NY44 HEALTH BENEFITS PLAN

FOR

PARTICIPATING SCHOOL DISTRICTS AND THEIR EMPLOYEES AND RETIREES

DENTAL BENEFITS PLAN AND SUMMARY PLAN DESCRIPTION

Effective July 1, 2007

As amended, effective July 1, 2015

Established and maintained by:
Board of Trustees of the
NY44 Health Benefits Plan Trust

Version 3.1

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THIS ORGANIZATION OPERATES UNDER THE SUPERVISION OF THE NEW YORK STATE INSURANCE DEPARTMENT PURSUANT TO ARTICLE 44 OF THE NEW YORK STATE INSURANCE LAW.

The Plan does not and cannot make treatment decisions for Enrollees. It makes only payment decisions. Treatment decisions are independent from payment decisions. It is the responsibility of the patient and his dentist to determine whether treatment should be rendered, regardless of whether the charges are totally or partially Covered or excluded from Coverage under this Plan. The Plan is only the payer of covered benefits, and it does not select, nor take any responsibility for the proper or improper performance of Dentist or other Service Provider.

Certain facts are needed by the Plan's Claims Administrator to make payment determinations and to process claims. The Claims Administrator has the right to decide which facts they need and may obtain medical records and other needed facts from any other organization or person. The Claims Administrator need not notify or obtain the consent of, any person to do this. Any such information given will be kept confidential, and will be used only as deemed necessary for proper Plan administration purposes.

Participating Districts are required to notify the Claims Administrator immediately if there is any change in Employee or Dependent status. Proof of Dependent status is required for processing of any Dependent claims.

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SECTION 1 – INTRODUCTION

The Board of Trustees and your Participating District are pleased to provide you with a copy of the NY44 HEALTH BENEFITS PLAN DENTAL BENEFITS PLAN AND SUMMARY PLAN DESCRIPTION. You should read this booklet carefully to acquaint yourself with its provisions for eligibility, benefits, filing a claim and other important information.

THE COVERED BENEFITS UNDER THIS PLAN ARE SELF-FUNDED. THIS MEANS THAT THE TRUST ASSUMES TOTAL RESPONSIBILITY FOR COVERED CLAIMS THAT ARE INCURRED, SUBJECT TO ANY STOP-LOSS ARRANGEMENTS THE TRUST MAKES WITH AN INSURANCE COMPANY.

The NY44 Health Benefits Plan Trust ("Trust" or "us" or "we" or "our") hereby agrees to provide benefits for the Dental Services set forth herein to Enrollees (or "you" or "your"), subject to the exclusions, limitations, conditions, and other terms of this Plan.

For claims incurred on and after July 1, 2007 this restated Plan document supersedes any and all predecessor Plan and Summary Plan Description documents.

You will find terms starting with capital letters throughout the Plan. To help you understand the benefits payable under this Plan, see the definitions of those terms in Section 2 of the Plan.

Important Information

Listed below is information that will be helpful to you if you have any questions about the administration of the Plan.

A. The Plan is the NY44 HEALTH BENEFITS PLAN (hereinafter referred to as the "Plan").

B. This Plan and Summary Plan Description were first effective as of July 1, 2007. Version 3.1 is effective as of July 1, 2015.

C. The Plan is established and maintained by the Board of Trustees of the NY44 Health Benefits Plan Trust, 355 Harlem Road, West Seneca, NY 14224.

D. The Plan Number is 501.

E. The Plan Year begins at 12:00 a.m. on each July 1 and ends at 11:59:59 p.m. on the following June 30. Each succeeding like period will be considered a new Plan Year.

F. The Plan's Fiscal Year begins at 12:00 a.m. on each July 1 and ends at 11:59:59 p.m. on the following June 30. Each succeeding like period will be considered a new Fiscal Year.

G. The Plan's Claims Administrator is ProBenefits Administrators, located at 100 Corporate Parkway, Suite 342, Amherst, NY 14226 (716-831-8171 or 888-683-3682, 8:00 a.m. until 4:00 p.m., Monday – Friday) or such other entity as designated by the Trustees of the Plan. The Claims Administrator is the entity providing services to the Plan in connection with the operation of the Plan and performing such functions, including processing and payment of claims, as may be delegated to it.

H. The Plan Administrator is named by the Board of Trustees of the NY44 Health Benefits Plan Trust, 355 Harlem Road, West Seneca, NY 14224. The Board of Trustees is comprised of five (5) managerial and five (5) bargaining unit representatives from Erie 1 BOCES.

I. Service of legal process may be made upon the Chair of the Board of Trustees of the NY44 Health Benefits Plan Trust.

J. This is a governmental employees' health plan providing payment and/or reimbursement for certain dental expenses. Contributions for funding benefits are provided by the Participating Districts and, in some cases, also by payroll deduction contributions of the Employee or contributions paid by Retirees or COBRA-eligible Enrollees. Benefits under the Plan are self-funded by the Trust's Plan assets, and may be reinsured with stop loss coverage.

K. The persons eligible for participation in this Plan as Enrollees are as defined by the Participating Districts, with their eligible Dependents, and COBRA-eligible covered Enrollees.

L. Authority for the Plan. The NY44 Health Benefits Plan Trust is not a licensed insurer. The Trust and Plan operate pursuant to Article 44 of the Insurance Law of the State of New York.

M. Number and Gender. All singular terms used herein shall be deemed to include the plural thereof and vice versa, and terms of the masculine gender shall be deemed to include the feminine and neutral gender and vice versa, unless the context of usage clearly requires that only the specific terminology used shall apply.

N. Amendment or Termination of the Plan. The Trustees intend to continue the Plan described herein as a permanent program. However, the Trustees specifically reserve the right to amend, suspend or terminate the Plan described herein at any time and for any reason, except that: (1) no amendment, suspension or termination of the Plan shall affect any claim for any expense incurred as of the effective date of the amendment, suspension or termination; (2) this paragraph shall not affect the rights and liabilities of any of the parties under any applicable collective bargaining agreements; and (3) no amendment of the Plan may be made which would permit any part of the Trust Fund to be used for, or diverted to, purposes other than for the exclusive benefit of the Covered Persons, or the payment of expenses of the Trust or Plan. Any amendment, suspension or termination of the Plan shall be by a motion duly made, seconded and passed by the Board of Trustees, and evidenced by an instrument in writing signed by the Trustees.

O. Construction and Determination by Trustees. The Trustees shall have full and exclusive discretionary authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and all other related matters. They shall have full and exclusive discretionary authority to construe the provisions this Plan and the terms used herein. They shall be the sole judges of the standard of proof required in any case. Any such determination, construction or judgment adopted by the Trustees in good faith shall be final and binding upon all of the parties hereto and any Enrollees and beneficiaries hereof. No decision of the Board of Trustees shall be reversed or overturned unless determined to be arbitrary and capricious. No matter respecting the foregoing or any difference arising thereunder or any matter involved in or arising under this Plan shall be subject to the grievance or arbitration procedure established in any collective bargaining agreement between an Employer and Union, provided, however, that this paragraph shall not affect the rights and liabilities of any of the parties under any such collective bargaining agreements.

Covered Persons' Rights

The people who operate this Plan are known as Plan "fiduciaries" and have a duty to do so prudently and in the interest of all Plan Enrollees and beneficiaries. No one, including an employer, union, or any other person, may fire or otherwise discriminate against a person in any way to prevent him from obtaining a benefit or from exercising his rights under this Plan. If a fiduciary misuses the Plan's money, or if a person is discriminated against for asserting his rights, he may file a suit in court. The court will determine who should pay court costs and legal fees. If the plaintiff is successful, the court may award him costs and fees. On

the other hand, if the claim is frivolous, and the plaintiff loses, the court may order him to pay costs and fees.

A Covered Person is entitled to examine all Plan documents, including insurance Plans, collective bargaining agreements and copies of all documents filed by the Plan, such as annual reports and Plan descriptions. This can be done, without charge, at the Trust office or at other specified locations. A Covered Person is also entitled to obtain copies of all Plan documents and other Plan information within 30 days, upon written request to the Plan Administrator, who may make a reasonable charge for copies. If such materials are not provided in a timely manner, the Covered Person may commence a legal action in court. In such a case, the court may require the Plan Administrator to provide the materials and pay a plaintiff up to $100.00 a day until the materials are received (unless the materials were not provided because of reasons beyond the Plan Administrator's control).

Questions about the Plan should be addressed to the Plan Administrator, c/o the Board of Trustees, whose address can be found in Section 1.C. of this Plan.

Entire Agreement

This Plan document, together with its amendments and any applicable endorsements, constitutes the entire Plan.

SECTION 2 – DEFINITIONS

Adoptive Child: a child or infant as described in Section 3 of the Plan.
Application: the form completed by an applicant requesting Coverage from us and listing all Family Dependents to be Covered on the date such Coverage takes effect; the information from the completed application form is entered into the online Benefficiency program by the Participating District's benefit staff.
Calendar Year: a twelve-month period beginning January 1 and ending at midnight of December 31 of each year.
Claim Form: the form provided by the Claims Administrator for incurred Eligible Expenses for treatment by Dental Providers.
Contribution for Coverage: the periodic amount of money we currently charge for benefits and services Covered under this Plan.
Coverage or Covered: the Dental Services reimbursed under the Plan.
Covered Person or "you" or "your": a person who meets all relevant eligibility requirements under Section 3 of the Plan, who applies and is accepted for Coverage from us, for whom the monthly Contribution for Coverage has been received by us, and is covered for benefits under this Plan.
Deductible: the amount payable by or on behalf of you for Out-of-Network Services before the Plan begins to pay; there is no deductible applicable to this Plan.
Effective Date: the date from which you are entitled to receive Dental benefits from us. Coverage begins at 12:01 a.m. Eastern Standard Time on the Effective Date in accordance with the following:

a. When a person makes application for enrollment within thirty (30) days after the date he was first eligible, Coverage will be effective on the Eligibility Date;
b. When a person fails to enroll within thirty (30) days of his Eligibility Date, he must wait until the next Open Enrollment Period to enroll in this plan unless he is eligible for a Special Enrollment;
c. When a person is eligible for a Special Enrollment and
d. When Contributions for Coverage for all persons under this Plan have been received by us.

Eligibility Date: the date(s) when a person is eligible to participate in the dental benefits plan, provided that the Contribution for Coverage for Coverage under this Plan has been received by us. An eligible person must elect Coverage within the thirty (30) day period following the date he could first obtain Coverage (including eligible dependents) or when a person is eligible under Special Enrollment. If a Covered Person terminates Coverage for any reason other than termination of employment or eligibility with the Participating District, Coverage may be added only during the Open Enrollment Period except where the Covered Person qualifies for a Special Enrollment.
Eligible Expenses: the reasonable fees for Medically Necessary Dental Services Covered under this Plan. Eligible Expenses include only fees for services actually provided to you. For services and items provided by

Participating and Non-Participating Providers, Eligible Expenses are the fee schedule amounts.

Enrollee: an employee or other individual with eligibility through a Participating District

Experimental and/or investigational: any dental treatment, procedure, drug, substance or device

a. that is the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
b. for which a written protocol or protocols or written informed consent, used by the treating facility or provider (or the protocol or written informed consent of another facility or provider studying substantially the same medical treatment, procedure, drug, substance or device), identify the medical treatment, procedure, drug, substance or device as a research or investigational or experimental or a clinical trial or study, unless the proposed medical treatment, procedure, drug, substance or device (1) is so identified solely for purposes of clinical data collection and statistical survival analysis and (2) is generally recognized by the medical community, as reflected in the published peer review medical journals, as the standard of care for the treatment of the Covered Person's specific Illness or Injury; or
c. that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration ("USFDA") and approval for marketing has not been given at the time the drug or substance or device is furnished; or
d. that is a drug or substance or device which is not, at the time it is furnished, approved by the USFDA for the specific Illness or Injury for which the patient is being treated; or
e. that is a drug or substance or device which is labeled: "Caution -- limited by federal law to investigational use" or a substantially similar label or warning.

Family Dependent(s): a person meeting all the eligibility requirements set forth in Section 3.

Group Benefit Plan(s): health benefit plans such as: HMO; health insurance; employer self-insurance or other group health plan that covers Enrollee or Family Dependents.

Dentist or Dental Provider: a person who is licensed, certified or otherwise qualified under a state's laws to provide the Covered benefits authorized pursuant to such license, certification or other qualification. All Dental Providers are independent contractors and are not our employees or agents.

Dental Services: Medically Necessary services to treat your dental condition, injury or disease. Dental Services do not include services which are not actually provided to you.

Fee Schedule: a listing of the Allowance for each Covered Dental Service

Identification Card: the card that we issue to you showing that you are entitled to Covered Dental Services.

In-Network Allowance: the maximum amount we will pay for Covered Dental Services received from a Participating Provider

In-Network Services/Benefits: Covered Dental Services which are provided by a Participating Provider.

Medically Necessary: any Dental Services required to preserve and maintain your oral health as determined by acceptable standards of dental practice. The Plan Covers only Medically Necessary services.

Non-Covered Service(s): the Dental Services not Covered by the Plan.

Non-Participating Provider: a licensed dentist or other licensed or certified dental services provider who does not currently have a Participating Provider agreement with ProBenefits Administrators and who provides services Covered under Section 5 of this Plan.

Open Enrollment Period: a period of time which we establish when the participating district or unit can add new Enrollees. The Open Enrollment Period shall occur not more frequently than once a year and usually coincides with the Plan's Fiscal Year.

Out-of-Network Allowance: the maximum amount we will pay for Covered Dental Services received from a Non-Participating Provider

Out-of-Network Services/Benefits: Covered Health Care Services that are provided or referred by a Non-Participating Provider which the Covered Person elects to have rendered.

Participating District: the District, employer, or unit which contracts with us to Cover Dental Services for you.

Participating Dentist(s): any dentist who has agreed to provide Dental Services to you as a Participating Provider.

Participating Provider(s): a participating Dentist or other duly licensed Health Care Provider that has a Participating Provider agreement with ProBenefits Administrators and provides services Covered under Section 5 of this Plan. All Dental Providers are independent contractors and are not employees or agents of ours.

Service Provider: a provider of services or supplies which are Covered under the Plan.

Special Enrollment: the ability of an eligible person or dependent to participate in the health benefits plan under this Plan as described in Section 3.B. of this Plan.

Totally Disabled: an injury, illness or disease, which renders a working Enrollee incapable of performing each and every task of any employment for which he has or can be trained. In the case of a non-working Enrollee when, by reason of illness, injury or disease, he is wholly unable to engage in the normal activities of a person of the same sex and age. The inability to perform some, but not all, of many tasks will not be deemed to be total disability.

SECTION 3 - ELIGIBILITY, ENROLLMENT, AND CONDITIONS OF COVERAGE

A. Eligibility

Individuals are accepted for enrollment when they meet the requirements outlined below:

1. Enrollees: To be eligible to enroll as an Enrollee, an individual must be entitled to participate through the Participating District and meet such eligibility requirements (such as length of service, active employment, etc.) as may be imposed by the Participating District.

2. Family Dependents: To be eligible to enroll as a Family Dependent, an individual must qualify under one of the following paragraphs:
   a. Married to the Enrollee;
   b. For an enrollee who is participating through a Participating District that has authorized domestic partner coverage by formal board resolution or by a specific language in a collective bargaining agreement coverage shall be available to the Enrollee's Domestic Partner who meets all of the following:
      1. Of the same or opposite sex; and
      2. At least eighteen (18) years of age; and
      3. Not related by marriage or by blood in a way that would bar marriage; and
      4. Not married to anyone else nor have had another domestic partner for a period of not
      5. less than one (1) year; and
      6. Registered as the Enrollee's domestic partner; and
      7. Provides proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
      8. Provides evidence of two or more of the following:
         a. a joint bank account;
         b. a joint credit or charge card;
         c. joint obligation on a loan;
         d. status as authorized signatory on the Enrollee's bank account, credit card or charge card;
         e. joint ownership of residence;
         f. joint ownership of real estate other than residence;
         g. listing of both partners as tenants on a lease of the shared residence;
         h. shared rental payments of residence (need not be shared 50/50);
         i. listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;

j. a common household and shared household expenses, (e.g., grocery bills, utility bills, telephone bills, etc.);
k. shared household budget for purposes of receiving government benefits;
l. status of one as representative payee for the other's government benefits;
m. joint ownership of major items of personal property (e.g., appliances, furniture);
n. joint ownership of a motor vehicle;
o. joint responsibility for child care;
p. shared child-care expenses;
q. execution of wills naming each other as executor and/or beneficiary;
r. designation as beneficiary under the other's life insurance policy;
s. mutual grant of durable power of attorney;
t. mutual grant of authority to make health care decisions (e.g., health care power of attorney);
u. affidavit by creditor or other individual able to testify to partners' financial interdependence;
v. other items of proof to establish economic interdependency under the circumstances of the particular case.

In order to enroll the Enrollee's domestic partner, the Enrollee must execute a Domestic Partner Affidavit and pay us the additional Contribution for Coverage, if any, within thirty (30) days of the Enrollee's Eligibility Date, during the Participating District's Open Enrollment Period or during a Special Enrollment period.

c. An unmarried child of the Enrollee including any stepchild; legally adopted child; grandchild, foster child, proposed adoptive child or child for whom the Enrollee is the legal guardian who is a member of the Enrollee's household; dependent upon the Enrollee for support and maintenance; and less than twenty-four (24) years of age, and is not on active duty in the armed forces of any country.

   Adoptive non-infant children less than age twenty-four (24) are Covered from the date we receive notification and payment for additional Contribution for Coverage, if any, provided that the following steps resulting in final adoption are completed:
   1. We are notified of the Coverage for the Adoptive Child within thirty (30) days of taking physical custody;
   2. the Enrollee files a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of taking physical custody;
   3. no notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law; and

4. consent to the adoption has not been revoked and the Enrollee retains a legal obligation for the total or partial support of the child in anticipation of adoption.

Adoptive infants are Covered from the moment of birth when the following steps resulting in final adoptions are completed:

1. we are notified of the Coverage for the adoptive infant and receive payment of additional Contribution for Coverage, if any, within thirty (30) days of the date of birth;
2. the Enrollee takes physical custody of the adoptive infant upon release from the Hospital;
3. the Enrollee files a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of birth;
4. no notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law; and
5. consent to the adoption has not been revoked and the Enrollee retains a legal obligation for the total or partial support of the infant in anticipation of adoption.

If we do not receive notification and payment of additional Contribution for Coverage, if any, on or before the thirtieth (30th) day from the date of birth or the date upon which the child is physically in the household of the Enrollee, then Coverage will begin on the Participating District's Open Enrollment Period or during a Special Enrollment event if notification and payment is received by us on or before the thirtieth (30th) day from that date. Coverage of the initial Hospital stay for a newborn adoptive infant is not provided by us if a natural parent has insurance or other coverage available for the adoptive infant's care.

Upon request, the Enrollee must provide us with a copy of the Enrollee's income tax form to demonstrate that the child is claimed as a dependent and, if applicable, the legal guardianship papers.

d. An unmarried child of the Enrollee including any stepchild, legally adopted child, or proposed adoptive child who is the age of twenty-four (24) or over and is:
   1. Incapable of self-sustaining employment because of mental illness, mental retardation or developmental disability, as defined by the N.Y.S. Mental Hygiene Law, or because of physical handicap, and
   2. Dependent upon the Enrollee for support and maintenance. The child must have been Covered by this Plan and must have become incapable prior to age twenty-four (24) for purposes of this. The dependent child, to remain eligible, must continue to be subject to the conditions set out above. Enrollee may be required by us to provide evidence of the handicapping conditions claimed to be existing for the dependent child. Enrollee may be required by us to provide evidence that the child is dependent upon the Enrollee for support and maintenance.

3. A new Family Dependent, because of marriage or adoption of a child, may be enrolled during an eligibility period extending for a period of thirty (30) days after the Family Dependent first becomes eligible for Coverage from us. If we do not receive notification and payment of additional Contribution for Coverage, if any, on or before the thirtieth (30th) day from the date the Family Dependent first becomes eligible, then Coverage will begin on the Participating District's Open Enrollment Period or a Special Enrollment event if notification and payment is received by us on or before the thirtieth (30th) day from that date. Newborn natural children of the Enrollee shall be Covered from birth if notification is received and additional Contribution for Coverage paid, if any, within thirty (30) days of the date of such child's birth; otherwise Coverage begins on the date we receive notification and payment, provided such notification and payment is received by us reasonably close to the child's birth.

4. Persons not entitled to Coverage include:
   a. Persons who are in the armed forces of any government other than for duty of thirty (30) days or less.
   b. Dependents who are Enrollees of the Plan through their own employment.
   c. Dependents who are Dependents of another Enrollee of this Plan.
   d. Any child born to an Enrollee's dependent child, except as provided in III.A.2.c.

5. We reserve the right to examine a Participating District's records including payroll records and an individual's employment or enrollment records in determining eligibility status for enrollment or under certain benefit exclusions such as, but not limited to, Workers' Compensation.

6. We reserve the right to request and be furnished with such proof as may be needed to determine eligibility status of an Enrollee.

B. Enrollment

1. Enrollees may be enrolled with us only within thirty (30) days of their first day of eligibility for enrollment, during the Open Enrollment period, or within thirty (30) days of a Special Enrollment event and upon meeting the eligibility requirements imposed by the Participating District.
2. A potential Enrollee may enroll other than during the Open Enrollment Period when one of the following changes in status occurs ("Special Enrollment Events") and when proof of such situation is presented to us:
   a. a person becomes a dependent of the potential Enrollee through marriage, birth, adoption or placement for adoption;
   b. exhaustion of COBRA continuation Coverage;

c. an involuntary loss of dental insurance coverage resulting from a loss of eligibility or the employer's contributions towards coverage were terminated, provided that such person had such coverage at the time coverage hereunder was previously offered.

3. An Enrollee's spouse or family member may enroll other than during the Open Enrollment Period when the person becomes a dependent of the Enrollee through:
   a. marriage or assumption of a domestic partnership;
   b. birth, adoption or placement for adoption, and the case of the birth or adoption of a child, the spouse of the Enrollee may enroll as a dependent if otherwise eligible.
4. Enrollees may enroll themselves and their Family Dependents during an eligibility period by completing an Application and submitting it to the Participating District's benefit staff; the Participating District's benefit staff will enter the enrollments into Benefficiency. The Participating District agrees to give all newly hired employees our descriptive literature as soon as they become eligible for Coverage. Such Enrollees may apply for Coverage from us within thirty (30) days of the date they become eligible for Coverage. If Enrollees do not apply within thirty (30) days of the date they become eligible they must wait until the next Open Enrollment Period or Special Enrollment event to become Covered.
5. Changes to the original Application Form must be made by completing a new Application Form and submitting it to the Participating District's benefits staff; the Participating District's benefit staff will make the changes through Benefficiency. The Participating District agrees to promptly notify us if there is any change in the Enrollee's eligibility for Coverage.
6. Coverage of Enrollees and Family Dependents shall take effect on the Effective Date.
7. Enrollees or Family Dependents (other than newborn children of the Enrollee) who are confined to a Hospital; Skilled Nursing Facility; Home Health Care; or other health care facility on the date when this Coverage would otherwise take effect, will be eligible for Coverage, effective the first day following the Enrollee's or the Family Dependent's final discharge from such confinement (the date after discharge).

SECTION 4 - PREDETERMINATION OF BENEFITS

A. PREDETERMINATION OF BENEFITS

If dental charges are expected to be more than $200, you or your dentist should request a predetermination of benefits:

- Submit the treatment plan to ProBenefits Administrators before treatment begins, unless emergency care is necessary. X-rays and other supporting records should be attached to the treatment plan.
- ProBenefits Administrators will then calculate benefits from the Plan before the Dentist begins work. ProBenefits Administrators will notify you and your dentist of what portion of the total bill will be paid by the Plan.

ProBenefits Administrators decides only whether a service is covered under the plan and, if it is covered, how much the Plan will pay for the service. ProBenefits Administrators does not decide what treatment is most appropriate for you. You and your dentist make the final decision on your treatment.

If the estimated charges are less than $200, or if emergency care is involved, it is not necessary to file a treatment plan before your dentist begins work.

B. COMPLETING THE CLAIM

After the dental work is completed, your dentist should send the claim back to ProBenefits Administrators for processing of payment.

SECTION 5 - COVERAGE OF DENTAL SERVICES

A. Dental Services which are Medically Necessary will be Covered or reimbursed in accordance with this Section 5 as follows:

1. ProBenefits Administrators Participating Providers: Dental Services received from ProBenefits Administrators Participating Providers will be Covered in conformance with Section 5, Schedule of Benefits under the In-Network benefits.

2. Non-Participating Providers. Dental Services received from Non-Participating Providers will be Covered in conformance with Section 5, Schedule of Benefits under Out-of-Network benefits.

B. Fee Schedules

1. We have approved an In-Network Fee Schedule for the Dental Services described in this Plan. The In-Network Fee Schedule determines the maximum amount we will pay for Dental Services received from a Participating Provider. This amount is called the In-Network Allowance.
   a. The In-Network Allowance for any planned Dental Service may be disclosed to the Covered Person by ProBenefits Administrators or the Participating Dentist.
   b. Upon request, a fee will be set for any Dental Service not listed in the In-Network Fee Schedule.
   c. The In-Network Fee Schedule may be changed by ProBenefits Administrators from time to time without notification to you.

2. We have approved an Out-of-Network Fee Schedule for the Dental Services described in this Plan. The Out-of-Network Fee Schedule is based on reasonable and customary charges in Western New York and determines the maximum amount we will pay for Dental Services received from a Non-Participating Provider. This amount is called the Out-of-Network Allowance.
   a. The Out-of-Network Fee Schedule is shown in Appendix B of this Summary Plan Description.
   b. Upon request, a fee will be set for any Dental Service not listed in the Out-of-Network Fee Schedule.
   c. The Out-of-Network Fee Schedule may be changed by the Plan from time to time without notification to you.

C. Payments, Deductibles, Additional Payments and Annual Maximums.

1. **No Deductibles are applicable to Dental Services.**

2. **Additional payments** The charges of Non-Participating Providers may exceed the Out-of-Network Allowance. You must pay the difference between the Out-of-Network Allowance and the Non-Participating Provider's charges.

3. **Benefit Maximums**

   a. Annual Maximum: The maximum benefit for Covered Services under this Plan is limited to $1,500 per person per Calendar Year for Class I, Class II, and Class III services, combined In-Network and Out-of-Network services.

   b. Orthodontia Lifetime Maximum: The maximum benefit for Covered Services for orthodontia (Class IV services) under this Plan is limited to $2,400 per person per lifetime, combined In-Network and Out-of-Network services.

D. SCHEDULE OF COVERAGE

Coverage is subject to the exclusions in Sections 7 and 8 and to the limitations of this plan.

Medically Necessary In-Network and Out-of-Network Services will be Covered as set forth below.

SUMMARY OF BENEFITS

Effective 7/1/2015

Medically Necessary In-Network and Out-of-Network Services will be Covered as set for below.

CLASS I - PREVENTIVE AND DIAGNOSTIC SERVICES

SERVICES	IN-NETWORK -	OUT-OF-NETWORK	NOTES
Prophylaxis (dental cleaning)	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Limited to maximum of four per contract year
Topical application of fluoride	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Limited to one every six months
Dental sealants	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Covered for Covered Persons under age 16, limited to one every 36 months for posterior teeth only
Oral Exams	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Limited to maximum of four per contract year
Emergency Palliative Treatment and other non-routine unscheduled visits	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Covered only if no other services, except x-rays, are provided during the visit
X-rays	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Intraoral x-ray - complete series including bitewings are limited to one every 60 months Intraoral periapical or occlusal X-rays-single films are limited to 4 periapical & 2 occlusal x-rays every 12 months

			Bitewing film are limited to 4 films per visit every 12 months Panoramic Film, maxilla and mandible, is limited to one every 60 months Extraoral superior or inferior maxillary films are limited to 2 every 12 months

CLASS II - MINOR RESTORATIVE SERVICES

SERVICES	IN-NETWORK -	OUT-OF-NETWORK	NOTES
Space Maintainers Fixed and removable, bilateral and unilateral	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Amalgam restorations (fillings) for primary or permanent teeth	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Composite resin restorations (fillings) for primary or permanent teeth	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Extractions	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Oral surgery **- Removal exposed root** **- Surgical removal of erupted tooth** **- Removal of impacted tooth, soft or bony** **- Alveoloplasty-per quadrant** **- Excision of benign tumor lesion** **- Removal of odontogenic cyst** **- Incision/drainage of intraoral abscess** **- Frenulectomy**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Anesthesia	Covered at 100% of	Covered up to the	General anesthesia

- local anesthesia - regional block anesthesia - trigeminal division block anesthesia - general anesthesia- first 30 minutes	Scheduled Allowance, subject to Annual Maximum	Scheduled of Allowances, subject to Annual Maximum	covered only if medically necessary
Prosthodontics - Adding teeth to partial dentures to replace extracted natural teeth - Repairs to crowns - Recementation inlay, onlay, crown - Crowns, acrylic or plastic, without metal, and stainless steel	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Endodontics - Pulp cap-direct and indirect (excluding final restoration) - Therapeutic Pulpotomy (excluding final restoration) - Root canal-anterior, bicuspid, molar (excluding final restoration) - Apexification - Apicoectomy	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Periodontics - Gingivectomy or Gingivoplasty-per tooth or quadrant - Mucogingival surgery-per quadrant - Osseous surgery-per quadrant - Periodontal scaling & root planing-per quadrant	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Occlusal adjustment, per quadrant	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Limited to 4 quadrants every 36 months

CLASS III - MAJOR RESTORATIVE SERVICES

SERVICES	IN-NETWORK -	OUT-OF-NETWORK	NOTES
-Crowns, resin - Crowns, porcelain fused to noble metal - Crowns, full cast high noble metal or 3/4 cast metallic - Inlay-metallic, one, two, three or more surfaces - Onlay, in the presence of an inlay - Core build-up, including any pins - Pin retention/tooth (in addition to crown) - Cast Post and Core (in addition to crown) - Prefabricated Post and Core (in addition to crown) - Temporary crown (fractured tooth) - Pontic-cast noble metal, high noble metal or base metal - Retainer-inlay or onlay-metallic - Crown-Retainer-Porcelain fused to noble metal, high noble metal or base	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Replacement crowns, inlays and onlays are limited to one every 5 years
Prosthodontics -Dental Implants Complete upper or lower denture - Partial upper or lower denture, resin base or chrome cast - Removable unilateral partial denture - Fixed bridgework - Adjustments to complete or partial dentures, upper or lower - Repair of dentures, bridges - Reline or rebase complete or partial denture, upper or lower	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Replacement prosthodontics are limited to one every 5 years

CLASS IV - ORTHODONTIA SERVICES

SERVICES	IN-NETWORK -	OUT-OF-NETWORK	NOTES
Diagnostic services	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	
Initial placement of appliance	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	
Monthly visits and adjustments	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	

SECTION 6 - LIMITATIONS OF COVERAGE

A. Non-Participating Providers

1. You must obtain Covered Dental Services from Participating Providers to receive the Coverages stated in Section 5 In-Network provisions.

2. You may obtain Dental Services from Non-Participating Providers subject to the Out-of-Network provisions of Section 5 of this Plan. If services are obtained from Non-Participating Providers, you may have to submit your own claim forms to the Claims Administrator, you will be responsible for payment of any charges in excess of the Out-of-Network Allowance, and you will be responsible for payment to the Non-Participating Provider.

SECTION 7 –GENERAL EXCLUSIONS

IN ADDITION TO CERTAIN EXCLUSIONS AND LIMITATIONS SET FORTH ELSEWHERE IN THIS PLAN, THE FOLLOWING ARE NOT COVERED UNDER THIS PLAN:

1. Benefits for any condition which is covered under any state or federal workers' compensation, employers' liability or occupational disease law; benefits provided for any loss for which mandatory automobile no-fault benefits are recovered or recoverable including but not limited to benefits which would have been recoverable except for the fact that a timely claim was not filed by you or by a Dental Provider.
2. Benefits for any dental condition which is covered under another Plan's extension of benefits coverage until that other Plan's coverage for that condition has terminated.
3. Any Dental Services rendered after the Termination of Coverage (see Section 10).
4. Experimental and/or Investigational dental treatments, procedures, drugs, substances or devices
5. Any work not necessary or not customarily provided for dental care.
6. A service or supply not included on the schedule of dental services (Section 5 D), unless approved as part of a treatment plan.
7. Charges made by Non-Participating Providers in excess of the Out-of-Network Allowance.
8. Any work not rendered by a dentist, except x-rays ordered by a dentist and services performed by a dental hygienist under the dentist's supervision.
9. Replacement of teeth which were missing prior to the Covered Person's enrollment in this Plan.
10. Extra costs incurred for a more expensive or elaborate course of treatment rather than a less expensive procedure which would have produced a professionally satisfactory result.
11. A crown, gold restoration, denture, or fixed bridge (or the addition of teeth to one) if the work involves a modification or replacement of one installed less than five years before.
12. Dental services and supplies that are performed or obtained exclusively for cosmetic improvement.
13. Appliances or restorations for the purpose of splinting, to change vertical dimension, or to restore occlusion.
14. Appliances and/or treatment for temporomandibular joint (TMJ) dysfunction.
15. Charges for lost or stolen appliance or prosthodontics.
16. Orthodontic (Class IV) services for those over the age of 18 years.
17. Orthodontic retainers.
18. Devices or equipment used solely for the purpose of athletic activities.

19. Any services which were not received in accordance with this Plan, including without limitation, when a procedure, treatment, or service is not a Covered Dental benefit.
20. The reproduction and furnishing of x-rays and medical records, or any costs associated with the reproduction or furnishing of x-rays and/or medical or dental records.
21. Services performed by your immediate family including spouse, brother, sister, parent, or child.
22. Free care or care where no charge, in the absence of any dental plan or insurance plan, would be made to you.
23. Any injury or sickness resulting from war or any act of war (declared or undeclared) or services in the armed forces of any country to the extent Coverage of such injury or sickness is provided through any governmental plan or program.
24. Benefits otherwise provided in the Plan which we are unable to provide because of any law or regulation of the federal, state, or local government or any action taken by any agency of the federal, state, or local government in reliance on said law or regulation.
25. Care for military service connected disabilities, when you are legally entitled to services and facilities are reasonably available to you.
26. Care for conditions that federal, state or local law requires be treated in a public facility.
27. Care or treatment provided in a governmental hospital.
28. Services required by third parties. Examples of non-Covered services are employment physicals, physicals for camp and school, and court-ordered examinations and treatments except when Medically Necessary.
29. Services for which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
30. Benefits for which you are eligible under any governmental program other than Medicare, except Title XIX of the Social Security Act.

SECTION 8 – ADDITIONAL EXCLUSIONS WHICH APPLY ONLY TO OUT-OF-NETWORK ITEMS AND SERVICES

There are no additional exclusions which apply only to Out-of-Network items and services.

SECTION 9 - CLAIM FILING, PAYMENT OF BENEFITS

A. Filing a Claim

In order to process claims, they must be submitted properly and completely. Many claims will be submitted directly by the Service Provider.

For those claims not submitted by the Service Provider, the Covered Person must submit the claim. Submission of a claim for reimbursement shall, to the extent not prohibited by applicable law or regulation, be deemed an authorization to release medical information for Plan administration purposes. A Covered Person should submit a claim even if he isn't certain the expense is covered. In this way benefits can be paid whenever possible. To file a claim, proceed as follows:

1. **Obtain a Claim Form** Claim forms for all types of benefits covered by the Plan are available through the Participating District or the Claims Administrator. Service Providers may use a standardized claim form to file a claim on behalf of a Covered Person.

2. **Complete the Claim Form** It is important that you carefully follow the instructions included on the claim forms. Failure to properly and completely supply necessary information will probably delay benefit payments. Service Providers filing a claim on behalf of a Covered Person must provide all required information.

   a. Complete the claim form, making certain all questions are answered and that you sign the form. Your address should be your home address, not your work address.

   b. Attach an original itemized statement showing the name of the patient; the date of service, treatment or purchase; a description (using the CDT or HCPCS code if possible) of the treatment or service performed; the amount charged for each item; and the reason for the treatment (diagnosis or condition).

   c. Separate claim forms should be submitted for each person for whom a claim is being filed.

   d. The completed claim form (with originals of appropriate bills or statements attached) should then be mailed to the Claims Administrator's Office for processing. The completed claim form should always be signed by the Enrollee.

   e. If another plan is primary to this Plan, you should submit a copy of the other plan's explanation of benefits to this Plan.

3. **Recovery of Overpayments** The Plan may make a payment in error. This might occur because the Covered Person is not covered under this Plan, or the service is not covered, or the payment is more than should have been made. If that happens, the Plan will provide an explanation to the Covered Person who must return the amount of the overpayment to the Plan within 60 days of the Plan's notice to the Covered Person.

4. **Notices** The Plan will mail notices to a person's address as it appears on the Plan's records. Covered Persons must notify the Claims Administrator and their Participating District of any change in their address. All notices to a Covered Person who is a minor or otherwise not legally competent to receive such notices shall be sent to that Covered Person's parent or legal guardian, who is the Covered Employee or covered Retiree.

5. **Medical and Dental Records** Covered Persons agree that, to the extent not prohibited by applicable law or regulation, any Dentist or other Licensed Provider or facility that has rendered services to them are authorized to give the Plan's Claims Administrator and stop-loss carrier all information and records relating to those services for Plan use in determining whether the person is entitled to coverage for those services, in processing that person's claim, and in calculating the amount of Plan coverage. Any further authorization to release information that may be required by applicable law or regulation is part of all Covered Persons' obligations under this Plan.

6. **Questions Regarding a Claim** If a Covered Person has any questions concerning the Plan, the status of a claim or a specific claim payment, the question(s) should be communicated to the Claims Administrator.

B. Proof of Claim

All events which determine the fact that the Plan is liable for a Covered Expense take place on the date the Covered Expense is incurred, which is when the services are performed or the purchases are made. Written proof of claim should be furnished to the Plan at the Claims Administrator's office on the appropriate forms. The filing of a claim by the Service Provider or the Covered Person is not a precondition to the Plan's liability for a Covered Expense. However, the filing of a claim is a precondition to payment of a claim and the Plan needs written proof of claim as soon as reasonably possible in order to process a claim.

C. Payment of Benefits

Payment of benefits described in the Plan will be made as determined on the basis of the submission of proof that a covered charge, fee or expense has been incurred. Payment for Covered Services provided by a Participating Provider will be made directly to the Provider. Payment for other Covered Services may be made only to the covered Enrollee or to a Service Provider to whom benefits have been assigned. Any assignment of benefits to a provider of dental services or supplies will not be accepted by, or binding on, the Plan unless approved by the Plan's Claims Administrator.

D. Legal Action

Subject to exhaustion of the Enrollee Appeal Procedures at Section 15, no action at law or in equity shall be brought to recover under the Plan prior to the expiration of ninety (90) days after submission of the itemized bill or Claim Form and any requested supporting information, nor shall such action be brought after twelve (12) months from the date of completion of a particular course of treatment.

SECTION 10 - TERMINATION OF COVERAGE

Your Coverage shall automatically be terminated on the first of the following to apply:

1. Upon the Participating District's failure to pay the required Contribution for Coverage to us in accordance with Section 17 of the Plan or if the Participating District notifies us prior to the expiration of the grace period that it will no longer pay the Contribution for Coverage.
2. The date that the Plan is terminated, or with respect to any specific Dental Services Covered by the Plan, the date such Coverage terminates.
3. The end of the Plan Month in which you cease to be eligible as an Enrollee or Family Dependent.
4. The date on which the Enrollee ceases to be eligible with the Participating District.
5. The end of the Plan Month during which the Participating District receives written notice from you requesting Termination of Coverage, or on such later date requested for such termination by the notice.
6. The date on which the Enrollee is retired or pensioned, unless Coverage is specifically provided for retired or pensioned individuals by the Participating District.
7. Death of an Enrollee or the Divorce from Enrollee or the dissolution of a domestic partnership with the Enrollee:
    a. Upon the death of the Enrollee, coverage of the Enrollee under this Plan shall automatically terminate as of the date of death and coverage of any Family Dependents shall automatically terminate at the end of the month in which the Enrollee's death occurs;
    b. Upon divorce from an Enrollee, or the dissolution of a domestic partnership with the Enrollee, coverage for the spouse or domestic partner under this Plan shall automatically terminate as of the date of divorce decree or dissolution of the domestic partnership.
8. You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Plan. We shall give the Participating District at least one month's prior written notice.
9. Such other reasons as the Superintendent of Insurance may approve consistent with applicable law. We shall give the Participating District at least one month's prior notice.
10. No Benefits after termination of Coverage. Upon termination of Coverage, the Covered Person shall cease to be entitled to any Benefits, including but not limited to, lifetime benefits, unlimited benefits or benefits provided to the Covered Person who is, at the time of termination undergoing a course of treatment.

SECTION 11 - CONVERSION PRIVILEGE

There is no conversion privilege associated with the dental benefits provided under the Plan.

SECTION 12 – CONTINUATION OF COVERAGE

There is no continuation of coverage associated with the dental benefits provided under the Plan.

SECTION 13 - COORDINATION OF BENEFITS (COB)

A. If you are eligible for services or benefits under two or more Group Benefit Plans; providing or paying for Dental Services rendered to you, the Coverage under those Group Benefit Plans will be coordinated so that up to, but no more than, 100% of any of our Eligible Expenses will be paid for; or provided by, all the benefit plans less any Deductible. When this Plan is the secondary plan, it will pay for eligible claims in the amount of any difference between the primary plan and the benefit amounts eligible for payment based on the terms of this Plan. When we have paid or you have received from other payment sources the allowable amount, no further payment will be made. We will be responsible, as either a primary or secondary payer, for Dental Services rendered by Participating Providers or the services of Non-Participating Providers and as a secondary payer for any item of Allowable Expense up to the allowable amount. The term "Allowable Expense" is the necessary, reasonable, and customary item of expense for Covered dental care. Primary responsibility for providing these services or benefits will be determined in the following order:
   1. The benefits of a plan that does not have a COB provision or that has a COB provision which does not comply with New York State Insurance Department regulations will be primary.
   2. The benefits of a plan which covers the person as an employee or Subscriber are determined before those of a plan which covers the person as a dependent.
   3. When a plan and another plan cover the child as a dependent of different persons, called "parents":
      a. The benefits of the plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the plan of the parent whose birthday falls later in that Calendar Year; but
      b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
      c. If the other plan does not have the rule described above, but instead, has the rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
      d. The word "birthday" refers only to month and day in a Calendar Year, not the year in which the person was born.
   4. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the order shown below. This paragraph shall not apply with respect to any Claim Determination Period of a plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
      a. First, the plan of the parent with custody of the child is primary;
      b. Then, the plan of the spouse of the parent with custody of the child;
      c. Finally, the plan of the parent not having custody of the child;

d. If the specific terms of a court decree or separation agreement state that one of the parents is responsible for the Dental expenses of a child, any entity obligated to pay or to provide the benefits of the plan of such parent that has actual knowledge of those terms, shall have benefits determined first.

5. The benefits of a plan, which covers a person as an employee who is neither laid off nor retired (or as the employee's dependent) are determined before those of a plan, which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee or Subscriber longer are determined before those of the Plan which covered that person for the shorter period of time.

B. We shall be entitled to:

1. Determine whether and to what extent you have indemnity or other Coverage for the Dental Services provided under the Plan;
2. Establish priorities for primary responsibility among the Health Plans obligated to provide Dental Services or indemnity benefits;
3. Release to or obtain from any other Health Plan any information needed to implement this provision; and
4. Recover the value of Dental Services rendered to the Covered Person under the Plan to the extent that such Dental Services are covered by any other Health Plan with primary responsibility for paying for such Dental Services.

C. When our Coverage is the primary Coverage, it will pay for all necessary Dental Services in accordance with the Plan. The secondary dental plan may be obligated to pay any Deductible or other charges not Covered by us if you file a claim with that group dental plan. When our Coverage is secondary, we reserve the right to request that you submit claims to the other group dental plan; recover any claim payment that you receive from that group dental plan to the extent such payment is for services actually received from or paid by that group dental plan; or to bill the group dental plan for Dental Services paid for by us.

D. For purposes of this Section, "other plans" include: Group or blanket coverage; Blue Cross Blue Shield, or other prepayment coverage; no fault coverage to the extent required in policies or Plans by a motor vehicle insurance statute or similar legislation; coverage under a labor-management trustee plan, union welfare plan, or an employee welfare benefit plan as defined in the Federal Welfare and Pension Plan Disclosure Act, including any federal or state or other governmental plan or law; or coverage under any

plan largely or solely tax supported or otherwise provided by or through action of any government, except Medicaid.

E. If the amount of the payments made by the Plan is more than should have been paid under this COB provision, the Plan, directly or through the Claims Administrator, may recover the excess from one or more of the following:
   1. The persons the Plan has paid or for whom the Plan has paid; or
   2. Insurance companies; or
   3. Other organizations.

F. This Plan may repay to any other dental plan the amount that it paid for covered expenses if this Plan decides it should have paid those expenses. These payments are the same as benefits paid to the Covered Person and they satisfy the Plan's obligation to the Covered Person under this Plan.

SECTION 14 – RIGHT OF REIMBURSEMENT AND ASSIGNMENT OF PROCEEDS

A. General

The term "third party" means a person or entity other than the Covered Person. No benefits shall be paid under any coverage of this Plan with respect to any Injury or Illness for which a third party may be liable or legally responsible. However, subject to the provisions of this Section, the Plan will advance payment of such benefits provided that the Covered Person (or his legally authorized parent, guardian, or representative) complies with certain conditions described below.

B. Notice of Claim against Third Party

Prior to advancing payment of any such benefits by this Plan, the Covered Person and the legal representative, if any, of the Covered Person must agree in writing to provide the Claims Administrator and the Plan Administrator with written notice whenever a claim is commenced against and/or recovery is received from any third party (or insurer or surety thereof) for damages as a result of the Injury or Illness.

C. Reimbursement Agreement

Also before the Plan advances any payments, the Covered Person must agree, in writing, to reimburse the Plan in accordance with this Section for any benefits paid by the Plan on account of such Injury or Illness, and the legal representative, if any, of the Covered Person, must agree in writing, to honor and enforce that agreement by the Covered Person.

D. Assignment of Proceeds.

Also before the Plan advances any payment, the Covered Person and the Covered Person's legal representative, if any, shall provide, in writing, a lien upon, and an assignment of, proceeds in favor of the Plan in the amount of any benefits paid by the Plan on account of such Injury or Illness; such lien and assignment to be valid against any judgment, settlement, or recovery in any manner received from such third party or such third party's insurer or surety or from any uninsured or underinsured motorist or similar type insurance coverage, irrespective of whether any such judgment, settlement or recovery is deemed to be for medical expenses, pain and suffering, economic loss, property damage, or other loss. The assignment shall contain a subrogation agreement authorizing, but not requiring, the Plan to sue, in the name of the Covered Person, the third

party if the Covered Person fails to commence a lawsuit against the third party within one year of the date the Injury or Illness occurs.

These conditions do not apply to any benefits payable by Medicare, or any amount received by the Covered Person under any other health insurance policy or certificate issued to the Covered Person or to any Dependent of an Employee covered hereunder.

The Plan has no obligation to share the costs of, or pay any part of, the Covered Person's attorneys' fees or costs or expenses incurred in seeking the amounts to be recovered by the Plan pursuant to the provisions hereof; accordingly, the reimbursement to the Plan required by this Section will not be reduced by any attorneys' fees, court costs, or other disbursements.

E. Form

A form to document the Covered Person's compliance with this section is found in Appendix A of this Plan.

SECTION 15 - APPEAL PROCEDURES

A. Notification

If your claim for benefits is denied, in whole or in part, you will be notified by the Claims Administrator, in writing, advising you of the specific reason for the denial and explaining the Plan's appeal procedure. If additional information or documentation is required to perfect a claim, you will be notified and told why the additional material is necessary. You (or your authorized representative) may review the pertinent documents upon which the denial is based.

B. Stage 1 Appeal

You, or your authorized representative, may request claim appeal by the Claims Administrator within 180 days of notification of a denial of initial claim. You can file a verbal or written contractual appeal or clinical appeal regarding a pre-service denial (a request to change a denial for any care of services that have not yet been provided to you) or a post-service denial (a request to change a denial for care or service already rendered) by contacting the Member Services department during normal business hours (8:00 a.m. until 4:00 p.m., Monday – Friday).

When filing an appeal, you have the opportunity to submit any written documents or other information relating to their appeal. Upon receipt of your Claim Appeal form and such additional information as supports the appeal, the Claims Administrator will review the appeal and respond in writing to the claimant within 15 days of receipt of the appeal and such additional information as supports the request for appeal for a pre-service appeal or within 30 days of receipt of the appeal and such additional information as supports the request for appeal for post-service appeals. The response will clearly identify the specific reasons for the decision with appropriate references to the relevant provisions of the Plan.

If you do not receive a decision on an initial appeal within 90 days of filing the Stage 1 appeal, you may file a Stage 2 Appeal.

C. Stage 2 Appeal

You, or your authorized representative, may appeal a Stage 1 denial by making a written application to the Plan Administrator within 180 days of notification of the Stage 1 denial or failure to receive a decision on an initial appeal within 90 days of filing the Stage 1 appeal, and submitting such additional information and comments, in writing, as supports the appeal. The Plan Administrator will then submit all pertinent documentation concerning the appeal to the Board of Trustees' Appeals Committee.

D. Determination of Appeal

A determination will be made by the Appeals Committee within 15 days of receipt of the appeal and such additional information as supports the request for appeal for a pre-service appeal or within 30 days of receipt of the appeal and such additional information as supports the request for appeal for a post-service appeal. The Appeals Committee, by the Trust's attorney, shall render a written decision specifying the reasons for its decision on the appeal and references to the Plan provisions on which the decision is based, in a manner calculated to be understood by an average person. The decision shall not be final and binding on you.

SECTION 16 - RELATIONSHIP BETWEEN PARTIES

The relationship between us and Participating Providers is a contractual relationship between independent contractors. Participating Providers are not agents or employees of ours, nor are we or any employee or designee of ours an agent or employee of Participating Providers. The relationship between a Participating or Non-Participating Dentist and you is that of a dentist and patient. The Participating or Non-Participating Dentist is solely responsible for the Dental Services provided to you. We are not liable for any act, omission, or other conduct of any provider in furnishing professional or any other services to you; nor is any Participating or Non-Participating Provider liable for the acts of any other provider based solely upon his or its association with us.

SECTION 17 - CONTRIBUTION FOR COVERAGE PROVISIONS

A. Contribution for Coverage Payment

All Contributions for Coverage are payable monthly in advance by the Participating District to us at our office indicated in Section 1.C. of the Plan. The Participating District will arrange to collect any applicable Enrollee contributions for the Contribution for Coverage directly from the Enrollee. The Participating District shall pay the total monthly Contribution for Coverage due us on behalf of those Enrollees on or before the fifth day of any month during which Coverage is to be provided to Enrollees. The Participating District shall act as the agent for the group's Enrollees and shall not, under any circumstances, be the agent; employee; or representative of ours in collecting any amounts from such Enrollees and paying it to us. We will provide the Participating District with at least thirty (30) days' notice of the Effective Date of any Contribution for Coverage increase or decrease approved by the Board of Trustees of the NY44 Health Benefits Plan Trust.

We shall send the Participating District its invoice for the following month according to the schedule provided by the NY44 Health Benefits Plan Trust.

We and the Participating District shall cooperate to complete any retroactive adjustments to the Contribution for Coverage necessary as a result of the addition or termination of Enrollees Covered by us. If an Enrollee is added to the group Covered under the Participating District's Plan during the period from the first (1st) to the fifteenth (15th) day of any month, the Contribution for Coverage will be retroactively adjusted as of the first (1st) day of the month. The Contribution for Coverage will not be adjusted if an Enrollee's Coverage becomes effective between the fifteenth (15th) and the last day of any month. If an Enrollee is terminated from the group Covered under the Participating District's Plan at any time during any month, the full Contribution for Coverage will be charged for that month.

The maximum adjustment period for any such retroactive adjustments to the Contribution for Coverage will be limited to 60 days.

B. Grace Period.

A grace period of ten (10) calendar days will be granted for the payment of any Contribution for Coverage during the time the Plan shall continue in force. Late fees of 2% will be assessed after the 15th of any month in which payment was not received.

If the Contribution for Coverage is not paid by the end of the month, the Coverage of all Enrollees Covered by the Plan will be deemed to have terminated automatically as of the last date for which Contribution for Coverage payments have been made, without notice from us to the Participating District or to the Enrollees. We shall be entitled to notify Enrollees and Bargaining Units of the non-payment of Contribution for Coverage and the expiration date of the grace period provided by this provision to enable them to make necessary arrangements to pay for their Dental Services upon termination of their coverage. The termination of Coverage upon expiration of the grace period shall not relieve the Participating District of its obligation to pay Contribution for Coverage due for Coverage provided. Upon termination of Coverage, the Participating District shall be liable to us for the payment of any and all Contributions for Coverage and accrued interest, which are due but unpaid at the time of termination.

SECTION 18 - PRIVACY PRACTICES

This is a brief summary of some of our key privacy practices. The Plan will protect the privacy of your Protected Health Information (PHI). PHI is health information that includes your name, Social Security Number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI. We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, Enrollee-identifiable medical information is shared with Participating Districts only with your authorization or as otherwise permitted by law. Generally, we will not use or disclose your PHI for any other purpose without written authorization from you (or your representative). Giving us authorization is at your discretion.

This Section, as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows the disclosure of Protected Health Information ("PHI") as defined under HIPAA, to Participating Districts for the purposes specified below.

A. Disclosure of PHI to Participating District. The Plan shall disclose PHI to the Participating District only to the extent necessary for the Participating District to perform the following Plan administrative functions:
    1. To make enrollment, termination and eligibility decisions;
    2. To respond to specific inquiries from a Enrollee concerning his or her medical claim;
    3. To determine disposition of health plan Enrollee appeals;
    4. As required by any applicable law.

B. Use and Disclosure of PHI by Participating District. Participating District shall use and/or disclose PHI only to the extent necessary to perform the following Plan Administration functions, which it performs on behalf of the Plan:
    1. To establish and determine eligibility;
    2. To respond to specific Inquiries from a Enrollee concerning his or her medical claims.

C. Participating District Certification. The Plan agrees that it will only disclose PHI to the Participating District upon receipt of a certification that this Amendment has been adopted and the Participating District agrees to abide by such conditions. The Participating District is subject to the following:

    1. Prohibition on Unauthorized Use or Disclosure of PHI. The Participating District will not use or disclose any PHI received from the Plan, except as permitted in these documents or required by law.

2. Subcontractors and Agents. The Participating District will require each of its subcontractors or agents to whom the Participating District may provide PHI to agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Participating District.

3. Permitted Purposes. The Participating District will not use or disclose PHI for employment-related actions and decisions or in connection with any other of Participating District's benefits or employee benefit plans.

4. Reporting. The Participating District will report to the Plan any impermissible or improper use or disclosure of PHI not authorized by the plan documents.

5. Access to PHI by Enrollees. The Participating District will make PHI available to the Plan to permit Enrollees to inspect and copy their PHI contained in the designated record set.

6. Correction of PHI. The Participating District will make a Enrollee's PHI available to the Plan to permit Enrollees to amend or correct PHI contained in the designated record set that is inaccurate or incomplete, and Participating District will incorporate amendments provided by the Plan.

7. Accounting of PHI. The Participating District will make a Enrollee's PHI available to permit the Plan to provide an accounting of disclosures.

8. Disclosure to Government Agencies. The Participating District will make its internal practices, books and records relating to the use and disclosure of PHI available to the Plan and to DHHS or its designee for the purpose of determining the Plan's compliance with HIPAA.

9. Return or Destruction of Health Information. When the PHI is no longer needed for the purpose for which disclosure was made, the Participating District must, if feasible, return to the Plan or destroy all PHI that the Participating District received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Participating District agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

10. Minimum Necessary Requests. The Participating District will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

D. Adequate Separation. The Participating District represents that adequate separation exists between the Plan and Participating District so that PHI will be used only for plan administration. The following employees or persons under the control of the Participating District have access to Enrollees' PHI for the purposes set forth under number 1 above: Trustees of the Plan; Controllers; Human Resources Personnel; Participating District Office Managers and Bookkeepers.

E. Adequate Separation Certification. The Plan requires the Participating District to certify that the employees identified above are the only employees that will access and use Enrollees' PHI. The Participating District must further certify that such employees will only access and use PHI for the purposes set forth under number 1 above.

F. Reports of Non-Compliance. Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the Plan's Privacy Official at NY44 Health Benefits Plan Trust, 355 Harlem Road, West Seneca, NY 14224.

SECTION 19 - GENERAL PROVISIONS

A. Entire Plan

The Plan, the application of the Participating District, your individual Application, and our policies and procedures as adopted or amended from time to time, shall constitute the entire Plan between the parties. All statements made by the Participating District or by you shall be deemed representations and not warranties. No such statement shall void or reduce Coverage under the Plan or be used in defense to a claim unless in writing signed by the Participating District and/or you.

B. Time Limit on Certain Defense

No statement, except a fraudulent misstatement, shall be used to void the Plan after it has been in force for a period of two (2) years.

C. Alteration

No alteration of the Plan and no waiver of any of its provisions shall be valid unless evidenced by an endorsement or an amendment attached to the Plan, which is signed by the Trustees of the NY44 Health Benefits Plan Trust. No agent has authority to change the Plan or to waive any of its provisions.

D. Consent to Release & Use of Health Information

1. You consent to the release of all health information to us or our designees for you and your other enrolled Family Dependents when you become Covered under this Plan. You also and consent to our using and disclosing your health information for our payment and health care operations activities and for another Health Care or Dental Provider or institution’s treatment, payment and health care operations activities. Such uses and disclosures shall be made in accordance with applicable laws, rules and regulations.
2. The Plan, at its own expense, shall have the right and opportunity through its medical representative to examine any person when and as often as it may reasonably require during the pendency of a claim under the Plan, but only with regard to the condition upon which the claim is based.
3. Unless otherwise prohibited by law, you give implied consent to release health information upon presenting your Identification Card to any Dental Provider.
4. We shall have the right to deny Dental Services or to refuse reimbursement for Dental Services to any Covered Person who refuses to consent to the release of health information.

5. You agree to execute any releases for health information which we request of you at no charge to us.
6. This consent to release of health information is subject to the provisions of the New York Public Health Law, Section 18 and 4410(2), unless otherwise preempted by applicable federal laws, rules and regulations.

E. Forms

The Participating District shall keep on file copies of all documents, forms, and descriptive literature provided by us for distribution to you. The Participating District agrees to give all new employees our descriptive literature, provided by us, at the time that the employee is hired.

F. Records

1. The Participating District shall furnish us with all information and proofs, which we may reasonably require with regard to any matters pertaining to the Plan. All documents furnished by the Participating District and any other records which may have a bearing on the Coverage under the Plan shall be open for inspection by us at any reasonable time and shall be kept confidential by us in accordance with applicable laws, rules and regulations.
2. You authorize and direct any person or institution that has examined or treated you to furnish us at any and all reasonable time, upon our request; any or all information and records or copies of records relating to the examination or treatment rendered to you. We shall have the right to submit any and all records concerning Dental Services rendered you to appropriate medical review personnel.
3. In the event of a question or dispute concerning the provision of Dental Services or payment for such services under the Plan, we may reasonably require that you be examined, at our expense, by a Participating Physician designated by us.

G. Notice

1. All notices to the parties to the Plan shall be in writing; postage prepaid; first class mail; and shall be deemed given when mailed. The notices shall be mailed to the Plan Administrator indicated in Section 1.I. or to such other address or person designated, in writing, during the term of the Plan.
2. Notice given by us to an authorized representative of the Participating District shall be deemed notice to all affected Enrollees in the administration of the Plan, including termination of the Plan or the

termination of Enrollees' Coverage. The Participating District agrees to provide appropriate notice to all affected Enrollees at its own expense.

H. Covered Benefits

In no event shall you be responsible to pay for Dental Services Covered by the Plan except as otherwise provided in the Plan.

I. Severability

The unenforceability or invalidity of any provision of the Plan shall not affect the validity and enforceability of the remainder of the Plan.

J. Workers' Compensation Not Affected

The Coverage provided under the Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance or Law.

K. Conformity with Statutes/Venue

The Plan shall be governed by the Laws of the State of New York and venue for any dispute shall be in Erie County, New York.

L. Events Beyond Our Control

In the event of circumstances not reasonably within our control (such as complete or partial destruction of health care facilities; war; riot; civil insurrection; or similar causes), we shall not be responsible for the performance of our obligations under this Plan provided however that we shall resume performance of our obligations under this Plan as soon as reasonably possible.

M. Waiver

Either party's waiver or failure to insist on strict performance of the Plan shall not be considered a waiver or act as a bar to any action for subsequent acts of non-performance.

N. Interpretation

We may adopt and amend from time to time reasonable and uniform policies; procedures; rules; regulations; guidelines; and interpretations in order to promote the orderly and efficient administration of this Plan, all of which shall be binding upon the Participating District and you upon reasonable notification to you.

O. Examinations

The Plan, at its own expense, shall have the right and opportunity through its medical representative to examine any person when and as often as it may reasonably require during the pendency of a claim under the Plan, but only with regard to the condition upon which the claim is based.

P. Legal Incompetence

Payments made to the Covered Person or his beneficiaries, rather than to a Service Provider, are subject to provisions allowing for payment to someone else where either the covered person or his beneficiary is a minor or otherwise not legally competent to give a valid receipt for payment.

When payment is due to a minor, it will be paid to the minor's parent or legal guardian. When payment is due to an incompetent, it will be paid to the incompetent's legal guardian. In the event that a Covered Person dies prior to the date that all benefits are paid hereunder, payment will be made to any of the following living relatives: spouse, child or children, parents, or brothers or sisters, or to the executors or administrators of the Estate. Payment as made above will release the Plan from any further liability with regard to those payments.

Q. Legal Proceedings

No action at law or in equity shall be brought to recover under this Plan of benefits prior to the expiration of the later of 69 days after proof of claim has been furnished to the Claims Administrator or 30 days after the exhaustion of all appeal rights under Section 15 of this Plan, nor shall any such action be brought at all unless commenced within two (2) years from the date the Covered Expense was incurred.

R. Non-Waiver of Plan Provisions

Failure of the Plan to insist upon compliance with any provision of the Plan at any given time, or under any given set of circumstances, shall not operate to waive or modify such provision, or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are the same or not.

APPENDIX A

AUTHORIZATION TO PAY OUT OF, AND ASSIGNMENT OF, PROCEEDS OF RECOVERY IN THIRD PARTY CLAIM

In The Matter of the Claim of

____

For Benefits from the

NY44 HEALTH BENEFITS PLAN TRUST

WHEREAS, ____________________________, a Participant in the NY44 Health Benefits Plan Trust (the "Plan" hereafter) has submitted dental bills incurred in the sum of $______________, and

WHEREAS, the Participant, has a pending claim, or intends to make a claim, against ____________________, the third party, arising out of the accident which occurred on or about ____________________, (the "third party claim"), and

WHEREAS, the Plan provides, in the Section entitled "Right of Reimbursement and Assignment of Proceeds".

The term "Third Party" means a person or entity other than the Covered Person. No benefits shall be paid under any coverage of this Plan with respect to any Injury or Illness for which a Third Party may be liable or legally responsible. However, subject to the provisions of this Section, the Plan will advance payment of such benefits provided that the Covered Person (or his legally authorized parent, guardian, or representative) shall comply with the following conditions:

A. Prior to advancing payment of any such benefits by this Plan, the Covered Person and the legal representative of the Covered Person shall agree, in writing, to provide the Claims Administrator with written notice whenever a claim is commenced against and/or recovery is received from any Third Party (or insurer or surety) for damages as a result of the Injury or Illness; and

B. Prior to advancing payment of any such benefits by this Plan, the Covered Person shall agree, in writing, to reimburse the Plan in accordance with this Section for any benefits paid by

the Plan on account of such Injury or Illness, and the legal representative of the Covered Person shall agree, in writing, to honor and enforce that agreement by the covered Person; and

C. Prior to advancing payment of any such benefits by this Plan, the Covered Person and the legal representative of the Covered Person shall provide, in writing, a lien upon, and an assignment of, proceeds in favor of the Plan in the amount of any benefits paid by the Plan on account of such Injury or Illness; such lien and assignment to be valid against any Judgment, Settlement, or recovery in any manner received from such Third Party or such Third Party's insurer or surety or from any uninsured or underinsured motorist or similar type insurance coverage irrespective of whether any such Judgment, Settlement or recovery is deemed to be for medical expenses, pain and suffering, economic loss, property damage, or other loss. The assignment shall contain a subrogation agreement authorizing, but not requiring, the Plan to sue, in the name of the Covered Person, the Third Party if the Covered Person fails to commence a lawsuit against the Third Party within one year of the date the Injury or Illness occurs.

The Plan shall have no obligation to share the costs of, or pay any part of, the Covered Person's attorneys' fees or costs or expenses incurred in seeking and/or obtaining recovery from the Third Party, and the amounts to be recovered by the Plan pursuant to the provisions hereof shall not be reduced by any attorney's fees, court costs, or other disbursements, and,

WHEREAS, the Participant, has requested that the Plan advance payment of dental expenses incurred in or as a result of the accident without awaiting the outcome of the Participant's Third Party claim, and,

NOW, THEREFORE, in consideration of the Plan advancing payment of those dental bills, and as a means of securing reimbursement to the Plan for the payment of the aforesaid bills, the Participant hereby authorizes and directs his/her attorney, _____ ___________, and the insurance carrier(s) for the Third Party, to pay to the Plan, out of the proceeds of any recovery on the Third Party claim, the sum of $_____________, and any additional amount as may hereafter be paid by said Plan on behalf of the Participant, for dental expenses arising out of or related to the said accident, and to the total extent of benefits paid the proceeds of the

recovery on the aforesaid Third Party claim are hereby assigned to the Plan, and it is further

AGREED, by ________________________________, as attorney for the Participant, that the authorization and directions to reimburse the Plan, herein set forth, will be honored and enforced by said attorney, and it is further

AGREED, that the Plan is hereby subrogated to the Participant and is authorized, but not required, to sue, in the name of the Participant, the Third Party if the Participant fails to commence a lawsuit against the Third Party within one year of the date of the occurrence of the Participant's Injury or Illness, and it is further

AGREED, the Plan shall have no obligation to share the costs of, or pay any part of, the Participant's attorneys' fees or costs or expenses incurred in seeking and/or obtaining recovery from the Third Party, and the amounts to be recovered by the Plan pursuant to the provisions hereof shall not be reduced by any attorney's fees, court costs, or other disbursements, and it is further

AGREED, that a copy of this Authorization and Assignment of Proceeds shall be served upon the liability insurance carrier(s) for the third party, which carrier(s) is (or are)

____

____

____

The terms and provisions of this instrument shall be binding upon our agents, heirs, executors, successors and assigns.

Date:___________________

____
Participant

____
Attorney for Participant

State of ________________)
County of _______________) SS:
City of _________________)

On the __________ day of __________, in the year , before me, the undersigned, personally appeared ________ ______, personally known to me or proved to me on the basis of satisfactory evidence to be the Participant whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

____
Notary Public

State of ________________)
County of ______________) SS:
City of _________________)

On the ___________day of _________________, in the year , before me, the undersigned, personally appeared _________ ___________, personally known to me or proved to me on the basis of satisfactory evidence to be the attorney for the Participant and whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

____
Notary Public

Appendix B

<u>In Network Benefits</u>

Benefits with Dental Pay Participating Dentists

- Services listed below are provided as a general guide of plan benefits and do not represent all covered services or plan limitations. It is highly recommended that a Pre-Determination of benefits be obtained for all amounts in excess of $200
- $1,500 Annual Maximum per person
- Dependent Children are covered until age 23 for all services except Orthodontia.
- Orthodontia benefits are available for dependent children up to age 19
- Lifetime Maximum Benefit for Orthodontia is $2,400
- Questions concerning coverage should be directed to Dental Pay at 716-831-8171 or toll free 1-888-683-3682

Preventive	covered at 100%
Minor Restorative	covered at 100%
Major Restorative	covered at 100%

Covered Maximum	$1,500 annual maximum per person
Dependent children covered to age 23	

Orthodontia Benefit	covered up to $2,400, Lifetime Benefit
Orthodontia benefit covers Dependent Children up to age 19	

<u>Out of Network Benefits, with any Dentist</u>

Schedule of Allowances

Out of Network Dental Plan Highlights:

- Eligible Services are covered at the scheduled amount listed below, The schedule is based upon Reasonable & Customary charges. You may be responsible for the difference between the scheduled allowance & the dentist's actual charges
- Services listed below are provided as a general guide of plan benefits & do not represent all covered services or plan limitations. It is highly recommended that a Pre-Determination of benefits be obtained for all amounts in excess of $200
- $1,500 Annual Maximum per person

- Dependent Children are covered until age 23 for all services except Orthodontia.
- Orthodontia benefits are available for dependent children up to age 19
- Lifetime Maximum Benefit for Orthodontia is $2,400
- Questions concerning coverage should be directed to Dental Pay at 716-831-8171 or toll free 1-888-683-3682

BENEFITS	**SCHEDULED FEE**
Preventive Services:	
Adult Prophylaxis (4 per year)	$73
Child Prophylaxis (4 per year)	$39
Space Maintainers & Mouth Guards (under age 19)	
Fixed, unilateral band type	$143
Fixed, bilateral	$204
Removable, unilateral	$181
Removable, bilateral	$270
Diagnostic Services:	
Initial Exam	$40
Periodic Exam (4 per year)	$31
Emergency visit for relief of pain	$38
Intraoral complete x-rays	$73
Intraoral, each film	$12
Intraoral occlusal single film	$19
Bitewing, first film (maximum 4 every 6 mos)	$18
Panoramic x-rays (every 36 months)	$71
Topical application fluoride – Child	$26
Topical application fluoride – Adult	$38
Basic Restorative Services:	
One surface Amalgam	$84
Two surface Amalgam	$97
Three or more surfaces Amalgam	$122
Composite filling	$101
Composite filling, 2 fillings per same tooth	$124
Composite filling, maximum per tooth	$149

Basic Restorative Services:

Extractions (per tooth)	$86
Extraction (each additional tooth)	$113

Removal of Impacted Teeth:

Completely covered by bone	$286
Soft tissue extraction	$186
Partial bony impaction	$251

Endodontics (Root Canal Therapy):

Pulp Cap	$48
Vital Pulpotomy	$94
Root Canal, Anterior	$510
Root Canal, Bicuspid	$602
Root Canal, Molar	$965

Periodontics:

Scaling & Root Planing – per quad	$142
Periodontal Maintenance (1 every 6 mos)	$87
Gingivectomy – per quadrant	$329
Osseous surgery – per quadrant	$670
Full Mouth Debridement	$92

Major Restorative Services:

Complete Dentures (upper or lower)	$1,024
Partial Dentures (upper or lower)	$856
Crown – porcelain/ceramic substrate	$806
Crown – porcelain fused to high noble metal	$806
Crown – porcelain fused to predominantly base metal	$719
Crown – porcelain fused to noble metal	$719
Crown – full cast high noble metal	$806
Crown – full cast predominantly base metal	$708
Crown – full cast noble metal	$719
Pre-fab post & core	$191
Pontic – porcelain fused to high noble metal	$650
Pontic – porcelain fused to predominantly base metal	$650
Pontic – porcelain fused to noble metal	$650
Pontic – porcelain/ceramic	$682
Retainer – cast metal for resin bonded fixed prosthesis	$277

Surgical placement of implant, endosteal implant	$1,730
Surgical placement of mini implant	$1,730
Prefab abutment, includes placement	$368
Custom abutment, includes placement	$455
Implant supported fixed & removable prosthetic procedures	$1,123
Implant maintenance procedures	$93

Anesthesia:

Local Anesthesia	$19
Regional Block Anesthesia	$41
Deep Sedation/general anesthesia – first 30 minutes	$195
Deep Sedation/general anesthesia – each addt'l 15 minutes	$81

Version 1.0 of this document was adapted from the Erie 1 BOCES Dental Benefit Plan Summary Plan Description prepared by The Dental Shop, pursuant to memoranda of agreement with affected bargaining units in March 2007.

Version 2.0 was adopted by the Board of Trustees of the NY44 Health Benefits Plan Trust as a restated version of the Plan at a regular meeting on June 15, 2010. (Resolution 47-6, Meeting #47)

Version 2.1 was adopted by the Board of Trustees of the NY44 Health Benefits Plan Trust as a restated version of the Plan at a regular meeting on September 21, 2011. (Resolution 47-7, Meeting #47)

Version 2.2 was adopted by the Board of Trustees of the NY44 Health Benefits Plan Trust as a restated version of the Plan at a regular meeting on June 14, 2011. (Resolution 53-5, Meeting #53)

Version 3.0 was adopted by the Board of Trustees of the NY44 Health Benefits Plan Trust as a restated version of the Plan at a regular meeting on February 14, 2012. (Resolution 57-2, Meeting #57)

Version 3.1was adopted by the Board of Trustees of the NY44 Health Benefits Plan Trust as a restated version of the Plan at a regular meeting on March 26, 2013. (Resolution 65-13, Meeting #65)

CERTIFICATION

In Witness whereof, the Trust Chair of the Trust has executed this amendment on the date set forth below.

06/14/11

John Pope, Trust Chair
Erie 1 Administrators Association
SAANYS

This is to certify that this Amendment to the Plan was approved and the execution hereof was authorized by vote of the Trustees of the NY44 Health Benefits Plan Trust at a meeting held on June 14, 2011 and has been made a part of the minutes of that meeting.

06/14/11

Lori Sosenko, Trust Secretary

CERTIFICATION

In Witness whereof, the Trust Chair of the Trust has executed this amendment on the date set forth below.

June 6, 2013

Doreen Casacci, Trust Chair
Director, Exceptional Education Services

This is to certify that this Amendment to the Plan was approved and the execution hereof was authorized by vote of the Trustees of the NY44 Health Benefits Plan Trust at a meeting held on June 6, 2013 and has been made a part of the minutes of that meeting.

June 6, 2013

Lori Sosenko, Trust Secretary

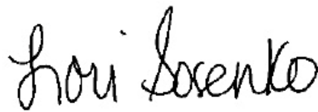
CERTIFICATION

In Witness whereof, the Trust Chair of the Trust has executed this amendment on the date set forth below.

June 16, 2015

John Pope, Trust Chair
Erie 1 Administrators Association
SAANYS

This is to certify that this Amendment to the Plan was approved and the execution hereof was authorized by vote of the Trustees of the NY44 Health Benefits Plan Trust at a meeting held on June 16, 2015 and has been made a part of the minutes of that meeting.

 June 16, 2015

Lori Sosenko, Trust Secretary