DUTCHESS BOCES

John C. Pennoyer
District Superintendent

This information does not apply to those members in the Support Staff Association

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As a member of our Dental plan, we are pleased to advise that effective immediately, you will now have access to 2 networks of Dental Preferred Providers (**Fitzharris Network** & the **Aetna Dental Administrators** network.) We want to remind you of the benefit of using a network provider whenever you can.
You may always use any Dentist of your choice, however, there are two major advantages when using a participating Network Dentist:

1. Their fees can be much lower than the fees of a non-participating Dentist. This means that your out-of-pocket expenses are substantially reduced.
2. The participating Dentist will always accept assignment (they accept payment directly from the insurance company.) Your payment will be only for the out-of-pocket expenses.

The Fitzharris PPO Network will continue to be the primary network. If a provider is a member of both the Fitzharris and Aetna Dental Administrators networks, the fees will be established according to the Fitzharris network.

Steps to access dentists under the Fitzharris and Aetna Dental Administrators networks on the internet:

Go to www.fitzharrisinsurance.com

Under Fitzharris & Company towars the right:

1. Click PPO
2. Click Fitzharris & Company Self-funded Dental Plans
3. Click either on **Fitzharris & Co**. Provider Network or **Aetna Dental Administrators**
4. You can print a directory from both websites

Please remember your Aetna network is **Aetna Dental Administrators**.
If you have any questions, please contact Fitzharris & Company (our broker and administrator) at 1-800-635-5651.

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Dutchess County BOCES Self- Insured Dental Plan

Please note: SSA Members please see your Union Rep for a copy of your dental plan.

Dutchess County BOCES Self- Insured Dental Plan

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DUTCHESS COUNTY BOCES

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DUTCHESS COUNTY BOCES

WHERE TO FIND CLAIM FORMS:

Dental forms are found in the Benefits Office.

WHEN SHOULD YOU SUBMIT A CLAIM?

When you have a claim you should promptly submit the completed claim form and any bills or receipts. We have the right to reject claims submitted more than 180 days after the service. A late claim might be accepted if it is not reasonably possible to submit the claim during the 180 days.

Please note: Benefit checks are **VOID** after 90 days. Please cash promptly.

HOW TO FILE YOUR CLAIM FORMS:

- The top portion of the Claim Form entitled "Employee's Section" on the dental form must be fully completed.
- If the Claim is for yourself, your coverage is the primary plan. If the claim is for your spouse and he/she has other coverage, be sure to attach the payment voucher or declination from his/her plan. If the claim is for your dependent children and your birthday (month and day) is earlier in the calendar year than your spouse's, you should file first. If your spouse's birthday is earlier, you must file with your spouse's plan first, and attach copies of their payment voucher to the claim you are filing through our plan.
- Either have the dentist complete his portion of the form or attach itemized bills to the completed form.
- Completed forms should be mailed to the Claims Administrator, Fitzharris Administrators Inc., at the address which appears on the claim form.
- Questions regarding coverage should be directed to Fitzharris Administrators Inc. at 800-321-1336 or 516-777-2244.

SCHEDULE OF BENEFITS

PLAN EFFECTIVE DATE: July 1, 2004

EMPLOYEES ELIGIBLE: As defined on Page 3

DEPENDENTS ELIGIBLE: All dependents as defined.

PLAN CONTRIBUTIONS: Your employer pays the entire cost for individual coverage. You and your employer share the dependent's dental coverage.

DENTAL BENEFITS FOR YOU AND YOUR DEPENDENTS:

Maximum Dental Benefit per calendar year.....$1,250

Orthodontia Maximum $1,250
(This is subject to the regular maximum) Lifetime

Deductible - $35 per individual up to $105 per family per calendar year.

CARRYOVER DEDUCTIBLE PROVISION:
Covered dental expenses applied to your individual or family deductible during October, November, or December will also be applied to your deductible(s) for the next calendar year.

NOTE: The deductible does not apply to Type A charges consisting of: Oral Exams, Prophylaxis, Fluoride Treatment, X-rays, and Biopsy and examination of Oral Tissue.

DENTAL CO-INSURANCE RATES:
100% of Reasonable & Customary for Type A charges consisting of: Oral Exams, including X-rays, Prophylaxis, and Topical Application of Fluoride. After the dental deductible is satisfied:

(a) 80% of Reasonable & Customary for Type B Charges
(b) 60% of Reasonable & Customary for Type C Charges
(c) 50% of Reasonable & Customary for TMJ Charges
(d) 50% of Reasonable & Customary for Orthodontic Treatment

For more details consult your Claims Administrator, Fitzharris Administrators Inc.

IMPORTANT: Read this document carefully. See "Definitions" and "What Expenses are Not Covered" for other conditions that may affect the coverage.

WHO IS ELIGIBLE AND WHEN COVERAGE BEGINS

WHO IS ELIGIBLE FOR COVERAGE?

All full-time Teachers, Administrators, Custodians, Clerical Employees, Aids, and Interpreters who work 30 hours or more per week.

1. Legally married spouse. Legally separated spouse or divorced spouses are not covered.

2. Each of your unmarried children: who are under 19 years of age; or who are full-time college students under 23 years of age and are dependent upon you for support; or stepchildren, adopted children, or foster children who are dependent upon you for support.

Exceptions - The dependent age limit does not apply to handicapped dependent children. You may be required to show proof of handicapped status once a year.

Mentally or Physically Handicapped Children

If a Covered **Dependent** child:

(a) reaches the age at which he would otherwise cease to be a Covered **Dependent**; but
(b) is then mentally or physically incapable of earning his own living; and
(c) is primarily dependent upon you for support; and if
(d) you submit satisfactory proof of the child's incapacity within 31 days of the date the child reaches such age,

then coverage may continue for such child for as long as he remains incapacitated, subject to payment of required contributions and all other terms of the plan.

HOW DO YOU ENROLL?

You enroll for coverage by completing a Request for Coverage Form which is available from the Personnel Office. If you wish to cover any eligible dependent, you must elect coverage for all of your eligible dependents. If you do not have any eligible dependents when you enroll, you may apply for dependent coverage when you acquire an eligible dependent.

If both you and your spouse are employees of the group, both of you may elect individual coverage, but only one may elect Dependent Coverage. In no event, may you be both covered as an individual and dependent.

WHEN DOES YOUR COVERAGE BEGIN?

If you are in our employment on the plan effective date your coverage begins on the later of July 1, 2004 or the date of your employment.

Employees must be actively at work at the employer's regular place of business; and physically able to perform all such duties.

Work or duties performed at home or while confined in a hospital or other medical institution may not be used to meet this requirement.

WHEN DOES A DEPENDENT'S COVERAGE BEGIN?

If you have enrolled for dependent coverage, coverage for your eligible dependents begins on the date your coverage begins. Dependents you later acquire will become covered on the day they become eligible dependents.

IF YOU DO NOT ENROLL PROMPTLY?

You should enroll promptly. Coverage cannot begin before the date you enroll. If your dependents enroll more than 31 days after that date, coverage will be limited during the first 12 months. See--LATE ENTRANTS.

The following applies only to Dental Benefits if provided on a Contributory Basis:

LATE ENROLLMENT BENEFIT LIMITATION:
If you enroll for coverage for your eligible dependents more than 31 days after the day your dependents become eligible, dental benefits will be subject to the following limitations:

(a) no payment will be made for charges incurred for any Type C Charges during the first twelve months of coverage or for Orthodontic appliances and treatment which began during the first twelve months of coverage.

(b) Type A and Type B charges will be limited to $100 during the first twelve months of coverage.

DEFINITIONS

Incurred Expense
Except as noted below, an expense is deemed to be incurred on the date a service is rendered or a supply is furnished.

EXCEPTIONS

- Expense for an appliance or modification of an appliance is deemed to be incurred on the date the master impression is made.
- Expense for a crown, a bridge, or an inlay or onlay restoration is deemed to be incurred on the date the tooth is prepared.
- Expense for root canal therapy is deemed to be incurred on the date the pulp chamber is opened.

Usual Charge

The charge usually made by an individual **Dentist** for a given service.

Customary Charge

The charge usually made by **Dentists** for a given service within the locality where the service is rendered.

Reasonable Charge

A charge which is both **Usual** and **Customary** for the service rendered.

Necessary Service or Supply
A service or supply which is generally considered by **Dentists** to be an appropriate dental service or supply for a given dental condition.

For purposes of this plan, The Plan Administrator reserves the right to determine:
(1) **Usual Charges;** and
(2) **Customary Charges;** and
(3) **Reasonable Charges;** and
(4) **Necessary Services or Supplies**

DEFINITIONS (continued)

Covered Expense

A **Reasonable Charge** incurred by a **Covered Person** for a **Necessary Service or Supply** which appears on a List of Covered Expenses.

Pre-Determination of Benefits

A **Dentist's** report to the Claims Administrator which:

- is on a claim form; and
- lists the dental services he proposes to render to a **Covered Person**; and
- shows his charge for each service; and
- is accompanied by pre-treatment x-rays or other diagnostic data which The Claim Administrator may require.

Dentist

A licensed **Dentist** who is practicing within the scope of his license.

Dental Hygienist
A person who:

- is licensed to practice dental hygiene; and
- works under the direct control and supervision of a **Dentist.**

Maximum Benefit
The total amount of benefits which will be available to a Covered Person during a Calendar Year.

Lifetime Maximum Benefit
The total amount of benefits which will be available to a Covered Person during his lifetime.

Calendar Year

The period beginning on January 1st of any year and ending December 31st of that year.

DEFINITIONS (continued)

Alternative Benefits

If: (1) there is a less costly alternative to any service or supply which is:

proposed; or
furnished; or
provided; and

(2) such alternative is within accepted standards of dental practice;

then only the **Reasonable Charge** for such alternative shall be considered to be **Covered Expense**.

Family Member

Refers to you or any of your eligible dependents covered under the plan.

Periodontal Prophylaxis

Scaling and polishing of the teeth when the following conditions are, or have been, present in the mouth:

1. A moderate or severe amount of redness, swelling and bleeding of the gum tissue;

2. Periodontal pockets greater than 4 millimeters deep;

3. Bone loss; and

4. A moderate or heavy amount of deposit.

Overpayment

If a benefit is paid under the plan and it is later shown that a lesser amount should have been, we will be entitled to a refund of the excess amount from the provider or you.

DENTAL CARE BENEFITS

Is There a Maximum Benefit?

The maximum we will pay for all Covered Expenses, including orthodontia, during a calendar year is $1,250. Also, the maximum we will pay for orthodontic treatment is $1,250 per lifetime.

Should Benefits Be Determined Before Treatment Starts?

One of the advantages of this dental plan is that it enables you to see the amount payable by the plan prior to having your dentist begin any extensive treatment. This procedure is known as a PRE-DETERMINATION OF BENEFITS. Through this process, you can prevent any misunderstanding as to what is covered by the dental plan. Benefits should be predetermined before you begin treatment if the charges for the treatment will be more than $300.00.

A dental claim form should be completed and submitted to the Claims Administrator. The Claims Administrator will advise you and your dentist of the approved covered dental procedures.

What If More Than One Method Of Treatment Is Available?

When more than one method of treatment is available, we will pay for Covered Expenses for the least expensive method of treatment, regardless of which method is actually used. Examples of this are: restoring teeth with a crown when the tooth could be restored with a filling; fixed bridgework when a partial denture would provide a similar result.

WHAT ARE COVERED EXPENSES?
Covered Expenses are CHARGES by a dentist for necessary dental services furnished to a covered person under the Plan, which do not exceed the allowable charge. There are four types of Covered Expenses: Preventive Expenses, Basic Dental Expenses, Major Dental Expenses and Orthodontic Expenses. Not all expenses are covered. See--WHAT EXPENSES ARE NOT COVERED?

Covered Charges for Preventive and Diagnostic Services
Preventive Services (Type A)

- Cleaning and scaling teeth (prophylaxis) twice each Calendar Year.
- Fluoride treatments once each in calendar year.
- Space maintainers and their fitting for children to Age 19 only.
- Charges for Biopsy and Examination of Oral Tissue.
- Routine oral exams twice each Calendar Year.
- X-rays and laboratory tests needed to diagnose a dental problem or to check the progress of treatment.
- Full mouth X-rays as part of a routine exam once every 36 months.
- Bitewing and other X-rays as part of a routine exam twice each Calendar Year, no more than 4 X-rays for any on oral exam.

Basic Services (Type B)

- Charges for emergency treatment for relief of pain.
- Removal of teeth (extractions) and cutting procedures in the mouth (oral surgery). Treatment of jaw fractures and dislocations are also covered when not covered by your medical plan. Extra charges for removing stitches and exams after surgery are not covered.
- Root canal work (endodontic treatment), including x-rays.
- Fillings - Amalgam or Composite to restore broken or decayed teeth.

Basic Services (Type B) - CONTINUED

- Scaling/root planning and osseous surgery require periodontal charting.
- Scaling/root planning limited to 4 quadrants per year. Code 04341.
- Osseous surgery--once in each 5 year period.
- Periodontal maintenance code(4910)--considered a maintenance service and subject to two treatments per benefit year.
- General Anesthetics administered in conjunction with a covered surgical procedure.
- Charges for prescription antibiotics and analgesics ordered or given by the dentist in connection with a covered dental charge.
- Charges for rebasing or relining of a denture.
- Charges for repair and recementing of crowns, inlays, onlays, bridgework or dentures.

TYPE C CHARGES

1. Charges for gold and crown restorations but only if the repair cannot be made with amalgam, silicate, plastic, or composite filling material. Replacement of a gold or crown restoration will be covered only if the one being replaced is over five years old.
2. Charges for installing for the first time a partial or fully removable denture or fixed bridge.
3. Charges for replacing an existing partial by a new partial denture or fixed bridgework. This includes the adding of teeth to an existing denture or bridgework. Charges will be payable if:
   (a) the existing denture or bridgework is at least five years old and cannot be made serviceable; and
   (b) the tooth is extracted while you are covered for these benefits or the group policy(ies) that were in force prior to the takeover of coverage with no lapse in coverage.

Note: A temporary dental service will be considered an integral part of the final dental service rather than a separate benefit.

TEMPOROMANDIBULAR JOINT DYSFUNCTION CHARGES (TMJ)
Charges for non-surgical treatment of temporomandibular joint disorders (TMJ)and all other craniomandibular disorders and injections other than those made directly into the temporomandibular joint as follows:

(a) initial examination.
(b) Dental x-rays.
(c) TMJ repositioning appliance.
(d) TMJ appliance adjustments.
(e) Transcutaneous Electro-Neural Stimulators (TENS).

ORTHODONTIC APPLIANCES AND TREATMENT CHARGES
Charges for orthodontic appliances and treatment if incurred during a course of orthodontic treatment while the person is covered for these benefits.

HOW MUCH
You will be paid for covered dental charges incurred by an insured person in a calendar year which exceed the dental deductible shown in the Schedule of Benefits. Covered dental charges which have been disallowed may not be used by an insured person to meet the dental deductible. You will be paid at the dental co-insurance rates shown in the Schedule of Benefits.

ORTHODONTIC SERVICES
DESCRIPTION OF SERVICES

There is a maximum lifetime orthodontic benefit. Adult orthodontia is covered if one of the following conditions exists:

- extreme bucco-lingual version of teeth, either unilateral or bilateral;
- a protrusion of maxillary teeth of more than 4 mm;
- a protrusive relation of the maxillary or mandibular arch of at least one cusp;
- an arch length discrepancy of 4 or more mm.

Payment will be made for active monthly treatment only. Retainers are considered part of the total treatment plan, and therefore are not a separate expense.

If a new member's dependent child is already in orthodontic treatment on the date they become eligible for orthodontic coverage, the following formula will apply. Twenty-four (24) months will be considered a full case. The plan will subtract the number of months already in treatment from 24 and pay the maintenance allowance for the remaining months.

Payments will be made up to the scheduled allowances for the covered orthodontic charges described above which are incurred while eligible, up to the maximum lifetime benefit.

PLAN EXCLUSIONS

Covered dental charges do not include charges for services and supplies:

a) which are in excess of the "charges/fees/expenses" as they are defined under General Information.
b) not ordered by a doctor.
c) in a Veterans' Administration Hospital for an insured person with a military service-connected disability.
d) due to loss or theft of an appliance.
e) which an insured person would not legally have to pay if there were no insurance.
f) for an injury or sickness due to employment with any employer or self employment for wage or profit; or for which benefits are payable under Workers' Compensation or Occupational Disease Laws.
g) due to war, if declared or not.
h) for treatment by a person other than doctor. Cleaning of teeth by a Dental Hygienist will be included.
i) for an appliance or supply to increase the distance between the upper and lower jaw.
j) for surgical implants of any type including specially designed fittings or attachments or dentures or a duplicate appliance or device.
k) from a health department maintained by an employer, a union, a trustee or a similar type of entity.
l) which are payable by a government agency, local or other.
m) for cosmetic reasons including altering or extracting and replacing sound teeth to change appearance.
n) for replacing a bridge or denture that meets or can be made to meet commonly accepted standards of functional acceptability.
o) For these items:
    a) fissure sealants.
    b) precision or semi-precision attachments.
    c) oral hygiene, dietary, plaque control and other educational programs.
    d) bite registration, splinting.

IMPORTANT: See "General Information" for other conditions that may affect this coverage.

EXTENDED DENTAL BENEFITS

If, at the time a person's dental coverage ends, he or she has not completed a course treatment which began while covered, benefits will be paid from the date covered dental charges are incurred for the unfinished dental work as if coverage had not ended.

Extended benefits will only cover the following covered charges:

1. root canal therapy, if the pulp chamber was opened prior to the date insurance ended; or
2. a crown bridge or restoration for which a tooth was prepared prior too the date the insurance ended; or
3. an appliance, if the impression was taken prior to the date the insured ended.

No benefits will be paid for any charges incurred:

(a) more than 90 days after the date the person's insurance ends.
(b) after the date the person becomes insured under another group policy.

NOTE: The Extended Benefits Provision does not apply to Orthodontic Appliances and Treatment.

IMPORTANT: See "General Information" for other conditions that may affect this coverage.

DUPLICATE BENEFITS

HOW DO OTHER GROUP TYPE PLANS AFFECT BENEFITS?

If a person has dental coverage under another group plan we will coordinate our benefits with those of that plan. One plan is primary. One plan is secondary. The primary plan pays regular benefits in full. The secondary plan pays a reduced amount which, when added to the benefits paid by the primary plan, will not exceed 100% of the total ALLOWABLE EXPENSES.

"ALLOWABLE EXPENSE" means the usual and customary charge for an item of care at least part of which is covered by one of the plans.

A plan that does not coordinate with other plans is always the primary plan. If both plans coordinate, the primary plan is determined as follows:

1. The plan which covers the patient as an employee, rather than as a dependent, is primary.

2. If both plans cover the patient as a dependent child, the following will determine which plan is primary:

(a) The primary plan will be the plan of the parent whose birthday occurs earlier in the calendar year, except that:

-If both parents have the same birthday, the primary plan will be the plan which has covered the parent for the longer period of time. "Birthday" refers only to month and day in a calendar year, not the year in which the parent was born.

-If either parent plan is issued in another state and does not have this rule for determining which plan is primary, but instead has a rule based upon the gender of the parent, the plan with the gender rule shall determine which plan is primary.

(b) If the child's parents are separated or divorced, the primary plan will be the plan of the parent with custody of the child, except that:
-If the parent with custody is covered as the spouse of the child's stepparent, the primary plan will be the plan of the stepparent.

DUPLICATE BENEFITS (CONTINUED):

-If a court decree has said which parent has financial responsibility for the child's covered expenses, the primary plan will be the plan of the parent who has that responsibility if the insurer of that plan has actual knowledge of the terms of the decree. This does not apply to any claim determination period or plan year during which benefits are paid before the insurer had that actual knowledge.

3. If neither 1. nor 2. applies, the primary plan will be the plan which has covered the patient for the longer period of time, except that:

   (a) If the coverage of one plan is based on present employment, and the coverage of the other plan is based on prior employment, the primary plan will be the plan which is based on present employment; and

   (b) If either plan is issued in another state and does not have this rule for determining which plan is primary, this rule will not apply.

HOW DOES NO-FAULT AUTO INSURANCE AFFECT BENEFITS?

We will reduce the benefits we would normally pay due to injuries from an automobile accident, so that our benefits plus NO-FAULT BENEFITS do not exceed 100% of the covered expenses for such injuries.

"NO-FAULT BENEFITS" means the minimum level of personal injury benefits which state law requires to be offered under automobile insurance policies and which would be paid, regardless of fault, if claim had been made for such benefits.

EFFECT OF PRIOR PLAN COVERAGE

THIS SECTION ONLY APPLIES TO PERSONS COVERED UNDER THE EMPLOYER'S DENTAL PLAN (THE PRIOR PLAN) ON THE DAY BEFORE THIS PLAN TOOK EFFECT. THE MAIN PURPOSE IS TO AVOID GAPS IN COVERAGE THAT MIGHT OTHERWISE OCCUR BECAUSE OF THE CHANGE IN PLANS. IT ALSO PREVENTS DUPLICATE CLAIM PAYMENTS.

WILL A NEW DENTAL CARE DEDUCTIBLE HAVE TO BE MET?

If a person has accumulated any portion of their benefit year deductible or maximum under the prior plan, that portion of their deductible or maximum will reduce the new plans deductible or maximum for that benefit year.

The Lifetime Orthodontic Maximum will be reduced by any benefits received under the prior plan.

WHEN YOU HAVE A CLAIM

SHOULD YOU KEEP RECORDS OF EXPENSES?

You should save all bills and receipts for dental expenses. We need them as proof of your claim.

MAY WE REQUIRE ADDITIONAL PROOF OF CLAIM?

Yes. Before paying benefits, we can require the following:

1. A dental chart showing work done before the treatment for which claim is made.

2. X-rays, lab or hospital records.

3. Cast molds or other evidence of the dental condition of treatment.

4. Post-treatment examination of the patient, at our expense, by a dentist we select.

WHEN COVERAGE ENDS

WHEN DOES YOUR COVERAGE END?

Your coverage will end when any of the following events occur:

1. Your employment ceases; i.e. you cease active full-time work in the eligible classes;

2. You cease to be an eligible employee of the Dutchess County BOCES;

3. You stop making any payments required for your coverage;

4. The Plan terminates.

WHEN DOES YOUR DEPENDENTS COVERAGE END?

Your dependents coverage will end on the earliest of the following events:

1. Your coverage ends;

2. The dependent ceases to be an eligible dependent;

3. You stop making any payments required for dependents coverage;

4. The Plan is changed to terminate coverage for all dependents.

ARE BENEFITS PAID AFTER COVERAGE ENDS?

We will pay Dental Care benefits for the following Covered Expenses incurred by a covered member or eligible dependent within 30 days after coverage ends:

1. A denture for which an impression was taken before the covered member or eligible dependent coverage ended; and

2. A crown, bridge, or gold restoration for which preparation of the teeth was begun before the member's or eligible dependents' coverage ended; and

3. Root canal therapy if begun before the employee's or eligible dependents' coverage ended.

FAMILY PROTECTION PROVISION

In the event of your death while covered, Dental Benefits will be continued for dependents who were covered at that time. The benefits continued are the same as those in force at the time of your death and are provided without premium contributions.

The coverage on all dependents will be continued until the first of the following events occurs:

1. the date your spouse remarries;
2. the date your dependent ceases to qualify as an eligible dependent;
3. two years from the date of your death;
4. the date your dependent is eligible for Medicare;
5. the date the Group Plan ceases.

COBRA - CONTINUATION OF COVERAGE

On April 7, 1986, a Federal law was enacted-Public Law 99-272, Title X - requiring that most employers sponsoring group dental plans offer employees and their families the opportunity for a temporary extension of dental coverage - called continuation coverage - at group rates in certain instances where coverage under the plan would otherwise end.

If you are an employee covered by this dental plan, you have a right to choose this continuation coverage if you lose your dental coverage because of a reduction in your hours of employment or the termination of your employment, except for reasons of gross misconduct on your part.

If you are the spouse of an employee covered by this dental plan, you have the right to choose continuation coverage for yourself if you lose dental coverage under this dental plan for any of the following reasons:

(1) the death of your spouse;
(2) a termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
(3) divorce or legal separation from your spouse; or
(4) your spouse becomes eligible for Medicare.

In the case of a dependent child of an employee covered by this dental plan, he or she has the right to continuation coverage if the dental coverage is lost for any of the following reasons:

(1) the death of a parent;
(2) the termination of a parent's employment (for reasons other than gross misconduct) or reduction in parent's hours of employment;
(3) parent's divorce or legal separation;
(4) a parent becomes eligible for Medicare; or
(5) the dependent ceases to be a dependent child under the dental plan.

COBRA - CONTINUATION OF COVERAGE (Cont'd)

Under the law, the employee or a family member has 60 days to inform the plan administrator of a divorce, legal separation, or a child losing dependent status under the dental plan.

Your employer has the responsibility to notify the plan administrator in the case of an employee's death, termination of employment or reduction in hours, or Medicare eligibility.

When the plan administrator is notified that one of these events has happened, the plan administrator will in turn notify you that you have the right to choose continuation coverage.

Under the law, you have at least 60 days from the day you would lose coverage because of one of the events described above to inform your employer or the plan administrator (whichever is appropriate) that you want continuation coverage.

If you do not choose continuation coverage, your dental benefits will end.

If you choose continuation coverage, your employer is required to offer you coverage which, as of the time coverage is being provided, is identical to the cover- age provided under the plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost dental coverage because of a termination of employment or reduction in hours.

In that case, the required continuation coverage period is 18 months. However, the law also provides that your continuation coverage may be terminated for any of the following reasons:

(1) your former employer no longer provides dental coverage to any of its employees;
(2) the premium for your continuation coverage is not paid;
(3) you become eligible for Medicare;

COBRA - CONTINUATION OF COVERAGE (Cont'd)

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium plus 2% administration fee for your continuation coverage. The law also states that, at the end of the 18 month, 29 month or three-year continuation coverage period, your dental coverage will be terminated.

Continuance During Disability

A special continuation period applies to persons who are (a) entitled to the 18 month continuance referred to on page 24, and (b) certified as disabled under the Social Security Act before the COBRA 18 month continuation period ends. These individuals will be entitled to an additional 11 month continuation (total of 29 months continuation) if they provide notice of their disability within 60 days of a determination and prior to the expiration of the 18 month continuation period. The covered individual will be required to pay the monthly premium (not to exceed 150% of the Employer's full premium cost) during the additional 11 month period. This continuation ends if the individual is no longer disabled or when the additional 11 month have elapsed, whichever occurs first. The individual must notify the Employer within 30 days of a final determination that he or she is no longer disabled.

Any questions about this law should be addressed to your Employer. Also, if you have changed marital status, name, or you or your spouse have changed addresses, please notify the Teachers Association.

FAMILY AND MEDICAL LEAVE ACT (FMLA)
as Federally Mandated

This rider is effective on the later of (a) the effective date of the policy; or (b) the date required by Federal law.

Family and Medical Leave

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) your coverage may be continued on the same basis as if you were an actively-at-work employee for up to 12 weeks during the 12 month period, as defined by your employer, for any of the following reasons:

(a) to care for your child after the birth or placement of a child with you for adoption or foster care; as long as such leave is completed within 12 months after the birth or placement of the child;

(b) to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or

(c) for your own serious health condition.

In the event you and your spouse are both Covered as employees of the school, the continued coverage allowed under item (a) and (b) may not exceed a combined total of 12 weeks.

Conditions:

(a) If, on the day your Coverage is to begin, you are already on an FMLA leave of absence you will be considered actively at work. Coverage for you and any eligible dependents will begin in accordance with the terms of the policy. However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.

FAMILY AND MEDICAL LEAVE (continued)

(b) You are eligible to continue coverage under FMLA if:

(1) you have worked for your employer for at least one year;
(2) you have worked at least 1,250 hours over the previous 12 months;
(3) your employer employs at least 50 employees within 75 miles from your worksite; and
(4) you continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.

(c) In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the policy during the time you were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the policy. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.

(d) You and your dependents are subject to all conditions and limitations of the policy during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

(e) If requested by us, you or your employer must submit proof acceptable to Claims Administrator that your leave is in accordance with FMLA.

(f) This FMLA condition is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the policy following the day your FMLA continuation ends:

FAMILY AND MEDICAL LEAVE (continued)

Conditions (continued)

(g) FMLA continuation ends on the earliest of:
- (1) the day your return to work;
- (2) the day you notify your employer that you are not returning to work;
- (3) the day your coverage would otherwise end under the policy;
- (4) the day your coverage has been continued for 12 weeks.

Important Notice:

Contact the Benefits Office for additional information regarding FMLA.

Plan arranged and Administered by:

FITZHARRIS & COMPANY INC.
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(516) 777-2244
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