate. Covered expenses include one panorex x-ray every 36 months, surgery, extractions, appliances, and installation of appliances.

What is not Covered? The Plan will not pay for the replacement or repair of any appliance for which benefits were already provided under this section. The Plan will also not pay for orthodontic treatment that is proposed primarily for cosmetic or beautifying purposes. Photo expenses are not covered. See Section 9 for a complete description of charges that may not be covered under this Plan.

How Payment is Made. Payments will be made to the Employee monthly over the course of the treatment. Payment is not automatic. The Employee must submit the bill for reimbursement each month before payment will be made.

TO OBTAIN ORTHODONTIC BENEFITS, you must submit a pre-treatment estimate from the dentist for any service that is expected to cost more than $600.00. Your Professional Provider must submit a written report outlining the planned treatment and cost. The Provider *may not* accept the Plan's Allowable Expense as payment in full. The Plan will pay 75% of the Allowable Expense and the patient must pay the Provider the remaining 25% of the Allowable Expense. In no case, however, will the Plan pay more than the current lifetime maximum payment per Covered Person. The maximum benefit is reviewed and revised at the beginning of every Plan Year and may change in the future. Contact your Employer Plan Representative for more information. The maximum orthodontic benefit is in addition to the Plan Year Maximum payment.

SECTION 9
EXCLUDED CHARGES AND LIMITATIONS

Benefit Limitations and Exclusions. In addition to any benefit limitations or exclusions described elsewhere in this Plan, we will not provide coverage for any of the following:

Accidental Injury. The Plan will not cover services for the treatment of an accidental injury to your sound natural teeth unless you are ineligible to receive benefits under another group health benefits plan. In some cases, these claims may be covered by your medical insurance first, with this plan paying second.

Acts of War. The Plan will not cover charges that result from and illness or injury that results from an act of war, declared or undeclared, or from terrorism and/or armed insurrection.

Care by more than one Professional Provider. If you transfer from one provider to another during a course of treatment, or if more that one provider renders services for the same dental procedure, the Plan will not cover more than it would if one provider had rendered the service.

Charges in Excess of the 80th percentile of the National Dental Advisory Service (NDAS) Pricing Program figures. Any charges of a Professional Provider that are more than the 80th percentile of the National Dental Advisory Service (NDAS) Pricing Program figures are the Covered Person's responsibility to pay.

Cosmetic Services. The Plan does not cover charges incurred to improve an individual's appearance, including, but not limited to charges for personalization or characterization of prosthetic devices.

However, it may cover surgery limited to improving or restoring bodily function or correcting a deformity which has resulted in a functional impairment caused by disease or trauma, or a congenital or developmental abnormality of a covered Dependent child.

Criminal Behavior. We will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in an illegal act, including driving while under the influence of alcohol or driving while intoxicated. The illegal act will be determined by the law of the state where the criminal behavior occurred.

Education. The Plan does not cover charges for educational programs, including but not limited to oral hygiene, plaque control, or dietary instructions.

Experimental and Investigational Treatment. The Plan does not cover treatment for dental procedures that do not meet common dental standards, or are experimental procedures as defined by the American Dental Association or other appropriate dental specialty society. The Plan Administrator determines whether the proposed procedure is Experimental and Investigational and is thereby excluded.

Free Care. We will not provide coverage for any service or care that is furnished to you without charge or that would have been furnished to you without charge if you were not covered under the Plan. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your brother, sister, mother, father, son or daughter, or the spouse of any of them, we will presume that the service or care would have been furnished without charge.

Functional/Myofunctional Therapy. The Plan will not cover orthodontic functional/myofunctional therapy or any related oral evaluations for this therapy.

Government Hospitals. The Plan will only cover services and care received in a Facility owned or operated by a federal, state, or local government if you are not entitled to free care at that Facility, and the Facility usually charges for its services. Emergency care may be covered under certain circumstances, however.

Government Programs. The Plan will not pay benefits that are payable under Medicare or any other government program except when required by state or federal law. When you are eligible for a government program such as Medicare, benefits will be reduced by the amount the program would have paid if you were eligible but failed to enroll in the program. We will not pay benefits if you receive services at a Facility that cannot bill Medicare.

Military Service-Connected Conditions. We will not provide coverage for any service or care related to any military service-connected disability or condition if the Veterans Administration (VA) has the responsibility to provide the service or care.

Mouth guards. The Plan will not pay for mouth guards *except* in specific circumstances such as injury or illness to the jaw. If you question whether a mouth guard will be covered, be sure to check with the Plan first.

No-Fault Automobile Insurance. We will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all the benefits of the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy. We will provide benefits for services covered under this Plan when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a Deductible, we will provide coverage for the services covered under this Plan up to the amount of the Deductible.

Non-Covered Service. We will not provide coverage for any service or care that is not specifically described in this Plan or that is related to service or care not covered under this Plan, even when a provider considers the service or care to be Medically Necessary and appropriate.

Non-medically Necessary Services. We will not cover charges for dental treatment unless it is determined to be Medically Necessary as described in this Plan.

Prohibited Referral. We will not provide coverage for any pharmacy, clinical laboratory, radiation therapy, physical therapy, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York Public Health Law.

Replacements or Repairs. The Plan does not cover charges for any of the following:

(1) Replacement of a lost, stolen or missing prosthetic device, appliance, space maintainer, or any duplicate device or appliance;
(2) Replacement of a bridge or denture within five years after the date it was originally installed unless (a) the replacement is required by the placement of an original opposing full denture or (b) it results from the necessary extraction of natural teeth;
(3) Any replacement of a bridge, crown or denture which is or can be made usable according to common dental standards;
(4) Replacement or repair of an orthodontic appliance;
(5) Replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;
(6) Replacement of an appliance, prosthetic device, or processed veneer with a like appliance or device unless (a) it is at least five years old and can't be made useable, or (b) it is damaged with in the patient's mouth and can't be made serviceable; or
(7) Appliances or restorations necessary to increase vertical dimension or restore the occlusion.

Self-Inflicted Injuries. We will not provide coverage for service or care resulting from self-inflicted injury.

Services Starting Before Coverage Begins. If you are receiving care on the day your coverage under this Plan begins, we will not provide coverage for any service or care you receive:

(a) Prior to the first day of your coverage under this Plan; or
(b) On or after the first day of your coverage under this Plan if that service or care is covered under any other health benefits contract, program, or plan.

Special Charges. We will not provide coverage for charges billed to you for telephone consultations, missed appointments, new patient processing, interest, copies of provider records, or completion of claims forms.

Unlicensed Provider. We will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider, or that is outside the scope of the license of the provider rendering the service or care.

VA Hospitals. We will only provide service and care in a VA Hospital if the condition results from a non-service related problem, and only if the VA is not required to pay benefits for the service. Emergency care may be covered under certain circumstances, however.

Vertical Dimension. The Plan does not cover treatment or services to alter vertical dimension of teeth or treatment to restore occlusion, including occlusion guards or bruxism devices, except in certain circumstances that are subject to review.

War. We will not provide coverage for any service or care which results from war, whether declared or undeclared, including terrorism or resistance to armed aggression.

Workers' Compensation. We will not provide coverage for any service or care for which you are eligible to receive benefits under a workers' compensation or similar law, even if you fail to apply for the benefits, or you lose benefits by failing to appear at a workers' compensation hearing.

Please note that treatment decisions are different from payment decisions. The Plan makes payment decisions only. The Professional Provider is responsible for determining whether treatment should be rendered regardless of whether the charges are totally included in or excluded from coverage under this Plan.

SECTION 10
COORDINATION OF BENEFITS

This section only applies if you, your spouse, or a Dependent is covered both under this Plan as well as under another group health plan or program. Coordination of benefits (COB) means that the coverage provided by this Plan is coordinated with coverage that may be available under the other plan, so that there is no duplication of payment or overpayment.

- **When You Have Other Dental Benefits.** When you are covered under this dental Plan as well as another dental plan, you have what is known as "primary" and "secondary" coverage. The primary plan is the one that pays its benefits first. The secondary plan is the one that pays second. When that is the case and you receive a service which would be covered by both plans, we will coordinate benefit payments with any payment made under the other plan. One company will pay its full benefit as the primary plan. The other company will pay secondary benefits, if necessary, to cover all or some of your remaining expenses.

How We Determine Which Plan Pays First. To decide which plan is primary and pays first, we use the following rules:

- If the other plan does not have a provision like this one, then it will be primary;
    - If you are covered under one plan as an employee and you are only covered as a dependent under the other plan, the plan which covers you as an employee will be primary.

- Subject to the provisions regarding separated or divorced parents below, if you are covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan which covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the rule in the other plan will determine the order of benefits.

  There are special rules for a child of separated or divorced parents:

    - If the terms of a court decree specify which parent is responsible for the dental care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.

    - If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's dental care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

        (1) First, the plan of the parent with custody of the child;
        (2) Then, the plan of the spouse of the parent with custody of the child;
        (3) Finally, the plan of the parent not having custody of the child.

- If you are covered by one of the plans as an active employee, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

- If none of the above rules determine which plan shall be primary, then the plan which has covered you for the longest time will be primary.

Payment of Benefits When This Plan is Primary. When we are primary, we will pay benefits covered under this Plan as if there were no COB provision.

Payment of Benefits When This Plan is Secondary. When this plan is secondary, the benefits of this plan will be reduced so that the total benefits payable under the other plan and this plan do not exceed your expenses for an item of service. **However, we will never pay more benefits for any item of service than we would have paid if we were primary, and we will never pay more than the plan's Allowable Expenses**. We count as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. We will request information from that plan so we can process your claims.

Right to Receive and Release Needed Information. We have the right to release or obtain information which we believe necessary to carry out the purpose of this section. We need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. We will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish to us any information which we request. If you do not furnish the information to us, we have the right to deny payments.

Our Right to Recover Overpayments and Repayment to Other Plans. In some cases, we may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund us the amount by which we should have reduced the payment we made. We also have the right to recover the overpayment from the other health benefits plan if we have not already received payment from that other plan. You must sign any document which we deem necessary to help us recover any overpayment.

SECTION 11
CLAIMS FILING, PAYMENT OF BENEFITS, APPEALS

Filing a Claim. Claim forms can be obtained from your Administrator or by going to www.oncboces.org. It is important to submit claims properly and completely, and as soon as reasonably possible. If you omit needed information, your benefit payments will probably be delayed. Your submission of a claim is an authorization to release medical information to the Plan for Plan administration purposes.

- Make sure you answer all the questions on the form, and that you sign it. Your address should be your home address, not your work address. Give the form to your Professional Provider who will complete the form and **return the claim form to Ameritas, PO Box 82520, Lincoln, NE 68501-2520.**

- The Dentist must attach an original itemized statement showing the name of the patient; the name and federal tax I.D of the Professional Provider; the date of service, treatment, or purchase; the amount charged for each item; and the reason for the treatment (diagnosis or nature of illness or injury). Separate claim forms should be submitted for each person for whom a claim is being filed. All claims must be signed by the participant.

- If this Plan is secondary coverage, an Explanation of Benefits must be included with the itemized bill and attached to the submission of a claim for reimbursement.

- If you expect an individual dental service to cost more than $600.00, the dentist should ask for a pre-treatment estimate of benefits. The Provider will be informed of the amount estimated to be paid by the Plan. This will help to eliminate any uncertainty regarding amounts payable and benefits remaining in the Plan year.

- The Plan will make the benefit payment directly to you and you are responsible to pay the Professional Provider unless you sign the claim form to allow payment directly to the provider or the provider is a Participating Provider in the Ameritas provider network. No claim will be considered for payment if submitted more than 12 months following the last date of treatment on the form.

If you have questions concerning the Plan, contact the Administrator's office at (800) 962-6294 or (607) 588-8917. For questions regarding the status of your claim or specific claim payment, contact the Third-Party Claims Administrator**- Ameritas, PO Box 82520, Lincoln, NE 68501-2520.** Phone: 800-487-5553.

Claims Appeal Review Procedure

Notification of a Claim Denial. If any claim for benefits under this Plan is denied, you will be advised in writing the reason for the denial. Typically, this will occur within 90 days after receipt of the claim by the Plan (or sometimes within 180 days under circumstances requiring a delay in the processing of the claim). If an extension is required, you will receive notice of that within the initial 90-day period. This notice will advise you of the reason an extension is required and give you the date by which a decision shall be made.

Appealing the Denial of a Claim. You have the right to appeal a denial of a claim to the Plan Administrator. The Plan Administrator has the authority to conduct a full, fair, and final review of any disputed claim. You or your designated representative should ask for a review of the claim denial by writing to the Plan Administrator, stating in writing the reasons you feel the claim should not have been denied. You can present any documents or records you believe support your appeal. You have 60 days from the receipt of the initial denial to appeal the decision, and you will be contacted with 60 days of the final decision of the Plan Administrator. In some special cases, the decision may take up to 120 days once your appeal is received by the Plan Administrator. The decision of the Plan administrator is the final decision on the claim denial.