NY44 HEALTH BENEFITS PLAN TRUST

DENTAL BENEFITS PLAN AND SUMMARY PLAN DESCRIPTION

FOR

PARTICIPATING SCHOOL DISTRICTS. THEIR ELIGIBLE EMPLOYEES AND RETIREES

Effective July 1, 2007 and as amended, effective January 1, 2024

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

Administered by Guardian

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

The NY44 Health Benefits Plan Trust (“Trust”) does not and cannot make treatment decisions for Enrollees. The Trust, pursuant to the terms of the Dental Benefits Plan (“Plan”) makes only payment decisions. Treatment decisions are independent from payment decisions. It is the responsibility of the patient and his/her dentist to determine whether treatment should be rendered, regardless of whether the charges are totally or partially Covered or excluded from Coverage under this Plan. The Plan is only the payer of covered benefits, and it does not select, nor take any responsibility for the proper or improper performance of a Dentist or other Service Provider.

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

Participating Districts and/or the Enrollee are required to notify the Claims Administrator immediately if there is any change in Employee or Dependent status. Proof of eligibility may be required for processing of any claims. The Trust and/or the Claims Administrator will notify Participating Districts, Employees, Retirees and/or Dependents of the documentation necessary to verify eligibility under the Plan.

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SECTION 1 – INTRODUCTION

The Trust and your Participating District are pleased to provide you with a copy of the NY44 HEALTH BENEFITS PLAN DENTAL BENEFITS PLAN AND SUMMARY PLAN DESCRIPTION. This document sets forth the terms and conditions of the Plan offered to you by the Trust and your Participating District. You should read this booklet carefully to acquaint yourself with its provisions for eligibility, benefits, filing a claim and other important information.

THE COVERED BENEFITS UNDER THIS PLAN ARE SELF-FUNDED. THIS MEANS THAT THE TRUST ASSUMES TOTAL RESPONSIBILITY FOR ELIGIBLE COVERED CLAIMS THAT ARE INCURRED.

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

For claims incurred on and after January 1, 2024 this restated Plan document supersedes any and all predecessor Plan and Summary Plan Description documents.

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

Important Information

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

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

B. **Effective Date.** The Plan was first effective as of July 1, 2007. This current version of the Plan and Summary Plan Description, administered by Guardian, is effective as of January 1, 2024.

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

D. **Plan Year.** The Plan Year begins at 12:00 a.m. on each January 1st and ends at 11:59:59 p.m. on the following December 31st. Each succeeding like period will be considered a new Plan Year.

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

F. **Claims Administrator.** The Plan's Claims Administrator is Guardian Life Insurance Company of America, located at 7 Hanover Square, New York, New York 10004 (888-600-1600, 8:00 a.m. until 8:30 p.m. ET Monday to Friday) or such other entity as designated by the Trustees of the Plan. The Claims Administrator is the entity providing administration services to the Plan in connection with the operation of the Plan and performing such functions, including processing and payment of claims, as may be delegated to it.

G. **Plan Administrator.** The Plan Administrator is the Board of Trustees of the Trust, located at 355 Harlem Road, West Seneca, NY 14224. The Board of Trustees, as established pursuant to the Trust Agreement, is comprised of five (5) managerial and five (5) bargaining unit representatives from Erie 1 BOCES.

H. **Agent of Legal Process.** Service of legal process may be made upon the Chair of the Board of Trustees of the Trust.

I. **Type of Plan.** This Plan is a governmental employee welfare fund providing payment and/or reimbursement for certain eligible dental expenses. Contributions for funding benefits are provided by the Participating Districts and, in some cases, also by payroll deduction contributions of the Employee or contributions paid by Retirees or COBRA-eligible Enrollees. Benefits under the Plan are self-funded by the Trust's plan assets.

J. **Eligibility.** The persons eligible for participation in this Plan as Enrollees are as defined by the Participating Districts, with their eligible Dependents, and COBRA-eligible covered Enrollees, as set forth in Section 3.

K. **Authority for the Plan.** The Trust is not a licensed insurer. The Trust and Plan is a governmental employee welfare fund that operates pursuant to registration under Article 44 of the Insurance Law of the State of New York.

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

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

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

Covered Persons' Rights

Those who operate and/or administer this Plan are known as Plan "fiduciaries" and have a duty to act prudently and in the interest of all Plan Enrollees and beneficiaries. No one, including an Employer, union, or any other person, may fire or otherwise discriminate against a person in any way to prevent him from obtaining a benefit or from exercising his rights under this Plan. If a fiduciary misuses the Plan's money, or if a person is discriminated against for asserting his rights, he may file a suit in court.

Any questions about the Plan should be addressed to the Trust or the Claims Administrator as appropriate.

Entire Agreement

This Plan document and Summary Plan Description, together with its amendments and any applicable Plan policies, constitute the entire Plan.

SECTION 2 – DEFINITIONS

Adoptive Child: a child or infant as described in Section 3 of the Plan.

Application: the form completed by an applicant requesting Coverage from us and listing all Family Dependents to be Covered on the date such Coverage takes effect; the information from the completed application form is entered into the online enrollment program by the Participating District's benefit staff.

Calendar Year: a twelve-month period beginning January 1 and ending at midnight of December 31 of each year.

Claim Form: the form provided by the Claims Administrator for incurred Eligible Expenses for treatment by Dental Providers.

Contribution for Coverage: the periodic amount of money we currently charge for benefits and services Covered under this Plan.

Coverage or Covered: the Dental Services reimbursed under the Plan.

Covered Person or "you" or "your": a person who meets all relevant eligibility requirements under Section 3 of the Plan, who applies and is accepted for Coverage from us, for whom the monthly Contribution for Coverage has been received by us and is covered for benefits under this Plan.

Deductible: an amount payable by an individual before a plan begins to pay; currently there is no Deductible applicable to this Plan.

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

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

Effective Date: the date from which you are entitled to receive Dental benefits from us, provided that the Contributions for Coverage under this Plan have been received by us. Coverage begins at 12:01 a.m. Eastern Standard Time on the Effective Date in accordance with the following:

a. When a person makes an application for enrollment within thirty (30) days after the date he was first eligible, Coverage will be effective on the Eligibility Date;

b. When a person fails to enroll within thirty (30) days of his Eligibility Date, he must wait until the next Open Enrollment Period to enroll in this plan unless he is eligible for a Special Enrollment; and

c. When a person is eligible for a Special Enrollment and requests and requests enrollment within thirty (30) days of being eligible under Special Enrollment (within sixty [60] days if due to Medicaid/CHIP eligibility), Coverage will be effective on the first day of the month following the request for enrollment (for birth or placement for adoption, Coverage will be effective on the date of birth, adoption or placement for adoption).

Eligibility Date: the date(s) when a person is eligible to participate in the Plan. An eligible person must elect Coverage within the thirty (30) day period following the date he could first obtain Coverage (including eligible dependents) or when a person is eligible under Special Enrollment. If a Covered Person terminates Coverage for any reason other than termination of employment or eligibility with the Participating District, Coverage may be added only during the Open Enrollment Period except where the Covered Person qualifies for a Special Enrollment.

Eligible Expenses: the reasonable fees for Medically Necessary Dental Services Covered under this Plan. Eligible Expenses include fees for only services actually provided to you. For services and items provided by Participating and Non-Participating Providers, Eligible Expenses are Covered up to the fee schedule amounts.

Employer: a school/school district or entity as permitted under the Trust Agreement.

Enrollee: an employee of an Employer or other individual (including but not limited to COBRA enrollees, Trust employees, retirees, etc.) who is eligible for Coverage under the Plan.

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

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

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

Identification Card: the card physically or digitally issued to you showing that you are entitled to Covered Dental Services.

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

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

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

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

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

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

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

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

Participating District: the school district, Employer, or union which contracts with us to Cover Dental Services for you.

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

Participating Provider(s): a Participating Dentist that has a Participating Provider agreement with the Claims Administrator and provides services Covered under Section 5 of this Plan. All Dental Providers are independent contractors and are not employees or agents of ours.

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

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

SECTION 3 - ELIGIBILITY, ENROLLMENT, AND CONDITIONS OF COVERAGE

A. Eligibility

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

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

2. Family Dependents: To be eligible to enroll as a Family Dependent, an individual must qualify under one of the following paragraphs:

    a. Married to the Enrollee;

    b. For an enrollee who is participating through a Participating District that has authorized domestic partner coverage by formal board resolution or by a specific language in a collective bargaining agreement coverage shall be available to the Enrollee's domestic partner who meets all of the following:

        1. Of the same or opposite sex as the Enrollee; and
        2. At least eighteen (18) years of age; and
        3. Not related by marriage or by blood in a way that would bar marriage; and
        4. Not married to anyone else nor have had another domestic partner for a period of not less than one (1) year; and
        5. Registered/verification/application or other requirements as established by your Employer (please contact your Employer); and
        6. Provides proof of cohabitation with the Enrollee (e.g., a driver's license, tax return or other sufficient proof); and
        7. Provides evidence of two or more of the following with the Enrollee:
            A. a joint bank account;
            B. a joint credit or charge card;
            C. joint obligation on a loan;
            D. status as authorized signatory on the Enrollee's bank account, credit card or charge card;
            E. joint ownership of residence;
            F. joint ownership of real estate other than residence;
            G. listing of both partners as tenants on a lease of the shared residence;
            H. shared rental payments of residence (need not be shared 50/50);
            I. listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;

J. a common household and shared household expenses, (e.g., grocery bills, utility bills, telephone bills, etc.);
K. shared household budget for purposes of receiving government benefits;
L. status of one as representative payee for the other's government benefits;
M. joint ownership of major items of personal property (e.g., appliances, furniture);
N. joint ownership of a motor vehicle;
O. joint responsibility for childcare;
P. shared child-care expenses;
Q. execution of wills naming each other as executor and/or beneficiary;
R. designation as beneficiary under the other's life insurance policy;
S. mutual grant of durable power of attorney;
T. mutual grant of authority to make health care decisions (e.g., health care power of attorney);
U. affidavit by creditor or other individual able to testify to partners' financial interdependence;
V. other items of proof to establish economic interdependency under the circumstances of the particular case.

In order to enroll the Enrollee's domestic partner, the Enrollee must execute a Domestic Partner Affidavit, which may include any additional requirements established by a Participating District, and/or any documentation required to prove dependent eligibility, and pay us the additional Contribution for Coverage (if such addition changes the enrollment status from "single" to "family" coverage), if any, within thirty (30) days of the Enrollee's Eligibility Date, during the Participating District's Open Enrollment Period or during a Special Enrollment period.

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

   Adoptive non-infant children less than age twenty-four (24) are Covered from the date we receive notification and payment for additional Contribution for Coverage, if any, provided that the following steps resulting in final adoption are completed:

   1. We are notified of the Coverage for the Adoptive Child within thirty (30) days of taking physical custody;

2. the Enrollee files a petition for adoption pursuant to applicable law within thirty (30) days of taking physical custody;
3. no notice of revocation of the adoption is filed pursuant to applicable law; and
4. consent to the adoption has not been revoked and the Enrollee retains a legal obligation for the total or partial support of the child in anticipation of adoption.

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

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

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

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

d. An unmarried child of the Enrollee including any stepchild, legally adopted child, or proposed adoptive child who is the age of twenty-four (24) or over and is:

   1. Incapable of self-sustaining employment because of mental illness, mental retardation or developmental disability, as defined by applicable law consistent with the requirements of the N.Y.S. Mental Hygiene Law, or because of physical handicap, and

2. Dependent upon the Enrollee for support and maintenance. The child must have been Covered by this Plan and must have become incapable prior to age twenty-four (24) for purposes of this. The dependent child, to remain eligible, must continue to be subject to the conditions set out above. Enrollee may be required by us to provide evidence of the handicapping conditions claimed to be existing for the dependent child. Enrollee may be required by us to provide evidence that the child is dependent upon the Enrollee for support and maintenance.

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

3. Persons not entitled to Coverage include:

   a. Persons who are in the armed forces of any government other than for duty of thirty (30) days or less.
   b. Family Dependents who are Enrollees of the Plan through their own employment.
   c. Family Dependents who are Family Dependents of another Enrollee of this Plan and enrolled for coverage by that other Enrollee.
   d. Any child born to an Enrollee's dependent child, except as provided in III.A.2.c.

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

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

B. Enrollment

1. Enrollees may be enrolled with us only within thirty (30) days of their first day of eligibility for enrollment, during the Open Enrollment period, or within thirty (30) days of a Special Enrollment event and upon meeting the eligibility requirements imposed by the Participating District.

2. A potential Enrollee may enroll other than during the Open Enrollment Period when one of the following changes in status occurs ("Special Enrollment Events") and when proof of such situation is presented to us:

   a. a person becomes a Family Dependent of the potential Enrollee through marriage, birth, adoption or placement for adoption;
   b. exhaustion of COBRA continuation Coverage;
   c. an involuntary loss of dental insurance coverage resulting from a loss of eligibility or the Employer's contributions towards coverage were terminated, provided that such person had such coverage at the time coverage hereunder was previously offered.

3. An Enrollee's spouse or Family Dependent may enroll other than during the Open Enrollment Period when the person becomes a dependent of the Enrollee through:

   a. marriage or assumption of a domestic partnership;
   b. birth, adoption or placement for adoption, and the case of the birth or adoption of a child, the spouse of the Enrollee may enroll as a Family Dependent if otherwise eligible.

4. Enrollees may enroll themselves and their Family Dependents during an eligibility period by completing an Application Form and submitting it to the Participating District's benefit staff; the Participating District's benefit staff will enter the enrollments into the enrollment system provided and used by the Trust. The Participating District agrees to give all newly hired employees our descriptive literature as soon as they become eligible for Coverage. Such Enrollees may apply for Coverage from the Employer within thirty (30) days of the date they become eligible for Coverage. If Enrollees do not apply within thirty (30) days of the date they become eligible they must wait until the next Open Enrollment Period or Special Enrollment event to become Covered.

5. Changes to the original Application Form must be made by completing a new Application Form and submitting it to the Participating District's benefits staff; the Participating District's benefit staff will make the changes through the enrollment system provided and used by the Trust. The Participating District agrees to promptly enter changes in such enrollment system when any change in the Enrollee's eligibility for Coverage occurs.

6. Coverage of Enrollees and Family Dependents shall take effect on the Effective Date.

7. Enrollees or Family Dependents (other than newborn children of the Enrollee) who are confined to a Hospital; Skilled Nursing Facility; Home Health Care; or other health care facility on the date when this Coverage would otherwise take effect, will be eligible for Coverage, effective the first day following the Enrollee's or the Family Dependent's final discharge from such confinement (the date after discharge).

SECTION 4 - PREDETERMINATION OF BENEFITS

A. PREDETERMINATION OF BENEFITS

When the expected cost of a proposed course of treatment is $300.00 or more, you or your Dentist should send the Claims Administrator a treatment plan before treatment begins. This must be done on a form acceptable to the Claims Administrator.

The treatment plan must include:

(a) a list of the Dental Services to be done, using the American Dental Association Nomenclature and codes;
(b) the itemized cost of each Dental Service; and
(c) the estimated length of treatment.

In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent with the treatment plan request.

A treatment plan should always be sent to the Claims Administrator before orthodontic treatment starts.

The Claims Administrator will review the treatment plan and estimate what the Plan will pay. The Claims Administrator will send the estimate to you and/or your Dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to the Claims Administrator, the Claims Administrator has the right to base the benefit payments on treatment appropriate to your condition using accepted standards of Dental practice.

You and your Dentist have the opportunity to have Dental Services, or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what the Plan will pay. It tells you, and your Dentist, in advance, what the Plan would pay for the covered Dental Services listed in the treatment plan. But payment is conditioned on: (a) the services being performed as proposed and while you are enrolled in the Plan; and (b) any deductible, payment rate and payment limits provisions, and all of the other terms of this Plan.

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment but may be done before the pre-treatment review is made.

The Plan will not deny or reduce benefits if pre-treatment review is not done. But what the Plan pays will be based on the availability and submission of proof of claim.

B. COMPLETING THE CLAIM

After the Dental Services are completed, your Dentist should send the claim back to the Claims Administrator for processing of payment.

SECTION 5 - COVERAGE OF DENTAL SERVICES

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

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

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

B. Fee Schedules

1. In-Network Fee Schedule: We have approved an In-Network Fee Schedule for the Dental Services described in this Plan. The In-Network Fee Schedule determines the maximum amount we will pay for Dental Services received from a Participating Provider. This amount is called the In-Network Allowance.

   a. The In-Network Allowance for any planned Dental Service may be disclosed to the Covered Person by the Claims Administrator or the Participating Dentist.
   b. Upon request, a fee will be set for any Dental Service not listed in the In-Network Fee Schedule.
   c. The In-Network Fee Schedule may be changed by the Plan and/or the Claims Administrators from time to time without notification to you.

2. Out-of-Network Fee Schedule: We have approved the out-of-Network reimbursement at the 90th percentile of reasonable and customary charges.

   The Out-of-Network Allowance is the lesser of: (a) the Dentist's actual charges; and (b) the reasonable and customary charges for the Dental Services covered under the Plan. To be covered by this Plan, a Dental Service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the list of Covered Dental Services.

   By "reasonable," we mean the charge is the Dentist's usual charge for the Dental Service furnished. By "customary," we mean the charge made for the given dental condition isn't more than the usual charge made by most other Dentists. But, in no event will the amount paid by the Plan be greater than the 90th percentile of the prevailing fee data for a particular Dental

Service in a geographic area. The Out-of-Network Fee Schedule may be changed by the Plan from time to time without notification to you.

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

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

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

3. **Benefit Maximums.**

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

   b. You may be eligible for a rollover of a portion of your benefit year payment limit for Class I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit" below for details.

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

4. **Rollover of Unused Calendar Year Annual Maximum**. You may be eligible for a rollover of a portion of your unused Calendar Year Annual Maximum for Class I, II and III Non-Orthodontic Services as follows:

   a. If you submit at least one claim for covered Dental Services during a Calendar Year and, in that Calendar Year, receive Dental Services that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the "Rollover Threshold" below, you may be entitled to a rollover.

   2. If all of the Dental Services that you receive in a Calendar Year are for Dental Services provided by a Participating Provider, you may be entitled to a greater rollover than if any of the Dental Services are provided by a Non-Participating Provider.

   3. Rollovers can accrue and are stored in your rollover account. If you reach your Calendar Year Annual Maximum for Class I, II and III Non-Orthodontic Services, the Plan pays up to the amount stored in your

rollover account. The amount of rollover stored in your rollover account may not be greater than the rollover account maximum.

4. Your rollover account may be eliminated, and the accrued rollover lost, if you have a break in coverage of any length of time, for any reason.

5. The amounts of the Plan's Rollover Threshold, rollover amount, and rollover account maximum are:

   - Rollover Threshold. $700.00
   - Rollover (if all Dental Services are provided by a Participating Provider) $500.00
   - Rollover (if any Dental Services are provided by a Non-Participating Provider).........$350.00
   - Rollover Account Maximum $1,250.00

6. If the effective date of your Coverage is in October, November or December, this rollover provision will not apply to you until January 1st of the next full Calendar Year. Only claims incurred on or after January 1st will count toward the Rollover Threshold and rollovers will not be applied to your rollover account until the Calendar Year that starts one year from the date the rollover provision first applies.

D. Schedule of Coverage

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

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

SUMMARY OF BENEFITS

Effective January 1, 2024

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

CLASS I - PREVENTIVE AND DIAGNOSTIC SERVICES

SERVICES	IN-NETWORK -	OUT-OF-NETWORK	NOTES
Prophylaxis (dental cleaning)	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Limited to maximum of 4 per Calendar Year (this benefit is limited to a maximum of 4 prophylaxes OR periodontal maintenance procedures per

			Calendar Year)
Topical application of fluoride	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Limited to 1 every 6 months
Dental sealants	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Covered for Covered Persons under age 16, limited to one every 36 months for permanent unrestored molars.
Oral Exams	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Limited to maximum of 4 per Calendar Year
Emergency Palliative Treatment and other non-routine unscheduled visits	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Covered even if multiple services are received during the same visit
X-rays	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Intraoral x-ray - complete series including bitewings are limited to one every 60 months Intraoral periapical or occlusal X-rays-single films are limited to 4 periapical & 2 occlusal x-rays every 12 months Bitewing film are limited to 4 films per visit every 12 months Panoramic Film, maxilla and mandible, is limited to one every 60 months Extraoral superior or inferior maxillary films are limited to 2 every 12 months

CLASS II - MINOR RESTORATIVE SERVICES

SERVICES	IN-NETWORK -	OUT-OF-NETWORK	NOTES
Space Maintainers Fixed and removable, bilateral and unilateral	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Under the age of 19
Harmful Habit Appliances	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	To age 14 for thumb sucking, initial appliance only

Restoration (fillings) **Amalgam and Composite resin for primary or permanent teeth**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	No distinction is made for coverage of Amalgam or Composite resin
Prefabricated (Stainless steel and resin) Crowns	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Limited to 1 in 24 months
Non-Surgical Extractions	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Non-surgical extractions, surgical extractions, removal of impacted teeth, root removal, alveoloplasty, removal of exostosis, incision and drainage, frenulectomy, frenectomy and frenotomy, biopsy, surgical exposure of impacted or unerupted teeth, excision of tooth related tumors cysts or neoplasms, excision of tooth related lesions, excision of hyperplastic tissue and pericoronal gingiva, removal of torus, oroantral fistula closure, sialolithotomy, sialodochoplasty, closure of salivary fistula, excision of salivary gland, vestibuloplasty and maxillary sinusotomy for removal of tooth fragment or foreign body. Allowance includes local anesthetic and post-surgical care.

Oral surgery **- Removal exposed root** **- Surgical removal of erupted tooth** **- Removal of impacted tooth, soft or bony** **- Alveoloplasty-per quadrant** **- Excision of benign tumor lesion** **- Removal of odontogenic cyst** **- Incision/drainage of intraoral abscess** **- Frenulectomy**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	
Anesthesia **- local anesthesia** **- regional block anesthesia** **- trigeminal division block anesthesia** **- general anesthesia-first 30 minutes**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	General anesthesia covered only if medically necessary; Considered with 3 or more non-surgical extractions (performed during the same visit) or with any covered surgical procedure.

Prosthodontics **- Adding teeth to partial dentures to replace extracted natural teeth** **- Repairs to crowns** **- Recementation inlay, onlay, crown** **- Crowns, acrylic or plastic**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Considered if performed more than 12 months after the insertion.
Crown and Fixed partial denture (bridge) repair	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	As needed.
Denture repairs	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	As needed.
Denture reline and rebasing procedures	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	1 per denture in 24 months. Considered if performed more than 12 months after the denture.
Denture adjustments	Covered at 100% of Scheduled Allowance subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	Considered if done more than 6 consecutive months after the insertion, rebase or reline.
Tissue conditioning	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	1 treatment, per arch, in 12 months. Considered if performed more than 12 months after the denture.

Endodontics **- Pulp cap-direct and indirect (excluding final restoration)** **- Therapeutic Pulpotomy (excluding final restoration)** **- Root canal-anterior, bicuspid, molar (excluding final restoration)** **- Apexification** **- Apicoectomy**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Guardian considers pulp caps, pulpotomies, pulpal debridement, pulpal therapy, root canals, root canal retreatment, root canal obstruction, incomplete endodontic therapy, internal root repair, apexification, apicoectomies, bone grafts and guided tissue regeneration in conjunction with periradicular surgery, root amputation, retrograde fillings and hemisections. Allowance includes local anesthetic and routine follow up care.
Periodontics **- Gingivectomy or Gingivoplasty-per tooth or quadrant** **- Mucogingival surgery-per quadrant**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Coverage is limited to a total of one service, per tooth, in 12 months. Considered part of the crown or bridge procedure if performed on the same day.
Bone replacement graft and Guided tissue regeneration	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	Coverage is limited to one per area or tooth (if performed on the same day), per lifetime, when the tooth is present.
Soft tissue grafts	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	Limited to once per quadrant in any 36-month period, when the tooth is present.
Scaling and root planing	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	Considered once per quadrant in 24 months.
Periodontal maintenance	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	Limited to maximum of 4 per Calendar Year (this benefit is limited to a maximum of 4 prophylaxes OR periodontal maintenance procedures per Calendar Year).
Full mouth debridement	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	1 in 36 months when no preventive, diagnostic, periodontal services or periodontal surgery have been performed in the previous 36 months.
Occlusal guards	Covered at 100% of Scheduled	Covered to the Scheduled of	1 per lifetime when performed within 6

	Allowance, subject to Annual Maximum	Allowances, subject to Annual Maximum	months after osseous surgery.
Occlusal adjustment - limited	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	Limited to a total of two visits. Considered when performed within 6 consecutive months after covered scaling and root planing or osseous surgery
Occlusal adjustment, per quadrant	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Coverage is limited to one service, per quadrant, in any 36-month period.
Consultations	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered to the Scheduled of Allowances, subject to Annual Maximum	Considered only when performed with a dentist other than the one providing treatment, limited to one consultation for each dental specialty in any 12-month period. Covered if no other treatment, other than radiographs, is performed on the same day.

Therapeutic drug injection	Covered at 100% of Scheduled Allowance, subject to Annual Maximum		As needed.

CLASS III - MAJOR RESTORATIVE SERVICES

SERVICES	IN-NETWORK -	OUT-OF-NETWORK	NOTES
-Crowns, resin **- Crowns, porcelain fused to noble metal** **- Crowns, full cast high noble metal or 3/4 cast metallic** **- Inlay-metallic, one, two, three or more surfaces** **- Onlay, in the presence of an inlay** **- Core build-up, including any pins** **- Pin retention/tooth (in addition to crown)** **- Cast Post and Core (in addition to crown)** **- Prefabricated Post and Core (in addition to**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Replacement crowns, inlays and onlays are limited to one every 5 years; Considered on permanent teeth only. Allowed when needed due to decay or injury and when the tooth cannot be restored on molars.

crown) **- Temporary crown (fractured tooth)** **- Pontic-cast noble metal, high noble metal or base metal** **- Retainer-inlay or onlay-metallic** **- Crown-Retainer-Porcelain fused to noble metal, high noble metal or base**			
Prosthodontics **-Dental Implants** **Complete upper or lower denture** **- Partial upper or lower denture, resin base or chrome cast** **- Removable unilateral partial denture** **- Fixed bridgework** **- Adjustments to complete or partial dentures, upper or lower** **- Repair of dentures, bridges** **- Reline or rebase complete or partial denture, upper or lower**	Covered at 100% of Scheduled Allowance, subject to Annual Maximum	Covered up to the Scheduled of Allowances, subject to Annual Maximum	Replacement prosthodontics are limited to one every 5 years If implant coverage is elected, we will consider the surgical placement of the implant, the implant abutment, the implant crown/appliance and any needed repairs. Implant maintenance procedures are not covered. See Replacement age and Missing tooth exclusion. If implant coverage is not elected the crown/appliance on top of the implant will be considered. See Replacement age and Missing tooth exclusion.

CLASS IV - ORTHODONTIA SERVICES

SERVICES	IN-NETWORK -	OUT-OF-NETWORK	NOTES
Diagnostic services	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	Dependent Child Orthodontia Only Services must begin prior to age 19
Initial placement of appliance	Covered up to the Scheduled of	Covered up to the Scheduled of	Must have placement under the age of 19

	Allowances, subject to Lifetime Maximum of $2,400	Allowances, subject to Lifetime Maximum of $2,400	Orthodontic retention, including any and all necessary fixed and removable appliance and related visits: limited to initial appliances only.
Monthly visits and adjustments	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	Covered up to the Scheduled of Allowances, subject to Lifetime Maximum of $2,400	Services must begin prior to age 19

E. Alternative Treatment

If more than one type of service can be used to treat a dental condition, the Plan has the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by the Claims Administrator. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. The denial of the requested service is treated as an adverse determination and is subject to the appeal rights.

SECTION 6 - LIMITATIONS OF COVERAGE

A. Non-Participating Providers

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

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

SECTION 7 –GENERAL EXCLUSIONS

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

1. Benefits for any condition which is covered under any state or federal workers' compensation, Employers' liability or occupational disease law; benefits provided for any loss for which mandatory automobile no-fault benefits are recovered or recoverable including but not limited to benefits which would have been recoverable except for the fact that a timely claim was not filed by you or by a Dental Provider.
2. Benefits for any dental condition which is covered under another Plan's extension of benefits coverage until that other Plan's coverage for that condition has terminated.
3. Any Dental Services rendered after the Termination of Coverage (see Section 10).
4. Any procedure or treatment method which does not meet professionally recognized standards of dental practice, including experimental and/or investigational dental treatments, procedures, drugs, substances or devices.
5. Any work not necessary or not customarily provided for dental care.
6. A service or supply not included on the schedule of Dental Services (Section 5 D), unless approved as part of a treatment plan.
7. Charges made by Non-Participating Providers in excess of the Out-of-Network Allowance.
8. Any work not rendered by a Dentist, except x-rays ordered by a Dentist and Dental Services performed by a dental hygienist under the Dentist's supervision.
9. Replacement of teeth which were missing prior to the Covered Person's enrollment in this Plan. (If teeth were extracted prior to benefit administration by Guardian, but while enrolled in the Plan, the Enrollee should provide information to Guardian showing the extraction date so Guardian and the Trust can verify extraction occurred while the Enrollee was covered under the Plan.)
10. Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
11. Extra costs incurred for a more expensive or elaborate course of treatment rather than a less expensive procedure which would have produced a professionally satisfactory result, except as otherwise specifically covered under the Plan.
12. A crown, gold restoration, denture, or fixed bridge (or the addition of teeth to one) if the work involves a modification or replacement of one installed less than five years before.
13. Replacing an existing appliance or dental prosthesis with a like or unlike appliance or dental prosthesis; unless (1) it is at least 10 years old and is

no longer usable; or (2) it is damaged while in the covered person's mouth in an injury suffered while insured and can't be made serviceable.

14. Dental services and supplies that are performed or obtained exclusively for cosmetic improvement. This includes but is not limited to: (a) characterization and personalization of a dental prosthesis; (b) facings on a dental prosthesis for any teeth posterior to the second bicuspid; (c) bleaching of discolored teeth; and (d) odontoplasty.
15. Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
16. Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
17. Any restoration, procedure, appliance or prosthetic device used for the purpose of: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons .
18. Appliances and/or treatment for temporomandibular joint (TMJ) dysfunction.
19. Charges for replacement of a lost, missing or stolen appliance, dental prothesis or prosthodontics or the fabrication of a spare appliance, dental prothesis or prosthodontic (including but not limited to orthodontic appliances or retainers).
20. Orthodontic (Class IV) services for those over the age of 24 years of age. Initiation of orthodontic services must begin prior to age 19.
21. Orthodontic retainers, except as otherwise covered under the Plan.
22. Devices or equipment used solely for the purpose of athletic activities.
23. Any services or supplies which were not received in accordance with this Plan, including without limitation, when a procedure, treatment, service or supply is not a Covered Dental benefit.
24. The reproduction and furnishing of x-rays and medical records, or any costs associated with the reproduction or furnishing of x-rays and/or medical or dental records.
25. Services performed by your immediate family including, but not limited to, spouse, brother, sister, parent, or child.
26. Free care or care where no charge, in the absence of any dental plan or insurance plan, would be made to you.
27. Any injury or sickness resulting from war or any act of war (declared or undeclared) or services in the armed forces of any country to the extent Coverage of such injury or sickness is provided through any governmental plan or program.
28. Care for military service-connected disabilities when you are legally entitled to services and facilities are reasonably available to you.
29. Benefits otherwise provided in the Plan which we are unable to provide because of any law or regulation of the federal, state, or local government or any action taken by any agency of the federal, state, or local government in reliance on said law or regulation.

30. Care for conditions that federal, state or local law requires be treated in a public facility.
31. Care or treatment provided in a governmental hospital.
32. Services required by third parties. Examples of non-Covered services are employment physicals, physicals for camp and school, and court-ordered examinations and treatments except when Medically Necessary.
33. Services for which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was you being engaged in an illegal occupation.
34. Benefits for which you are eligible under any governmental program other than Medicare, except Title XIX of the Social Security Act.
35. Prescription medication or desensitizing medications or desensitizing resins for cervical and/or root surface.
36. Localized delivery of chemotherapeutic agents.
37. The completion of claim forms, OSHA or other infection control charges.
38. Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
39. Tooth transplants.
40. Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
41. Except as specifically noted as covered, the use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and surgical procedures.
42. Except as specifically noted as covered, the use of local anesthetic.
43. Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment.
44. Pulp vitality tests or caries susceptibility tests.
45. Bite registration or bite analysis.
46. Gingival curettage.
47. Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
48. Temporary or provisional dental prosthesis or appliances except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan.
49. A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
50. Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.

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

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

SECTION 9 - CLAIM FILING, PAYMENT OF BENEFITS

A. **Claims.** When you receive Dental Services from a Participating Provider, you will not need to submit a claim form. However, if you receive Dental Services from a Non-Participating Provider either you or the Dentist must file a claim form to the Claims Administrator.

B. **Notice of Claim.** Claims for Dental Services must include all information designated by the Claims Administrator as necessary to process the claim, including, but not limited to: identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Dentist making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information.

   Claim forms are available from Guardian by calling 888-618-2016 or visiting Guardian's website at guardiananytime.com. Completed claim forms should be sent to the address on your ID card. You may also submit a claim electronically by visiting: guardiananytime.com.

C. **Timeframe for Filing Claims.** Claims for services must be submitted for payment within 180 days after you receive the Dental Services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180-day period, you must submit it as soon as reasonably possible. In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.

D. **Claims for Prohibited Referrals.** We are not required to pay any claim, bill or other demand or request by a Dentist for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

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

F. **Notices** The Plan will mail notices to a person's address as it appears on the Plan's records. Covered Persons must notify the Claims Administrator and their Participating District of any change in their address. All notices to a Covered Person who is a minor or otherwise not legally competent to receive

such notices shall be sent to that Covered Person's parent or legal guardian, who is the Covered Employee or covered retiree.

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

H. Questions Regarding a Claim If a Covered Person has any questions concerning the Plan, the status of a claim or a specific claim payment, the question(s) should be communicated to the Claims Administrator. All events which determine the fact that the Plan is liable for a Covered Expense take place on the date the Covered Expense is incurred, which is when the Dental Services are performed, or the purchases are made. Written proof of claim should be furnished to the Plan at the Claims Administrator's office on the appropriate forms. The filing of a claim by the Service Provider or the Covered Person is not a precondition to the Plan's liability for a Covered Expense. However, the filing of a claim is a precondition to payment of a claim and the Plan needs written proof of claim as soon as reasonably possible in order to process a claim.

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

J. Legal Action and Anti-Assignment Subject to exhaustion of the Enrollee Appeal Procedures at Section 15, no action at law or in equity shall be brought to recover under the Plan prior to the expiration of ninety (90) days after submission of the itemized bill or Claim Form and any requested supporting information, nor shall such action be brought after twelve (12) months from the date of completion of a particular course of treatment. Except for voluntary assignments to Service Providers as may be required by law, your right to receive Dental Services under the Plan may not be assigned, voluntarily or involuntarily, to any other person. A direct payment by the Plan to a person or entity that provides Dental Services to you or your Family Dependent is not a waiver of this provision. Additionally, a Service

Provider may not bring a claim for benefits against the Plan, a Plan fiduciary, the Plan Administrator, the Claims Administrator or the Employer with respect to the Dental Services it provides to you or your Family Dependent.

SECTION 10 - TERMINATION OF COVERAGE

Your Coverage shall automatically be terminated on the first of the following to apply (unless otherwise dictated by your Employer):

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

SECTION 11 - CONVERSION PRIVILEGE

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

SECTION 12 – CONTINUATION OF COVERAGE

Dental benefits under this Plan are subject to COBRA continuation coverage. In the event of a COBRA qualifying event, affected Enrollees and their Family Dependents will be given a notice of entitlement to elect continuation coverage for periods that can range up to 18, 29 or 36 months depending on the qualifying event. An election to take continuation coverage must be made within 60 days of the COBRA Election Notice and persons making this election must pay the full amount of the premiums and may be charged a 2 percent administrative charge. The initial premium is due within 45 days of returning a notice electing coverage and must cover the entire premiums due from the date your coverage otherwise would have ceased. An Enrollee or affected Family Dependent must notify the benefit administrator at the Participating District within 60 days of divorce, legal separation or a Family Dependent's no longer satisfying the age or other conditions of eligibility in order for the benefits administrator to send out a qualifying event notice and other materials to affected Covered Persons. More detailed information on COBRA can be found in the COBRA General and Election Notices, if applicable, or by contacting the benefits administrator at the Participating District.

SECTION 13 - COORDINATION OF BENEFITS (COB)

This section applies when you also have other Group Health Plan coverage with another plan. When you receive a Covered Service, this Plan will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. "Allowable expense" is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. "Other Plan" is other Group Health Plan coverage with which this Plan will coordinate benefits. The term "Other Plan" includes:

   - Group dental benefits and group blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

   - Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Dental benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. "Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: a) the plan has no order of benefits rules or its rules differ from those required by regulation; or b) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a Primary plan (for example, two plans which have no order of benefit determination rules).

4. "Secondary plan" is one which is not a Primary plan. If a person is covered by more than one Secondary plan, the order of benefit determination rules

decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment. The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Enrollee and is covered only as a Dependent under the Other Plan, this Plan will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:

   - The plan of the parent who has custody will be primary;

   - If the parent with custody has remarried, and the child is also covered as a child under the stepparent's plan, the plan of the parent with custody will pay first, the stepparent's plan will pay second, and the plan of the parent without custody will pay third.

   - If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active member (i.e., not laid-off or retired), or as the spouse or child of such an active member and is also covered under another plan as a laid-off or retired member or as the spouse or child of such a laid-off or retired member, the plan that covers such person as an active member or spouse or child of an active member will be primary. If the Other Plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination. When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the Primary plan and this Plan during a claim determination period will not exceed the maximum available benefit for each Covered Service. Also, the amount this Plan pays will not be more than the amount this Plan would pay if it were primary. As each claim is submitted, this Plan will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information. This Plan may release or receive information that it needs to coordinate benefits. This Plan does not need to tell anyone or receive consent to do this. This Plan is not responsible to anyone for releasing or obtaining this information. You must give this Plan any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment. If this Plan made a payment as a Primary plan, you agree to pay this Plan any amount by which this Plan should have reduced its payment. Also, this Plan may recover any overpayment from the Primary plan or the Dentist receiving payment and you agree to sign all documents necessary to help this Plan recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans. This Plan will coordinate benefits with Other Plans, whether insured or self- insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

- If this Plan is primary, as defined in this section, this Plan will pay benefits first.
- If this Plan is secondary, as defined in this section, this Plan will pay only the amount it would pay as the Secondary plan;
- If this Plan requests information from a non-complying plan and does not receive it within thirty (30) days, this Plan will calculate the amount it should pay on the assumption that the non-complying plan and this Plan provide identical benefits. When the information is received, this Plan will make any necessary adjustments.

SECTION 14 – RIGHT OF REIMBURSEMENT AND SUBROGATION

In addition to the provisions of Section 13, if you or a Family Dependent is injured or ill and a third party is found liable, that third party will be liable for any expenses incurred by the Plan as a result of the injury. You will be responsible for reimbursing the Plan, in first priority, for the applicable expenses paid by it and to cooperate fully to perform all actions necessary to secure the Plan's rights of recovery. If payment by a third party is made or is expected to be made in the future, the Plan will process claims and will seek reimbursement of funds through the recovery process from either you, the person(s) responsible for the injury and/or that person's insurer.

Note that accidents that occur in someone else's home are typically covered under that person's homeowner's policy. If you require treatment as a result of an accident in someone else's home, you should seek reimbursement under his or her insurance policy.

SECTION 15 - APPEAL PROCEDURES

A. Claim Determinations

1. Pre-Service Claim Determinations. A pre-service claim is a request that a service or treatment be approved before it has been received. If the Claims Administrator has all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), it will make a determination and provide notice to you (or your designee) within fifteen (15) days from receipt of the claim.

   If the Claims Administrator needs additional information, it will request it within fifteen (15) days from receipt of the claim. You will have forty-five (45) calendar days to submit the information. If the information is received within forty-five (45) days, the Claims Administrator will make a determination and provide notice to you (or your designee) in writing, within fifteen (15) days of receipt of the information. If all necessary information is not received within forty-five (45) days, the Claims Administrator will make a determination within fifteen (15) calendar days of the end of the forty-five (45) day period.

2. Urgent Pre-Service Reviews. With respect to urgent pre-service requests, if the Claims Administrator has all information necessary to make a determination, it will make a determination and provide notice to you (or your designee) by telephone, within seventy-two (72) hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If additional information is needed, the Claims Administrator will request it within twenty-four (24) hours. You will then have forty-eight (48) hours to submit the information. The Claims Administrator will make a determination and provide notice to you (or your designee) by telephone within forty-eight (48) hours of the earlier of receipt of the information or the end of the forty-eight (48) hour time period. Written notice will follow within three (3) calendar days of the decision.

3. Post-Service Claim Determinations. A post-service claim is a request for a service or treatment that you have already received. If the Claims Administrator has all information necessary to make a determination regarding a post-service claim, it will make a determination and notify you (or your designee) within thirty (30) calendar days of the receipt of the claim. If additional information is needed, the Claims Administrator will request it within thirty (30) calendar days. You will then have forty-five (45) calendar days to provide the information. The Claims Administrator will make a determination and provide notice to you (or your designee) in writing within fifteen (15) calendar days of the earlier of receipt of the information or the end of the forty-five (45) day period.

If you disagree with the claim determination, you may submit an appeal as set forth below.

B. Claim Denials

If a claim is denied, you will be provided a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the Plan's claim review procedures and the time limits applicable to such procedures;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

C. Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to the Claims Administrator by telephone, facsimile or similar expeditious manner. The Claims Administrator will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;
- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without

regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, the Claims Administrator will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

The Claims Administrator will notify the claimant of its decision regarding review of an appeal as follows:

1. Urgent Care Claims. As soon as possible but no later than seventy-two (72) hours after receipt of the request for review of the adverse benefit determination.

2. Pre-Service Claims. No later than thirty (30) days after receipt of the request for review of the adverse benefit determination.

3. Post-Service Claims. No later than sixty (60) days after receipt of the request for review of the adverse benefit determination.

SECTION 16 - RELATIONSHIP BETWEEN PARTIES

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

SECTION 17 - CONTRIBUTION FOR COVERAGE PROVISIONS

A. Contribution for Coverage Payment

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

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

We and the Participating District shall cooperate to complete any retroactive adjustments to the Contribution for Coverage necessary as a result of the addition or termination of Enrollees Covered by us. If an Enrollee is added to the group Covered under the Participating District's Plan during the period from the first (1st) to the fifteenth (15th) day of any month, the Contribution for Coverage adjustment will be reflected on the next invoice. The Contribution for Coverage will not be adjusted if an Enrollee's Coverage becomes effective between the sixteenth (16th) and the last day of any month. If an Enrollee is terminated from the group Covered under the Participating District's Plan at any time during any month, the full Contribution for Coverage will be charged for that month.

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

B. Grace Period.

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

C. Default.

If the Contribution for Coverage is not paid by the end of the month, the Coverage of all Enrollees Covered by the Plan may be deemed to have terminated automatically as of the last date for which Contribution for Coverage

payments have been made, without notice from us to the Participating District or to the Enrollees. Any claims submitted by providers or Enrollees that are received by the Plan after such date (regardless of the date of service) or incurred after such date will not be payable by the Plan and will be the responsibility of the Participating District. We shall be entitled to notify Enrollees and unions of the non-payment of Contribution for Coverage and the expiration date of the grace period provided by this provision to enable them to make necessary arrangements to pay for their Dental Services upon termination of their coverage. The termination of Coverage upon expiration of the grace period shall not relieve the Participating District of its obligation to pay for Coverage provided. Upon termination of Coverage, the Participating District shall be liable to us for the payment of any and all Contributions for Coverage and accrued interest, which are due but unpaid at the time of termination, and for any payment of claims as noted above.

D. **District Withdrawal from Participation.**

In the event a Participating District withdraws from participation in the Plan and does not satisfy the obligations of the Participating District with respect to such withdrawal as set forth in the Trust Agreement and/or Memorandum of Agreement between the parties or does not make any required Contributions during the notice period, the Plan will deem a default to have occurred and the provisions of 17(C) above will apply.

SECTION 18 - HIPAA PRIVACY AND SECURITY PRACTICES

Under the Health Insurance Portability and Accountability Act (HIPAA), the Trust and its contracted vendors (Business Associates) are required to follow specified policies and procedures regarding the protection and transmission of your protected health information (PHI). As a result, the Trust has developed and maintains specified HIPAA Privacy and Security Practices. The dental benefits provided under this Plan are covered under the Trust's HIPAA Privacy and Security Practices.

SECTION 19 - GENERAL PROVISIONS

A. Entire Plan

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

B. Alteration

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

C. Forms

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

D. Records

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

E. Notice

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

F. Covered Benefits

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

G. Severability

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

H. Workers' Compensation Not Affected

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

I. Conformity with Statutes/Venue

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

J. Events Beyond Our Control

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

K. Waiver

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

L. Interpretation

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

M. Examinations

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

N. Legal Incompetence

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

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

O. Non-Waiver of Plan Provisions

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

CERTIFICATION

In Witness whereof, the Trust Chair and Vice Chair of the Trust have executed this amendment and restatement of the Plan on the date set forth below.

Jim Fregelette, Chair

Donna Walters, Vice-Chair

Dated: March 21, 2024