TST BOCES
555 Warren Street
Ithaca, New York 14850

Group Dental Plan
Custom Schedule

Rev: 082418

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Section One
Introduction To Your Dental Benefits Plan

This part of the booklet explains your dental benefits under the TST BOCES Dental Benefits Plan ("Plan"). The Plan is funded by TST BOCES ("Plan Administrator"). Lifetime Benefit Solutions, Inc. ("LBS") administers the claims for the dental benefits of the Plan on behalf of the Plan Administrator.

Section Two
Important Terms and Phrases You Need To Know

It is important that you understand all aspects of the Plan in order to get the most out of your coverage. To help make the information easier to understand, the definitions of important words and phrases used throughout the document are described below.

You should understand that information and definitions in one section may be used in later sections.

1. **Active Work (actively at work).** Active work means the performance of all duties that pertain to your work at the place where it is normally done, or where it is required by your employer to be done.

2. **Allowable Amount.** Means the maximum amount that will be paid to the provider for services or supplies covered under this Plan, before any applicable deductible, or coinsurance amounts are subtracted. We determine our Allowable Amount as follows:

   A fee schedule amount is assigned to dental services or procedures based upon a review of factors such as provider specialty, geographic location, and network adequacy, in addition to market forces such as price point. In the absence of a set fee schedule amount, the Allowable Amount will be determined by taking into consideration the type of Covered Service and the average fee schedule amount for similar Covered Services.

   a. If the Plan has a preferred provider reimbursement schedule, the Allowable Amount for a Covered Service received from a dentist who is a participating provider will be the lower of:

      i. The preferred provider reimbursement schedule amount for the Covered Service, or
      ii. The dentist's billed charge.

   b. If the Plan has a Maximum Amount Payable (MAP) Fee Schedule, the Allowable Amount for a Covered Service received from a dentist who is a participating provider or a non-participating provider will be the lower of:

      i. The maximum amount payable under the MAP Fee Schedule for the Covered Service, or

ii. The dentist's billed charge.

c. The Allowable Amount for a Covered Service received from a non-participating provider will be the lower of:

i. A percentage of the reasonable and customary charge, as defined below, or
ii. The dentist's billed charge.

The reasonable and customary charge is a fee or charge the Plan determines based on provider charge data known as the Prevailing Healthcare Charges System (PHCS), which the claim administrator purchases from Fair Health, Inc., or provider charge data that the claim administrator purchases from a New York State-approved vendor of provider pricing data.

3. **Charge.** Charge is the amount the provider actually bills for a Covered Service or supply. A charge for a Covered Service or supply is considered to have been incurred on the date the service or supply was provided to you.

4. **Covered Service.** A Covered Service is a service or supply specified in the Plan and for which a benefit payment is made.

5. **Dentally Necessary or Medical Necessary** means health care or dental services that a dentist or provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical or dental practice;
b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's sickness, injury or disease; and
c. Not primarily for the convenience of the patient, physician, or other health care provider, and
d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's sickness, injury or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendations, the views of prudent providers practicing in relevant clinical areas, and any other clinically relevant factors.

6. **Plan Administrator.** The Plan Administrator is TST BOCES.

7. **Plan Year.** The Plan Year begins July 1st and ends June 30th.

8. **Professional providers.** Professional providers are: individuals licensed to practice dentistry and/or to perform oral surgery, and other health care

professionals who are licensed to provide the services covered under the Plan. Benefits are only provided for services that are usually billed by the provider.

Section Three
Who Is Covered And When Coverage Begins

1. **Eligibility.** You may select coverage for yourself only (individual coverage); or you may select coverage for yourself and your spouse and/or your eligible dependents (family coverage). You must meet the Plan's eligibility requirements for this coverage.

2. **How to apply for coverage.** To apply for coverage, you must complete a form approved by LBS. The form must state whether you want individual coverage or family coverage. You must give the form to the Plan Administrator.

3. **Who is covered.** Only you are covered under the Plan if you selected individual coverage. If you selected family coverage, you may also cover all of the following:

   a. your legal spouse.

   b. your eligible dependents until the last day of the month in which they reach their 19th birthday. An eligible dependent is:

      i. your biological child;

      ii. a child of your spouse;

      iii. a child for whom you are legal guardian; and

      iv. your adopted child or a child who has been placed with you for adoption;

      provided you claim the child on your federal income tax return or you can prove to LBS that you provide more than 50% of the child's financial support; and provided at least one of the following has occurred:

      i. the eligible dependent starts living with you in a regular parent-child relationship; or

      ii. a court of law places a child with you for adoption by accepting a consent to adopt and you enter into an agreement to support the dependent; or

      iii. a court of law make you, or your spouse, legally responsible for the support and maintenance of the dependent.

   c. your unmarried eligible dependents to the end of the month of their 25th birthday, if they are full-time students. An eligible dependent is a full-time student if the dependent is:

i. registered at, and attending, what LBS determines is an accredited institution of learning. An accredited institution of learning is:

- ♦ an institution that offers courses of study leading to a high school diploma, associate, bachelor or graduate degree; or

- ♦ an institution that provides programs for career training and, upon completion of study, credentials the full-time student through licensing, certification or diploma. Such an institution of learning may include a: business, vocational, technical, trade or mechanical school. It does not include an on-the-job training course or a correspondence school; and

ii. considered by LBS to be a full-time student at an accredited institution of learning and is continuously registered as a full-time student until the completion of the program.

Coverage will be provided during the period of time that an accredited institution of learning recognizes as the recess period between semesters, provided the full-time student is enrolled for the next academic session. Coverage will also be provided to a full-time student during an institution's recognized legal holidays and vacation periods.

d. your unmarried eligible dependents who are unable to work or support themselves. Your dependent must be incapable of working because of mental illness, developmental disability or mental retardation, all as defined in the New York Mental Hygiene Law, or because of physical disability. The condition must have occurred: before the dependent reached age 19; or before the dependent reached age 25, if a full-time student. For your dependents to be covered under this paragraph, you must notify the Plan Administrator within 31 days of the date your dependent's eligibility would otherwise end.

If you have selected family coverage, all the Covered Services available to you are also available to your spouse, and eligible dependents. Remember, you must notify the Plan Administrator when you gain a spouse or eligible dependent, or when your spouse or eligible dependent no longer qualifies for coverage.

4. **When coverage starts.** The Plan Administrator establishes the date you are eligible for coverage under this Plan.

a. If you apply for coverage before the day you become eligible, your coverage begins on the eligibility day.

b. If you apply for coverage within 31 days after you are eligible, coverage starts on the date the application is accepted by the Plan Administrator.

c. If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to work.

d. If you have individual coverage and apply for family coverage before a person becomes your spouse or eligible dependent (other than a newborn child), family coverage will start on the date the person, except for a newborn child, becomes your spouse or eligible dependent. If you have individual coverage and apply for family coverage within 31 days after a person becomes your spouse or eligible dependent (other than a newborn child), family coverage will start on the date the application is accepted by the Plan Administrator. Coverage for your newborn child is discussed in e. below.

e. If you have family coverage, your newborn child is covered at birth. If you have individual coverage at the time your child is born, you may change to family coverage and obtain coverage for your newborn child from the moment of birth. You must apply for family coverage, and the Plan Administrator must receive the applicable premium for the new coverage, within 31 days of the birth. If you are in the process of adopting the newborn, there are additional requirements (explained below).

f. If you have family coverage, or if you apply for family coverage and the Plan Administrator receives the applicable family premium for the new coverage within 31 days of the birth of a child you intend to adopt, the child will be covered from the moment of birth if:

   i. you take physical custody of the child upon discharge from the hospital or birth center; and

   ii. within 31 days of the child's birth, you file a petition to adopt or for temporary legal guardianship under the New York Domestic Relations Law.

   The Plan will not provide coverage if a notice of revocation of the adoption has been filed, or one of the biological parent's revokes consent to the adoption. If the Plan pays benefits for Covered Services for an adopted newborn child and the adoption is revoked, or one of the biological parents revokes consent, the Plan has the right to recover any payments that it made for care of the newborn child.

g. Coverage will not begin until the Plan's next reopening date, which occurs once every six months, if:

   i. the Plan Administrator receives your application for coverage later than 31 days after you meet the eligibility requirements;

   ii. the Plan Administrator receives your application for family coverage later than 31 days after a person becomes your spouse or an eligible dependent; or

   iii. the Plan Administrator receives your reapplication for coverage after you choose to end individual or family coverage.

Section Four
Preventive/Diagnostic Dental Coverage

1. **Preventive/Diagnostic Dental Coverage.** Your dental coverage meets the basic needs for preventive dental care. This dental coverage encourages regular visits to the dentist and treatment of minor dental care problems before they become major problems. The basic dental benefits of this Plan cover the most common dental care services for most people. Procedures are diagnostic, restorative, and preventive – all essential to good health.

   a. **prophylaxis**, including scaling and polishing – 2 cleanings in a calendar year including periodontal cleanings

   b. **oral evaluations** – 2 exams in a calendar year

   c. **periapical and bitewing x-rays** – 2 sets in a calendar year, 1 every 36 months for full mouth or panorex x-ray

   d. **topical fluoride applications** for dependents under age 15. 1 application in a calendar year

   f. **palliative emergency treatment** of dental pain as needed

Section Five
Additional Dental Coverage

1. **Additional dental benefits.** The following benefits are in addition to the dental benefits described in Section Four.

   a. **biopsy and exams of oral tissue (hard & soft)**

   b. **temporary crowns**

   a. **recementing of inlays and other prosthodontics, and crowns**

   b. **sedative fillings**

   c. **minor restoration**

   d. **extractions**

   e. **Endodontics**

Section Six
Exclusions

In addition to the exclusions and limitations described in other sections, the Plan does not cover the following:

1. **Services starting before your coverage begins.** The Plan does not cover any service or care given to you before your coverage begins under the Plan.

2. **VA/Government/Uniformed Service Hospitals.** The Plan does not cover any service or care you receive in an institution owned or operated by: the Veterans Administration; a federal, state, or local government; or by the United States uniformed services, except as follows:

   a. **VA hospitals.** The Plan will cover service and care for non-service related conditions received in an institution owned or operated by the VA.

   b. **Government hospitals.** The Plan will cover service and care received in institutions owned or operated by a federal, state, or local government if you are a patient in a hospital that is state or municipally owned and operated, and the hospital usually charges for its services.

   c. **Uniformed Service hospitals.** The Plan will cover service and care while an inpatient in a hospital operated by the United States uniformed services for the following covered persons: retired military personnel and their dependents; and dependents of military personnel on active duty.

d. **Emergency care.** The Plan will cover service and care in any of the above hospitals if:

i. you suffer a sudden and serious illness or serious injury;

ii. you are treated immediately at the hospital because of its closeness;

iii. it is impossible to transfer you to another institution; and

iv. you stay in that hospital only as long as emergency care is necessary.

3. **Government programs.** The Plan will not cover any benefits that are payable under Medicare, or any other federal, state or local government program, except when required by state or federal law. When you are eligible for a government program, benefits will be reduced by the amount the government program would have paid for the services. If you are eligible for a government program, this reduction is made even if: you fail to enroll; you do not pay the charges for the program; or you receive services at a hospital that cannot bill Medicare.

4. **Workers' compensation.** The Plan will not cover any service or care for which you are eligible under a Workers' Compensation Act or similar law. The Plan will not cover the services even if you do not receive benefits because: a proper or timely claim for the benefits available to you under the Act was not submitted; or you fail to appear at a Workers' Compensation hearing.

5. **No-fault automobile insurance.** The Plan will not cover any service or care that is eligible for coverage by no-fault automobile insurance until you have used up all the benefits under the no-fault policy. If your claim for no-fault benefits is denied, you must file for an arbitration hearing if requested to do so. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under any available mandatory no-fault policy. The Plan will pay for services covered under this contract when you have exceeded the maximum benefits of the no-fault policy.

   Should you be denied benefits under the no-fault policy because it has a deductible, the Plan will pay for Covered Services.

6. **Free care.** The Plan will not cover any service or care if furnished to you without charge, or if it would have been furnished to you without charge if you were not covered under this Plan.

7. **Employer services.** The Plan will not cover any service or care furnished by a medical department or clinic provided by your employer.

8. **Cosmetic surgery.** The Plan will not cover any service or care related to cosmetic or beautifying surgery. This exclusion applies when it is determined the service is not medically necessary and is intended only to improve your appearance. However, the Plan will cover services in connection with reconstructive surgery as a result of an infection, injury or disease. The Plan will also cover reconstructive surgery to correct a functional birth defect of a covered dependent child.

9. **Experimental and investigational services.** Benefits will not be provided for any treatment, procedure, facility, equipment, drug, device or supply (collectively, "Service") that is determined to be experimental or investigational. It may be determined that a Service is experimental or investigational even if it has received governmental approval or is ordered by your professional provider.

"Experimental or investigational" means:

a. the Service is considered experimental or investigational by LBS or any appropriate technological assessment body established by a state or federal government; or

b. the Service does not have appropriate governmental or regulatory approval when it is provided to you; or

c. reliable Evidence (defined below) shows that the Service is not customarily recognized as standard medical treatment for your condition; or

d. reliable Evidence (defined below) shows that the Service is, or there is consensus among experts that it should be, the subject of further study or ongoing clinical trials to determine maximum tolerated dosage; toxicity; safety; effectiveness; or effectiveness as specifically compared with the standard means of treatment or diagnosis for your condition.

"Reliable Evidence" includes:

a. the views and practices of medical or dental communities throughout the country.

b. reports and articles published in authoritative medical, dental, and scientific literature.

c. the opinion of professional consultants.

d. written protocols used by your professional provider or any other professional provider studying substantially the same Service.

e. informed consent forms used by your professional provider or any other professional provider studying substantially the same Service.

10. **Unnecessary care.** The Plan will not cover any service or care when it is determined that the care is not needed for your proper medical care or treatment. This exclusion applies wherever you receive the service or care.

11. **Criminal behavior.** The Plan will not cover any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred.

12. **Prohibited referral.** The Plan will not cover any pharmacy services, clinical laboratory, x-ray, or imaging services that were provided pursuant to a referral prohibited by the New York State Public Health Law.

13. **Special charges.** The Plan will not cover charges for telephone consultations, missed appointments, or fees that may be added for completing a claim form.

14. **Act of war.** The Plan will not cover an illness or injury that occurs as a result of any war or act of war, whether declared or undeclared.

15. **Other non-Covered Services.** In addition to the exclusions listed above, benefits are also not provided for the following: sealants, myofunctional therapy; athletic mouth guards; oral hygiene, dietary, plaque control, and other educational programs; porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid, to the extent the charges would be more than the charge that would have been a covered benefit for acrylic veneered crowns or pontics.

    However, benefits may be available for some of the following services under a medical surgical or major medical type contract: excision of tumors; removal of cysts and neoplasms; excision of bone tissue; surgical incision; treatment of fractures; repair of traumatic wounds; and other repair procedures.

16. **Not Dentally/Medically Necessary.** For charges that are not dentally or medically necessary, as defined, except as specifically provided for in this Plan.

    The fact that a physician may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device, or drug does not, in and of itself, make it “Medically Necessary” or make the charge a Covered Service under the Plan, even if it has not been listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

17. **Medical Plan Benefits**. The Plan does not cover charges for dental services that are payable under a medical benefits Plan sponsored by this employer.

    Please refer to the attached fee schedule for any other covered or non-covered benefits under this Plan.

Section Seven
Coordination of Benefits

1. **Other health benefits programs.** This section only applies if you, your spouse, or an eligible dependent is also covered under another health benefits program that provides dental benefits. These programs, whether insured or self-insured, include the following group programs:

    a. group contracts issued by a hospital service, health service, or medical expense indemnity corporation (such as a BlueCross or BlueShield Plan) or a dental expense indemnity corporation;

b. group or group remittance insurance contracts;

c. HMOs, and other prepayment group practice and individual practice plans;

d. labor-management, union, employer organization, or employee benefit plans;

e. blanket contracts, except school accident or similar coverage where the organization pays the premium; or

f. governmental programs for hospital, medical and surgical benefits offered, required, or provided by law, except Medicare and Medicaid. These programs do not include programs whose benefits, by law, are in addition to any private or nongovernmental health benefits program.

It also includes health benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.

2. **Purpose.** Coordination of benefits (COB) means that the coverage provided under this Plan is coordinated with coverage available to you under another health benefits program. The purpose of COB is to avoid both programs paying benefits for the same services.

3. **Payment rule.** When you are covered under this Plan and another health benefits program, you have primary and secondary coverage. Primary means the program that is required to pay its benefits first. Secondary means the program paying second.

In deciding which program is primary, the first of the following rules that applies will be used:

a. if a program does not have a COB provision like this one, it is primary;

b. the program is which the patient is covered as an employee or member (that is, other than as a dependent) is primary, except that:

i. if the patient is also a Medicare beneficiary;

ii. if the rules established by the Social Security Act of 1965, as amended, make Medicare primary to the program covering the patient as an employee or member; and

iii. if the rules established by the Social Security Act of 1965, as amended, make Medicare secondary to the program covering the patient as a dependent of a person in current employment status (defined as an employee, employer, or person associated with an employer in a business relationship) with respect to the employer maintaining the program; then

iv. the following rules apply:

- ♦ the program covering the patient as a dependent of a person in current employment status pays first,

- ♦ Medicare pays second,

- ♦ the program covering the patient as an employee or member pays third.

c. if a child is covered as a dependent of two people (parents/married or joint custodians of the child without a court decree establishing financial responsibility for health care expenses) under different programs, the following rules apply:

   i. the program of the parent whose birthday (month and day) is earlier in the year is primary

   ii. if both parents have the same birthday, the program that covered a parent longer is primary; however,

   iii. if the parents are divorced or separated, and joint custody has not been decreed, the special rule in (d) may apply

   However, some programs may not have adopted this "birthday rule". When the two COB provisions do not agree on which program is primary, the following will be used: if the other program has a rule based on the parent's gender, the program under which the child is a dependent of a male is primary.

d. for children of divorced or separated parents the following rules apply:

   i. if there is a court decree establishing financial responsibility for the health care expenses of the child of divorced or separated parents, the program that covers the child as a dependent of the parent with financial responsibility will be primary, if the program has actual knowledge of the court decree. If the program has no actual knowledge, the following rules apply.

   ii. if the parents are divorced or separated, the program that covers the child as a dependent of the parent with custody is primary; provided, the parent with custody has not remarried.

   iii. if the parents are divorced and the parent with custody of the child has remarried, the primary program is the first of the following to apply:

      - ♦ the program that covers the child as a dependent of a parent with custody;

      - ♦ the program that covers the child as a dependent of the spouse of the parent with custody; or

- ♦ the program that covers the child as a dependent of the parent without custody.

e. when the above rules do not determine priority, the program that covered the patient for the longest time is primary. The other program is secondary, except when:

   i. the program in which the patient is covered as an employee but not as a laid-off or retired employee or the dependent of such an employee is primary; the program in which the patient is covered as a laid-off or retired employee or the dependent of such an employee is secondary; and

   ii. if both programs do not have a provision like this for laid-off or retired employees, then this rule will not apply.

4. **How COB affects payments.**

   a. **When the Plan is primary.** The Plan will pay for Covered Services as if there were no COB provision, when the Plan is primary.

   b. **When the Plan is secondary.** The Plan bases its payments, when it is secondary, on allowable expenses during a claim determination period. Allowable expenses are the necessary, reasonable, and customary items of expense for health care that are covered at least in part by one or more health benefit programs. A claim determination period means a calendar year; it does not include any part of a year when you were not covered by this Plan.

   The Plan will pay for Covered Services after the payment by the primary program. Benefits may be reduced so the total of all benefits available to you from the Plan and the primary program is not more than the allowable expenses.

   The Plan counts as actually paid by the primary program any items of expense that would have been if you had made the proper claim. If the primary program claims it is “excess only” or “always secondary,” information will be requested from that program so they can process your claim. If the primary program does not respond within 30 days, it will be assumed that its benefits are the same as under the Plan. If the primary program sends the information after 30 days, payment under the plan will be adjusted, if necessary. When the Plan is secondary, benefit payment will never be more than the full amount of benefits due under the Plan had the Plan been primary.

5. **Right to receive and release necessary information.** Without your permission and without notice to you, LBS or the Plan Administrator may release to, or obtain from, any person, company or organization information that is believed to be necessary to carry out the purposes of this section. Neither LBS nor the Plan Administrator will be legally responsible to anyone for releasing or obtaining information. You must furnish to LBS or the Plan Administrator any information

that they request. If you do not furnish the information to them, benefits may be denied under the Plan until you do.

6. **Payments to other health benefits programs.** Benefits may be repaid to any other health benefits program that were paid for your Covered Services under the Plan, if it is decided that the Plan should have paid. These payments are the same as benefits paid to you, and they satisfy any obligation to you under the Plan.

7. **Right to recover payment.** In some cases, payment may have been made even though you had coverage under another program. If this happens, you must refund the amount of the Plan's payment. LBS also has the right to recover the payment from the other program. You must sign any document that is needed to help recover payment.

Section Eight
How Your Coverage May End

This section describes how your benefits under the Plan may end and how your coverage stops. When the benefits or your coverage ends, benefit payments stop on the termination date. This applies even if you are receiving benefits under the Plan, except as otherwise specifically provided under the Plan.

1. **If your benefits terminate.** Your benefits may be terminated at any time if the Plan Administrator and LBS agree to end their arrangement.

2. **When you no longer qualify.** When you fail to meet the eligibility requirements of the Plan Administrator, your coverage will end.

3. **On your death.** Your coverage will automatically end on the day after your death. If you have family coverage, your spouse's and eligible dependents' coverage will also end on the day after your death.

4. **Termination of marriage.** If you have family coverage and you become legally separated or divorced, the coverage of your spouse will end automatically on the date the legal separation agreement or decree is actually filed. You should immediately notify the Plan Administrator of your change in marital status.

5. **Termination of coverage of an eligible dependent.** Coverage of your eligible dependent will end on:

   a. the last day of the month in which the dependent child reaches their 19th birthday;

   b. the day your dependent marries;

   c. the day you no longer claim the dependent on your federal income tax return, or provide more than 50% financial support.

d. the day your dependent over 19 years of age (or over 25 if a full time student) no longer has a mental illness, developmental disability, mental retardation or physical handicap, or can support himself or herself.

e. the last day of the month your dependent under 25 years of age no longer qualifies as a full-time student or the last day of the month in which the dependent reaches their 25th birthday while attending school.

Section Nine
Miscellaneous

1. **General information.** This Plan is maintained for the exclusive benefit of employees of TST BOCES. Employees' rights under this Plan are legally enforceable. It is the intention of TST BOCES that this Plan be maintained for an indefinite period of time.

2. **Effective date.**

   If you are in regular full-time employment on the Plan effective date, and have satisfied all eligibility requirements, you and your dependents will be eligible for coverage on that date. The Plan effective date is July 1st .

3. **When a charge is incurred.** A charge is incurred on:

   a. the date the dentures or fixed bridges are completed;

   b. the date the crown has been inserted/seated;

   c. the date the work on the tooth is begun, in the case of root canal therapy; or

   d. the date the work is done, in the case of any other work.

Section Ten
Submitting a Claim

When you or an eligible dependent has an appointment with a dentist you should proceed as follows:

1. Obtain a claim form from the Human Resources Department at TST BOCES. Complete and sign the top portion of the claim form indicating the name of the patient who is to be treated by a dentist and the employee's name, and fill in other information requested on the form. You must sign the section authorizing use of claim information. If you sign the section authorizing plan payment to the dentist, any plan payment will be made payable to the dentist. If you do not sign this section, any payment will be made directly to you.

2. You must give the claim form to the dentist. The dentist is expected to fill out the form upon completion of services and send the form to LBS at the address printed on the top of the form. Applicable benefits will be determined and payment will be made by LBS on behalf of the Plan Administrator. The amount of coverage will be determined by LBS on behalf of the Plan Administrator, in accordance with the terms of the Plan. If for any reason you are unable to obtain a claim form in advance of treatment (for example, if an emergency service is required, or service is required while you are on vacation), you should attach a copy of the dentist's bill to a claim form obtained as soon afterward as possible. After completing the appropriate portion of the claim form, YOU MUST SUBMIT IT TO LBS.

3. LBS will pay the applicable benefit amount for all completed work to the dentist or directly to you. If you are not entitled to payment, you will receive an explanation of the amount of benefits paid. Upon receipt, the explanation of benefits should be examined for accuracy and any questions directed to LBS or the Plan Administrator.

4. When another dental appointment is scheduled, you should obtain another claim form for the dentist to complete.

5. LBS reserved the right to deny payment relative to any claim form received more than 180 days following the last date of treatment on the form.

6. If a claim for benefits under the Plan is denied, LBS will provide you with the reason for denial, in writing, within 15 calendar days following receipt of the claim.

   You, or a person on your behalf, may ask for a review of the denied claim in writing within 180 days of receipt of the denial notice. This written request for review should state the reason(s) why you feel your claim should not have been denied. It should include any additional documents (medical or dental records, etc.) that you feel support your claim. You may ask additional questions or make comments, and you may review pertinent documents. In normal cases, you will receive the final decision within 15 days of the date that your request for review is received by LBS.

   All requests for Plan Administrator *review of denied claims* should be sent to:

   Lifetime Benefit Solutions, Inc.
   Attn: Claim Denial Department
   P.O. Box 21951
   Eagan, MN 55121

   You have the right to appeal any claim denial to your Plan Administrator. The Plan Administrator has the duty and the authority to conduct a final full and fair review of any claim(s) denied in full or part by LBS.

   All requests for Plan Administrator *review of denied claims appeal* should be sent to:

Lifetime Benefit Solutions, Inc.
Attn: Claim Appeals Department
P.O. Box 21951
Eagan, MN 55121

Section Eleven
COBRA

This information is group specific. If you would provide us with approved language we will insert it here.

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you and/or your covered family members may have a right to continue your coverage under this Plan, when your coverage would otherwise end. If you are eligible to continue your coverage under COBRA, the Plan Administrator should give you notice. If you do not receive notice, ask the Plan Administrator if you qualify.

Section Twelve
Your Rights Under ERISA

This information is group specific. If you would provide us with approved language we will insert it here.

The Federal Employee Retirement Income Security Act of 1974, as amended (ERISA) provides certain rights and protections to participants whose employer group health plans are subject to the requirements of ERISA. If ERISA applies to this Plan, the Plan Administrator is responsible for complying with its requirements. The Plan Administrator can advise you what rights, if any, you have under ERISA.

PLAN ADMINISTRATOR

TST BOCES

PLAN YEAR

July 1st – June 30th