NORTH SHORE SCHOOLS FEDERATED EMPLOYEES BENEFIT TRUST FUND

DENTAL BENEFIT PROGRAM

Revised December 2019

Administered by:
ADMINISTRATIVE SERVICES ONLY, INC.

www.asonet.com

•Benefit Information
•Claim Inquiries
•Claim Forms
•Participating Dentist Lists

This Brochure provides a brief general description, written in non-technical language. Nothing in this brochure is meant to interpret or extend or change in any way the provisions of this Plan. All provisions are subject to terms and conditions in the North Shore Schools Federated Employees Benefit Trust Fund Booklet

ELIGIBILITY: Members and eligible dependents, which include the lawful spouse and unmarried children from birth until the child's 26th birthday.

ENROLLMENT: Members must enroll themselves and their eligible dependents in order to receive dental benefits coverage. Members may enroll as an individual; an individual employee plus spouse; individual employee plus dependent child (only one dependent child may be enrolled at a time; this enrollment cannot be changed unless the dependent child is no longer eligible for benefits as a dependent, according to the terms of the plan); and family (member plus all eligible dependents, as defined by the Fund).

PLAN YEAR: The Dental Plan year is a calendar year (January through December). All annual maximums and frequency limitations are based upon the plan year.

WAITING PERIODS FOR LATE ENTRANTS:
All members must complete and submit a new enrollment/rejection form within thirty (30) days from the date of employment (hire). If you decide that you want to enroll and purchase the Fund's dental benefits plan after thirty (30) days from your date of employment (hire), then all enrolled individuals will be subject to the following waiting periods:

Type of Dental Service	**Waiting Period**
Preventative	No Waiting Period
Basic Restorative:	
• Fillings	6 Months from Effective Date
• All Others	12 Months from Effective Date
Major Restorative	24 Months from Effective Date
Orthodontics	24 Months from Effective Date

Hereafter, enrollment can take place on a periodic basis, to be determined by the Board of Trustees.

ANNUAL MAXIMUM: Effective January 1, 2014, the annual maximum has been increased to $3,000 per covered individual per calendar year. The annual maximum applies to services other than orthodontic services rendered by Participating and Non-Participating Providers.

ORTHODONTIC MAXIMUM: Effective January 1, 2019, $3,600 lifetime maximum per covered individual. The orthodontic maximum applies to services rendered by Participating and Non-Participating Providers.

ANNUAL DEDUCTIBLE: Effective January 1, 2019, there is no deductible for this plan.

COVERED EXPENSES: Covered Expenses include charges incurred for the performance of Dental Services provided for in the Schedule of Covered Dental Expenses, when the Dental Service is performed by or under the direction of a duly licensed Dentist (or orthodontist in the case of orthodontia), is essential dental care, and begins and is completed while the individual is covered for benefits.

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and removable dentures, it starts when the first impressions are taken and/or abutment teeth are prepared;
- for a crown, it starts on the first date of preparation of the tooth involved;
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

SCHEDULE OF PLAN ALLOWANCES:
In-Network- North Shore Schools Federated Employees Benefit Trust Fund Participating Providers will be reimbursed in accordance with the Schedule of Maximum Provider Charges.

You will not incur any other out-of-pocket expenses when you use a participating provider, except in the following instances:

- For non-covered services.
- For services that are listed in the Schedule but for which the Plan will not pay, e.g:*
    a) Where dental plan benefits exceed your $3,000 calendar year maximum.
    b) Where procedure frequency limitations have been met.

**In these instances, the participating dentist's charges may not exceed the Maximum Charges as stated in the Schedule.*

Out-Of-Network- When you utilize the services of an out-of-network provider, you will be reimbursed the amount listed on the Schedule of Plan Allowances for all covered services.

SELECTING A DENTIST- You are free to select the dentist or dental specialist of your choice. And of course, each family member may select his or her own dentist. You may utilize the services of a participating specialist whether or not you utilize the services of a participating general dentist for your routine dental care. You may change your dentist at any time for any reason. **It is important to understand that North Shore Schools Federated Employees Benefit Trust Fund does not recommend or endorse any particular dentist. You should exercise the same care and apply the same criteria in selecting a participating dentist as you would in selecting a non-participating dentist.**

HOW TO LOCATE A PARTICIPATING DENTIST:

To locate a participating provider, go to: www.asonet.com

Go to "Find Your Dentist" at the top of the page. Select plan "North Shore Schools FEBTF" and click "Search for Dentist" (once member eligibility is established, you will be able to log on as a member)

SCHEDULING AN APPOINTMENT- After selecting a dentist from the directory, call the dental office for an appointment. Identify yourself as a **North Shore Schools Federated Employees Benefit Trust Fund member** when scheduling. **Due to the fact that there are occasional additions and deletions, please verify that the dentist is still participating when scheduling your appointment and at the time of your visit. If you have any questions, please contact Administrative Services Only, Inc at 1-800-537-1238 / 1-516-396-5500**

HOW TO FILE A CLAIM:

In-Network- Participating dentists will handle all the necessary paper work. You simply complete the Assignment of Benefits section of your claim form and reimbursement will be paid directly to the dentist. You will be responsible for reimbursing the dentist only in those instances stated above. You will receive an Explanation of Benefits (EOB) voucher when a claim is paid on your behalf. Please review the EOB carefully. If you have any questions regarding services paid on your behalf, please contact ASO.

Out-of-Network-After dental work is performed, have your Dentist complete all items in the Dentist Information portion of the Universal or Standard ADA Claim Form and list the procedures, dates of services and charges and sign in the space provided for Dentist signature. You should then complete all items in the Employee section. Be sure to include spouse and dependent information. Completed claim forms, with x-rays and other attachments, should be sent to:

Administrative Services Only, Inc.
P.O. Box 9005, Dept 152
Lynbrook, NY 11563-9005
516-396-5500

Dental claims must be filed within 12 months after the date of service. Claims filed after 12 months will not be reimbursed. If you would like the payment made directly to your Dentist, you may do so by signing the "Authorization to Assign Benefits" box on the claim form.

CLAIMS APPEAL AND REVIEW PROCEDURE: The benefits provided by this Fund may be changed by the Board of Trustees at their sole and absolute discretion. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this plan and pamphlet are subject to such rules and regulations and to the Trust Agreement, which established and governs the Fund operations.

All rules are uniformly applied by the Fund Office. The action of the Fund Office is subject only to review by the Board of Trustees. A member may request a review of action by submitting notice in writing to the Board of Trustees within 60 days after the denial of a claim, at the Fund office, explaining the reason(s) why the adverse determination should be changed. The Board of Trustees will review the documents provided and render a final and binding decision.

EXTENSION OF BENEFITS: An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while that person was eligible if:

- for crowns, fixed bridgework and full or partial dentures, a pre-treatment authorization was issued and impressions were taken and/or teeth were prepared while that person was an eligible beneficiary and the device was installed or delivered within one month after that person's eligibility terminated.
- for root canal therapy, the pulp chamber of the tooth was opened while that person was eligible for benefits and the treatment was completed within one month after that person's eligibility terminated.

There is no extension for any dental service not shown above.

PRE-TREATMENT REVIEW (RECOMMENDED): This process is intended to inform you and your dentist, in advance of treatment, whether the service will be deemed dentally necessary and what benefits are provided by the Dental Program. It enables you to obtain knowledge of the operation of your dental plan prior to undertaking treatment and incurring expenses.

It is recommended that a Claim Form for Pre-Treatment Review be filed by you or your Dentist if the course of treatment prescribed for you is expected to cost more than $500 and/or includes any of the following services: crowns, bridges, dentures, laminate veneers or periodontal surgery. The Dentist should complete the claim form describing the planned treatment and the intended charges before starting treatment. Complete your part of the form and mail it, BEFORE TREATMENT IS RENDERED, together with the necessary x-rays and other supporting documentation to:

Administrative Services Only, Inc.
P.O. Box 9005, Dept 152
Lynbrook, NY 11563-9005

Our dental consultants will review the proposed treatment plan and apply the appropriate Plan provisions. You and your Dentist will receive a report showing the amount the Plan will pay for each procedure. If there is a disallowance, it will be indicated and an explanation will be provided. Discuss the treatment plan and the benefits payable with your Dentist.

If you receive a pre-treatment authorization for a proposed course of treatment that was submitted by one Dentist, that pre-authorization will remain valid if you elect to have some or all of the work done by another Dentist. The pre-treatment authorization will be honored for one year after issuance.

Please be aware that a pre-treatment authorization is not a promise of payment. Work must be done while you are still covered by the Fund for benefits (except where there is an Extension of Benefits) and no significant change occurred in the condition of your mouth after the pre-treatment authorization was issued. Payment will be made in accordance with plan allowances, limitations and maximums in effect at the time services are provided.

ALTERNATE BENEFITS PROVISION: Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could produce a suitable result based on accepted dental standards. **In these instances, although you may elect to proceed with the original treatment plan, reimbursement allowances will be based on a less expensive Alternate Course of Treatment.** This should in no way be considered a reflection on your treating dentist's recommendations. By using the pre-treatment review and authorization procedures you and your Dentist can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun, or has been completed without a pretreatment authorization estimate, the benefits paid by the Dental Plan may be based on the less expensive treatment.

COORDINATION OF DENTAL BENEFIT: If you or your family members are eligible to receive dental benefits under another group plan in addition to the **North Shore Schools Federated Employees Benefit Trust Fund** Dental Plan, benefits will be coordinated with the benefits from your other group plan so that up to 100% of the **allowable expenses** incurred will be paid jointly by the plans. However, a member cannot receive benefits as both a member and dependent under this plan. In order to obtain all of the benefits available, you and your family members should file claims under each plan. Members should file with the primary plan first and then the secondary plan. Be certain to enclose a copy of the payment voucher from the primary plan when filing a claim with the secondary plan.

BIRTHDAY RULE: The Birthday Rule is applied for determining the primary plan for payment of dental benefits for dependent children. The plan of the parent whose birthday, month and day, falls first in the calendar year is primary. For example, if your birthday is July 9 and your spouse's birthday is October 27, your dental plan will be primary for your child. Payment claims for dependent children should be submitted to the primary plan first, and then to the secondary plan, enclosing a copy of the payment voucher from the primary plan.

EXPENSES NOT COVERED: Covered Expenses will not include, and no payment will be made for, expenses incurred for:

1. treatment solely for the purpose of cosmetic improvement.
2. replacement of a lost or stolen appliance.
3. replacement of a bridge, crown or denture within **five** years after the date it was originally installed.
5. replacement of a bridge, crown or denture which is or can be made usable according to common dental standards.
6. procedures, appliances or restorations (except full dentures) whose main purpose is to:
   a) change vertical dimension; or
   b) diagnose or treat conditions or dysfunctions of the temporomandibular joint (TMJ); or
   c) stabilize periodontally involved teeth.
7. multiple bridge abutments.
8. dental services that do not meet common dental standards.
9. services not included as Covered Dental Expenses in the Dental Schedule.
10. services for which benefits are not payable according to the "General Limitations" section.

GENERAL LIMITATIONS: No payment will be made for expenses incurred for you or any one of your Dependents:

1. for or in connection with services or supplies resulting from an accidental injury and which are deemed to be the responsibility of a third party.
2. for or in connection with a sickness or injury arising out of, or in the course of, any employment for wage or profit, which is covered under any workers compensation, occupational disease, or similar law.
3. for charges made by a hospital owned or run by the Federal, State and Municipal agencies unless there is a legal obligation to pay such charges whether or not there is any insurance.
4. for charges which would not have been made if the person had no insurance or dental benefits, including services provided by a member of the patient's immediate family.
5. to the extent that they are more than Reasonable and Customary Charges or the Fee Schedule amount.
6. for charges for unnecessary care, treatment or surgery.
7. to the extent that you or any of your Dependents is in any way paid for, or furnished by, any government agency, except Medicaid; or that the Insured is not required to pay.
8. for a sickness or injury that is the result of war, declared or undeclared, or any act of war or aggression.
9. for an injury that is the result of participation in a felony, a riot, or an insurrection.
10. for or in connection with experimental procedures or treatment methods not accepted in the dental industry.