NORTH SHORE SCHOOLS FEDERATED EMPLOYEES BENEFIT TRUST FUND
40 Railroad Avenue
Glen Head, New York 11545

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Administrative Services Only, Inc.

January 1, 2015

Dear Member:

The Trustees are pleased to provide you with this Comprehensive Benefits Booklet, which describes your benefits through the North Shore Schools Federated Employees Benefit Trust Fund.

This booklet includes the Trust Fund's dental benefits program, as well as details of enrollment, eligibility, coverage for dependents, and other general information concerning Trust Fund procedures.

We suggest that you read this booklet carefully and share it with your family. Keep it available so that you can refer to it in the future.

Yours truly,

Board of Trustees
Bruce Fichtman, Chairman
Barbara Brennan
Sara Black-Cano
Ronnie Heller
Greg Perles

Fund Director
Susan McCormack

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GENERAL INFORMATION

FUND INFORMATION

The North Shore Schools Federated Employees Benefit Trust Fund (hereinafter referred to as the "Fund"), is a legal entity separate and distinct from the North Shore Schools Federated Employees (hereinafter referred to as the "Union"), and was established as a result of collective bargaining between the North Shore Central School District, (hereinafter referred to as the "District") and the Union. The Fund provides supplemental health-related and other benefits to its members and eligible dependents. Contributions to the Fund are predicated on the amount stipulated in the collective bargaining agreement(s) between the Union and the District and other pertinent documents.

The primary source of contributions to the Fund is the employer, the District. Contributions are remitted on behalf of each covered active employee. Contributions are used to provide benefits for the covered members and their eligible dependents and to finance the cost of administration of the Fund. Employee and retiree contributions for benefits provided by the Fund are determined by the Board of Trustees of the Fund.

The Fund is governed by a Board of Trustees comprised of five members all of whom are appointed at the recommendation of the President of the Union and approved by the Executive Board of the Union. The current members of the Board of Trustees are listed in the beginning of this booklet.

The Board of Trustees employs personnel who are responsible for the daily functioning of the Fund and Third Party Administrator(s), whose primary function is the processing of claims.

ENROLLMENT REQUIRED FOR BENEFITS

In order to receive benefits from the Fund, you must complete an Election/Rejection Form, which may be obtained from the Fund Director or downloaded from the Union's website www.nssfe.com. You and your eligible dependents will become eligible for Fund benefits on your first day of active

employment with the District. If your first day of active employment is after the first day of the school year, you and your eligible dependents will become eligible for Fund benefits on the first day of the following month. (For example – if your first day of active employment is October 15th, your first day of eligibility is November 1st.) **However, no member may receive any benefit(s) provided by the Fund until he/she enrolls for said benefit(s).**

Retirees who wish to continue and pay for eligible Fund benefits must complete a Retiree Election/Rejection Form within 30 days from their loss of benefits as an active member. Retirees will receive written notice from the Fund of when their benefits as an active member terminate.

It is important that you notify the Fund, in writing, of any changes in your marital or family status and any change of your address. **Payment of benefits can be put in jeopardy if the member fails to notify the Fund of a subsequent change in marital status, change of dependent status or address, or neglects to confirm college-attendance status of a dependent child of their household.**

Provided your dependents are eligible under the terms of the Fund as previously outlined, you can enroll and pay for dental benefits coverage for your spouse/domestic partner and/or dependent children. However, you must *timely* enroll your eligible dependents in order to avoid the waiting period.

Timely enrollment occurs when you enroll and pay for, via payroll deduction or if a retiree, via direct billing, your spouse/domestic partner either (1) upon employment, provided you were already married/in the domestic partner relationship; or (2) within 30 days of getting married or enrolling your domestic partner with the Fund or retirement. Enrollment of an eligible dependent must occur upon employment or retirement, for those dependent children who were eligible at the time you were first employed.

Other coverage

If an active member or retiree is eligible for coverage as a dependent of another member, active or retired, or is eligible as a dependent through his/her spouse's plan, then that active or retired member can "waive" benefits until s/he loses benefits due to his/her spouse's employment termination or reduction, or death. In such an event, the active or retired member may enroll in either the active member's or retiree benefits plan, without being subject to late enrollment penalties provided the enrollment is completed no later than 30 days of the date of

the event which causes the active member and/or retiree to lose coverage and evidence of other coverage termination is provided to the Fund.

Annual Opt-Out Requirement for Dental Benefits

Actively employed members may decline coverage of Fund Benefits (dental) for themselves and/or any enrolled dependents at any time by completing the Election/Rejection Form, which can be obtained by contacting the Fund Director or downloading it from the Union's website www.nssfe.com.

ELIGIBILITY

Covered Member

In order to be eligible for benefits through the Fund, you must enroll as described on page 4 of this booklet. Covered members include each member of the negotiating unit represented by the North Shore Schools Federated Employees, as defined by the collective bargaining agreements with the District, regularly scheduled by the District to work **full-time** and employees of the District in other bargaining units and non-bargaining units, whom the Trustees may determine in their sole discretion, are eligible to participate in the Fund. Employees who work **at least 0.5 position** are eligible for **dental** benefits only.

A member is entitled to benefits as long as the member is on active payroll status. Active payroll status means the period for which contributions are required to be paid on a member's behalf by the District.

Each member is eligible for individual, individual + one or family dental benefits, at the self-pay premium established by the Fund. All members have the option to enroll his/her spouse/domestic partner or family, at an annual self-pay premium cost, determined by the Trustees, on an annual basis. This annual premium will be automatically deducted from the member's pay check and remitted to the Fund by the District.

Your eligibility for Fund benefits coverage will end when the first of the following events occurs:

- You are no longer eligible for coverage, as defined in this booklet, or
- Contributions made by the District on your behalf, or due from you, stop.

Retirees

A former covered member who retires from employment with the District and is receiving a pension from the applicable New York State retirement system is eligible to continue the Fund's dental benefits plan in effect at that time, and as subsequently may be amended, from time to time, provided the retiree continues to timely remit the appropriate self-pay premium to the Fund, in the amounts established by the Board of Trustees. Only retired members who are members in good standing of the Retiree Chapter of the union may elect Fund benefits.

Retirees and their eligible dependents are eligible for Fund benefits upon election, enrollment and payment of the applicable self-pay premium. You must return the Retiree Election/Rejection Form within thirty (30) days of the date you lose coverage as an active member, and pay the applicable premium, in order to continue coverage without interruption or penalty. If you decline coverage, you will be able to enroll during open enrollment periods (i.e., "late enrollment"), as determined by the Board of Trustees, which are currently January and July, however, your coverage will be subject to the waiting periods set forth on page 20.

If a retiree is eligible for coverage as a dependent of an active member, then the retiree can "waive" retiree benefits until the active member retires or loses Fund benefits due to employment termination or reduction, or death. In such an event, the retiree may enroll in the retiree benefits without being subject to late enrollment penalties provided the enrollment is completed no later than 30 days of the date of the event which causes the active member and/or retiree to lose coverage.

Eligible Dependents

Coverage for eligible dependents will begin:

a) On your first day of active employment, provided you enroll your eligible dependent(s) and the appropriate form for payroll deduction is completed and submitted by you to the Fund; or

b) For new dependents, once the member's new dependent(s) are enrolled and the appropriate form for payroll deduction is completed and submitted to the Fund. New dependents must be enrolled within 30 days of their eligibility in order to avoid late enrollment penalties. See page 20.

Subject to enrollment, your eligible dependents will receive certain benefits outlined in this booklet. Eligible dependents include:

- Your spouse to whom you are legally married;

- Your domestic partner
  - who is eighteen years of age or older;
  - who is not married or related by blood in a manner that would bar marriage in New York State;
  - who has an exclusive mutual, close and committed personal relationship with the member;
  - who lives with the member and has been living with same on a continuous basis for one year and you are able to provide proof of residency and financial interdependence[#];
  - who has been enrolled as a domestic partner by the member; and
  - has not terminated the partnership.

[#] *Evidence of financial interdependence is not required if the member has received, and provides the Fund with a copy of, a certificate of domestic partnership issued by the New York State Empire Plan.*

No person is eligible to be enrolled as a domestic partner who at the time of enrollment or at any time during the prior one year was enrolled as a member of another domestic partnership or was married to another individual and whose divorce decree was issued less than one year prior to submission of the application for enrollment.

Note on Tax Implications: Under the Internal Revenue Service (IRS) rules, the fair market value of the health-related benefits is treated as income to the covered member/employee, for tax purposes when a person who is not a qualified dependent under Federal IRS rules, is covered under the Fund. Please ask your tax consultant how enrolling your domestic partner will affect your taxes.

If the partnership ends, the member must notify the Fund Office and end coverage for their domestic partner. There will be a one-year waiting period from the termination date of a previous partner's coverage before the member may again enroll a domestic partner.
Members who fraudulently enroll a domestic partner will be held financially and legally responsible for any benefits paid by the Fund on

behalf of the wrongfully enrolled domestic partner. The Fund reserves the right to suspend the member's benefits until said indebtedness is satisfied.

- Your unmarried dependent children until the end of the month in which they reach their 19th birthday. Dependent children are your natural children, stepchildren, legally adopted children, including children in a waiting period prior to finalization of adoption, and any other children related to you by blood or marriage who are living in a regular parent-child relationship with you and are chiefly dependent upon you for financial support and maintenance. **To establish the eligibility of a stepchild or any other child related to you by blood or marriage, a member must submit an affidavit verifying that said child resides full-time with the member and proof of financial dependency as shown by income tax returns. This affidavit is available at the Fund Office.**

- Unmarried dependent children who are full-time students at an accredited educational institution are covered by the Fund until they graduate, but in no event later than their 24th birthday. An unmarried child who is a full-time student will be covered up to the last day of the calendar year in which they graduate or reach age 24, whichever comes first. A full-time student means he/she is enrolled for 12 undergraduate credit hours or 6 graduate credit hours per semester. A Student Verification Form must be completed and submitted to the Fund before a claim can be honored. This form must be completed each semester and is available at the Fund Office.

- Your unmarried children, regardless of age, who are incapable of self-sustaining employment by reason of mental or physical handicap and become so prior to their attaining age 19 and further provided that such children reside with a covered member and are wholly dependent on the covered member for support. You must submit proof of your dependent child's incapacity to the Fund within 31 days after he or she attains the age at which his or her coverage would otherwise terminate or within 31 days after you are notified of his or her ineligibility, whichever is later. Proof of the continued existence of such incapacity shall be furnished to the Fund from time to time at its request.

NON-DUPLICATION OF BENEFITS

Under this rule a member cannot be covered both as an employee and as a dependent at the same time. Therefore, if your spouse/domestic partner also works for the District or any other employer participating in the Fund:

1. Each must enroll separately, or
2. Only one may enroll as the dependent of the other.

If you enroll separately, one may not cover the other as a dependent, and all children must be enrolled with the same parent.

COORDINATION OF BENEFITS

In the event that a person covered by the Fund is covered under another group health plan, there will be "coordination of benefits" regarding reimbursement by this Fund. This coordination will apply in the event that an expense is incurred for a covered item under this Fund that is also covered under the other plan. A determination will be made as to which plan is "primary", or the first plan to pay, and which plan is the "secondary" payer. The method to determine which plan is primary is based on the following rules:

1. If the claimant is a covered member of the Fund, then the Fund will pay benefits first, while a plan covering a member as a dependent will pay second.

2. If a dependent child is covered by plans of both parents, the benefits of the plan, which covers the child of the parent whose date of birth (month and day only, excluding year) occurs earlier in the calendar year, will be determined to be the primary payer. The benefits of the plan which covers the child of the parent whose date of birth (excluding the year) occurs later in the calendar year, will be determined the secondary payer. If a plan containing this "Birthday Rule" is coordinated with a plan, which contains a gender-based rule, and as a result, the plans do not agree on the order of benefits payment, the gender-based rule plan will determine the order.

3. When parents are divorced or separated, the order of benefit payment for a dependent child is:

(a) The plan of the parent with custody pays first and the plan of the parent without custody pays second.

(b) If the parent with custody has remarried the order is:

(1) The plan of the parent with custody pays first.

(2) Next, the plan of the step-parent pays.

(3) The plan of the parent without custody pays last.

If there is a court decree, which states that one parent is responsible for the child's health care expenses, the plan of that parent will pay first. That court decree will supersede any order stated above.

4. If a person is covered under more than one plan, the plan that he or she was under for the longer time period pays first, as if there were no other plan. If this Fund is the secondary plan, it will coordinate the benefits with the primary plan so that no greater than 100% of the allowable expense will be paid.

If you or your family members are eligible to receive benefits under another group plan in addition to this one, 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. 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 include a copy of the payment voucher ("Explanation of Benefits" Form) from the primary plan when filing a claim with the secondary plan.

AMENDMENT AND TERMINATION OF BENEFITS

The benefits provided by this Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees in its sole discretion. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust Agreement, which established the Fund and governs its operations.

Your coverage and/or your dependents' coverage will stop on the earliest of the following dates:

- When the Fund is terminated.
- When you are no longer eligible.
- When the Employer ceases to make contributions on your behalf to the Fund.

- Your dependents' coverage will terminate when you cease to make contributions on behalf of your eligible dependents to the Fund.
- Your dependents' coverage will also terminate when they are no longer eligible dependents.

Member benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the sole prudent discretion of the Trustees. No person acquires a vested right to such benefits. The Trustees may expand, modify or cancel the benefits for members and dependents; change eligibility requirements or the amount of the self-pay premiums; and otherwise exercise their sole prudent discretion at any time without legal right or recourse by a member or any other person.

RIGHT TO RECOUP BENEFIT PAYMENTS MADE IN ERROR OR TO SUSPEND BENEFITS COVERAGE

The Fund has the right to recoup overpayments as a result of an error in the processing of a claim, or, if additional information comes to the attention of the Fund after the claim has been paid. Furthermore, the Fund has the right to suspend one or more benefits if you have received overpayments or have in any way abused the Fund's benefit program.

RIGHT TO APPEAL

The benefits provided by this Fund may be changed by the Board of Trustees in their sole and absolute discretion. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet 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 action of the Fund Office at the following address:

North Shore Schools Federated Employees Benefit Trust Fund
C/O Susan McCormack, Fund Director
40 Railroad Avenue
Glen Head, New York 11545

THIRD-PARTY REIMBURSEMENT/SUBROGATION

If a covered member or dependent is injured through the acts or omissions of a third party, the Fund shall be entitled, to the extent it pays out benefits, to reimbursement from the covered member or dependent from any recovery obtained from the responsible third party (including Workers' Compensation cases). Alternatively, the Fund shall be subrogated, unless otherwise prohibited by law, to all rights of recovery that the covered member or dependent may have against such third party arising out of its acts or omissions that caused the injury. Subrogation means that the Fund becomes substituted in the injured person's place to pursue a claim recovery against the third party. Fund benefits will be provided only on the condition that the covered member or dependent agrees in writing:

(A) To reimburse the Fund, to the extent of benefits paid to it, out of any monies recovered from such third party, whether by judgment, settlement or otherwise;

(B) To provide the Fund with an Assignment of Proceeds to the extent of benefits paid out by the Fund on the claim and to cooperate and assist the Fund in seeking recovery. The Assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services; and

(C) To take all reasonable steps to affect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement or subrogation, and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

BENEFITS PAYABLE ON BEHALF OF DECEASED MEMBER

With respect to any benefits payable to a deceased member upon the date of death, or with respect to death benefits payable by virtue of the death of the member where the member's designated beneficiary has predeceased the member and a successor has not been designated, or where the member has not designated a beneficiary, then these benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The covered member's:

A. Surviving spouse/domestic partner;

B. If no surviving spouse/domestic partner, to the surviving children equally, or

C. If no surviving children, to the covered member's estate.

NOTICE OF PRIVACY PRACTICES

A federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires the North Shore Schools Federated Employees Benefit Trust Fund ("the Fund") to protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Fund's privacy notice, which was previously distributed to all members and is distributed to all new members upon enrollment, a copy of which is available from the Fund office.

The Fund will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, operations of the Fund, or as permitted or required by law. By law, the Fund has required all business associates to also observe the Fund's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

CONTINUATION OF COVERAGE

A. Statutory Continuation of Coverage

1. COBRA Continuation of Coverage

Federal law requires that most group health plans (including the North Shore Schools Federated Employees Benefit Trust Fund, the "Fund") give employees (known as "members" in the case of the Fund) and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan (in this case, the Fund's plan of benefits under which the individual was covered). Depending on the type of qualifying event, "qualified beneficiaries" can include the employee/member (or retired employee/member) covered under the Fund's plan, the covered employee's/member's spouse/domestic partner, and the dependent children of the covered employee/member.

Continuation coverage is the same coverage that the Fund's plan gives to other members or eligible dependents who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other members or eligible dependents covered under the Fund's plan.

The following language required by the federal health care law. The Fund cannot represent whether or not dental only coverage is available through the health care exchanges.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

How long will continuation coverage last?

In the case of a loss of Fund coverage due to end of employment or reduction in hours of employment with the North Shore Central School District, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to a member's/ employee's death, divorce or legal separation, the member's/employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Fund's plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the member's/employee's hours of employment with the North Shore Central School District, and the member/employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the member/employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium for continuation coverage is not paid to the Fund in full and on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Fund ceases to provide any health related benefits to its members.

Continuation coverage may also be terminated for any reason that the Fund would terminate the coverage of a member who is not receiving continuation coverage.

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage from the Fund, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Fund's Director of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide the Fund's Director with a copy of an SSA disability determination letter within 60 days of the determination in order to extend the period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Fund's Director of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered member/employee, divorce or separation from the covered member/employee, the covered member's/employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund's plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Fund's plan if the first qualifying event had not occurred. You must notify the Fund's Director within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Fund's **Continuation Coverage Election Form** and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the member's/employee's spouse may elect continuation coverage even if the member/employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The member/employee or the member's/employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your Fund health-related benefits coverage may affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30

days after your Fund's health-related benefits coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the Fund for coverage of a similarly situated Fund member or eligible dependent who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

For more information

If you have any questions concerning COBRA continuation coverage, you should contact the **Fund's Third Party Administrator, Administrative Services Only, Inc., P.O. Box 9005, Dept. 152, Lynbrook, NY 11563-9005 or by calling 516-396-5500.**

For more information about your rights under COBRA and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Fund informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund's Director.

2. Continuation of Coverage During Leave Under the Family Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) entitles eligible employees of the District with up to twelve (12) weeks of family leave in a twelve (12) month period to care for a dependent child, covered family members or for the serious illness of the employee. If you take a FMLA leave, the District must continue to contribute to the Fund on your behalf. In addition, you must then remit directly to the Fund the applicable self-pay "premium" for the Fund's benefits in order for certain health-related benefits through the Fund to continue. If you do not return to work after the end of your FMLA leave, you may be eligible for COBRA continuation of coverage. Upon submission by the District to the Fund of documentation verifying your FMLA status, the Fund will provide benefits during the FMLA period.

B. Non-Statutory Continuation of Coverage

1. Continuation of Dependent Coverage After the Death of a Member

If you are covered for benefits when you die, any of your dependents who are covered, will remain so covered for six (6) months after your death without further payment for them.

The dependent benefits payable after you die will be those in effect for your dependents on the day prior to your death.

2. Continuation Coverage for Retirees

Eligible members who retire may elect to continue coverage of the dental benefits for as long as the applicable premiums set by the Fund are paid. However, in order to avoid any lapse in coverage or waiting period, enrollment in and payment for continuation of the benefits as a retiree must be made within thirty (30) days of losing your Fund benefits as an active member, or as otherwise determined by the Board of Trustees. See page 7 for further details.

SELF-FUNDED DENTAL BENEFITS

The North Shore Federated Employees Benefit Trust Fund provides dental benefits on a self-insured basis, which is administered by ADMINISTRATIVE SERVICES ONLY, INC. whose website is www.asonet.com. Dental benefits can be obtained through several options. The first is a Reimbursement Plan based upon reasonable and customary charges and the other is through a Participating Provider Dental Panel Program. Dental benefits are available to all covered active and retired members and their eligible dependents if enrolled and paid for.

Who is Covered?

Active and Retired Member ("Members"), spouses/domestic partners and/or eligible dependent children, upon enrollment and payment of appropriate self-pay premium, as applicable, are eligible for the Fund's dental benefits.

When is coverage effective?

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 (the member may select which child s/he wishes to enroll, however, 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).

What is the waiting period?

All members must complete and submit a new enrollment/rejection form within thirty (30) days from the date of employment (hire) or retirement. 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) or retirement, 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

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

What is Covered by the Dental Plan?

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, 2014, $1,200 per calendar year per covered individual with a lifetime maximum of $3,600. The orthodontic maximum applies to services rendered by Participating and Non-Participating Providers.

ANNUAL DEDUCTIBLE: There is $75 per individual per calendar year deductible with a maximum deductible of $225 per family. The deductible does not apply to Diagnostic, Preventive or Orthodontic services. The deductible applies to services rendered by Participating and Non-Participating Providers.

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 Plan Allowances and Participating Provider Maximum Charges.

Once you have satisfied the deductible, 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) When covered expenses are applied to satisfy your annual deductible.
    b) Where dental plan benefits exceed your $3,000 calendar year maximum.
    c) 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 Non-Participating Providers 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, log onto: www.asonet.com. Go to the "I am a Member of" in the middle of the page and select plan "North Shore Schools FEBTF" (once member eligibility is established, you will be able to log on as a member).

CAREINGTON'S MAXIMUM CARE PPO NETWORK

To enhance access to participating providers in the New York Metropolitan Region and across the country you will also have access to Careington's Maximum CARE PPO Network. To find a Careington network dentist, visit www.careington.com/co/maxcare/

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.

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.

PLAN EXCLUSIONS

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.

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.