Dental Benefits Handbook

Wallkill Teachers' Association Benefit Trust

Revised: November 1, 2016

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Plan Benefit Highlights for: Wallkill Teachers Association

Group No: 17958 **Effective Date:** 1/1/2016

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age 26
Deductibles	None
Maximums	$2,000 per person each calendar year
D & P counts toward maximum?	Yes

Waiting Period(s)	Diagnostic & Preventative	Basic Services	Major Services	Orthodontics
	None	6 Months	12 Months	12 Months

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	60 %	60 %
Prosthodontics Bridges and dentures	60 %	60 %
Orthodontic Benefits Dependent children to age 19	50 %	50 %
Orthodontic Maximums	$2,200 Lifetime	$2,200 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

Delta Dental of New York
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

HLT_PPO_2COL_DDP (Rev. 10/22/2015)

Wallkill Teachers' Association Dental Benefits Plan Booklet

Plan Effective Date ..... July 1, 1991
Employees Eligible ..... As defined on Page 4
Dependents Eligible ..... All dependents as defined
Plan Contributions .....As determined by the Board of Trustees of the Benefit Trust

Orthodontic Expense Coverage Supplement (For Eligible Dependent Children)

Some of the charges incurred for Orthodontic Procedures performed on your qualified dependent children who are age 19 or less on the date the orthodontic procedure starts are paid.

There is a Maximum Orthodontic Benefit for all orthodontic procedures performed on each qualified dependent child who is age 19 or younger on the date the orthodontic procedure starts.

Covered Percent.....50% of reasonable and customary rates

Maximum Orthodontic Benefit per Covered Individual..... $2,200 (Effective 02/01/2011)

For more details consult the Benefit Trust Office.

IMPORTANT: Read this document carefully. See-*Dental Care Benefits (Pages 7-10)* for other conditions that may affect the coverage.

All terms and conditions in this handbook are subject to review and may be changed at any time.

Eligibility

Who Is Eligible to Receive Benefits?

Individuals:

A member is eligible to receive benefits from the Trust if the DISTRICT makes payment on your behalf to the Trust as defined in the collective bargaining agreement between the Wallkill Teachers' Association and the Wallkill Central School District. Members must complete and return all required enrollment forms, including Enrollment Forms and Annual Enrollment Update Forms (see page 6) to maintain continuous eligibility.

-OR-

A member is eligible to receive benefits from the Trust if YOU make payment on your behalf to the Trust. The payment will be equal to the amount of the District's contribution as specified in the collective bargaining agreement between the Wallkill Central School District and the Wallkill Teachers' Association. Payment will be made in two equal payments on October 1 and February1 of each year. Members must complete and return all required enrollment forms, including Enrollment Forms and Annual Enrollment Update Forms (see page 6) to maintain continuous eligibility.

Dependents:

The following dependents, if any, are also eligible for coverage:

- The spouse or domestic partner of an eligible member
- Each of the children* of an eligible member who are under 26 years of age

*Children include adopted children and step-children who are dependents of the enrolled employee, who are claimed as eligible dependents on the enrolled employee's Internal Revenue tax return, and who reside with the enrolled employee.

Domestic Partner Eligibility

A Domestic Partner is defined as an unmarried person who:

1) Has lived with an unmarried WTA Benefit Trust member in a committed, interdependent financial relationship, as each other's sole domestic partner.
2) Is not related by marriage or blood to the WTA Benefit Trust member in a way that would bar marriage;
3) Demonstrates financial interdependence by submission of proof of three (3) of the documents listed below;
4) Meets any applicable federal, state, or local laws that are now in force or may be enacted in the future.

Possible Documents to be used for proof:

- A domestic partner agreement;
- A joint mortgage or lease;
- A designation of one of the partners as beneficiary in the other partner's will;
- A durable property and health care power of attorney;
- A joint title to an automobile, or joint bank account or credit account;

-OR-

- Such proof as is sufficient to establish financial interdependency.

Active Military Duty

If a dependent is on active military duty, there will be no waiting period when that duty terminates. The Trust will remain the secondary provider during the period of military service.

Handicapped Dependents

Mentally or Physically Handicapped Children

If a Covered Dependent Child:

- Reaches the age at which he or she would otherwise cease to be a Covered Dependent;

-BUT-

- Is then mentally or physically incapable of earning his own living

-AND

- Is primarily dependent upon you for support

-AND

- If you submit satisfactory proof of the child's incapacity to the Benefit Trust within 31days of the date the child reaches such age, then insurance may continue for such child for as long as he or she remains incapacitated, subject to payment of a premium equal to the established COBRA rate and all other terms of the policy.

Exceptions

The dependent age limit may not apply to handicapped dependent children. Coverage will continue until the dependent reaches the age of eligibility for governmental entitlements (i.e. SSI, Medicaid, etc.). If entitlement is denied after appeal to governmental agencies and the child remains the member's dependent under Internal Revenue Service rules coverage will be reinstated. Proof of handicapped status will be required.

If there are any changes in the status of the dependent children, it is the member's responsibility to notify the Trust. Failure to do so will result in loss of dependent's benefits. Upon late notification to the Trust, the dependent may be re-enrolled but will be subject to the Late Entrant Restrictions. See-*Restrictions For Late Enrollees (Page 6)*

Non-Eligible Dependents

Non-Eligible Dependents are defined as follows: Emancipated children*, parents, grandchildren, nieces, nephews, brothers, sister, or other relatives of an Eligible Member are not Eligible Dependents under any circumstances.

*Emancipated children are children who you no longer claim as a dependent when filing your federal and state taxes. Even if you still pay for everything they do, if they are emancipated they are not Eligible Dependents under any circumstances.

Enrollment

How Do You Enroll?

You enroll for coverage by completing an Enrollment Form that is available from a WTA Building Representative or may be printed from the WTA website at:

http://www.nysut.org/wallkill/newsHIPAAnotice.html.

If you wish to cover any eligible dependent, you must elect coverage for all of your eligible dependents. If you do not have any eligible dependents when you enroll, you may apply for dependent's coverage when you acquire an eligible dependent.

New members will have 60 days from the date of appointment to enroll in the Wallkill Teachers' Association Benefit Trust. Members enrolled after this date will be considered late entries.

If both you and your spouse are eligible employees, both of you may elect to be covered as a dependent. Contact your Benefit Trust for details.

When Does Your Coverage Begin?

New employees' coverage will begin on the first day of the month that the eligibility requirements have been satisfied. See-*Who Is Eligible for Coverage? (Pages 3-4)*
Members must be actively at work at the Employer's regular place of business, and physically able to perform all such duties. Work or duties performed at home or while confined in a hospital or other medical institution may not be used to meet this requirement.

New Enrollee Restrictions

A) For the **first 6 months** after enrollment, coverage is limited to **Diagnostic** and **Preventive Services.**

B) During the **next 6 months**, coverage is limited to **Diagnostic, Preventive** and **Basic Services**, **excluding Periodontal Services.**

C) After 12 months, **Major, Periodontal and Orthodontic Services** are available.

When Does Dependents' Coverage Begin?

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

You should enroll your dependents promptly. Coverage for your dependents cannot begin before the date you enroll. If you enroll your dependents more than 61 days after the date you enroll, dependents' coverage will be limited during the first 24 months. (See Restrictions for Late Enrollees-Dental, page 6.)

Maintaining Your Enrollment Status

Each year in May, every Benefit Trust member is required to complete and return an *Annual Enrollment Update Form.* A member who fails to return the *Annual Enrollment Update Form* by June 15th of the same year will have all benefits suspended until the Benefit Trust office has received his/her completed form. (Effective 03/10/10)

Changes in Enrollment Status

When any change from the information listed on the enrollment form occurs, it is the member's responsibility to contact the WTA Benefit Trust in order to receive continued benefits. Failure to promptly inform the Trust of any change may result in either losing benefit coverage or being subject to the **Late Entrant Restrictions.** See-*Restrictions for Late Enrollees (Page 6)*

Restrictions for Late Enrollees-Dental

If you become insured more than 61 days after you become eligible, you will be considered a Late Enrollee. If any of your dependents becomes insured more than 61 days after such dependent becomes eligible, he or she will be considered a Late Enrollee. Late Enrollees are subject to the following restrictions:

1) Under Diagnostic and Preventive Services, only routine oral examinations and x-rays will be covered for the first 6 months.

-AND-

2) Periodontal treatment, Major services and Orthodontia Services will **not** be covered for the first 24 months.

Dental Care Benefits

Effective January 1, 2016, the Trustees of the WTA Benefit Trust appointed Delta Dental to be a third party administrator (TPA) for the Benefit Trust. In this capacity, they will assume the responsibility of processing all of our dental claims. They also have the ability to provide our members with a wide network of participating dental offices that may provide our members with additional convenience and potential savings.

What Do We Pay?

We will pay

- 100%* of Preventive Dental Expenses
- 80%* of the Basic Dental Expenses
- 60%* of Major Dental Expenses
- 50%* of Orthodontic Expenses

*Percentages are based on Reasonable and Customary rates as published by the ADA and adopted by the Board of Trustees.

This applies to each ***Family Member*****,** meaning you or any of your eligible dependents covered under the plan.

What Is The Maximum Benefit?

The maximum we will pay for all Covered Expenses, excluding orthodontia, during a calendar year is $2,000 per covered individual. Also, the maximum we will pay for orthodontic treatment during an eligible dependent's lifetime is $2,200 per covered individual.

Predetermination: Should Benefits Be Determined Before Treatment Starts?

The Trust does not require a predetermination before you begin treatment. If your dentist is a Delta Participating Provider, his or her office should be able to provide you with a predetermination of how much we will consider as Covered Expenses and how much we will pay. If your dentist is not a Delta Participating Provider, you should ask your dentist to describe the proposed treatment (including ADA codes and charges) on a Dental Claim form. The form should then be sent to Delta Dental Claims Office; PO Box 17055, Mechanicsburg, PA 17055-6999 for a predetermination.

What If More Than One Method Of Treatment Is Available?

When more than one method of treatment is available, we will pay for Covered Expenses for the least expensive method of treatment, regardless of which method is actually used.

What Are Covered Expenses?

Covered Expenses are reasonable and customary rates by a dentist for necessary dental services furnished to a member while covered under the Plan's Dental Care. There are three types of Covered Expenses:

1) Preventive Expenses
2) Basic Dental Expenses
3) Major Dental Expenses

Not all expenses are covered. See-*What Expenses Are Not Covered? (Pages 10-11)*

Dental Care Benefits (Continued)

What Are Preventive Expenses?

Preventive Expenses are the following:

- Oral exams or office visits during regular office hours (limited to 2 per calendar year per covered individual).
- Prophylaxis, including the scaling and polishing of teeth (limited to 2 per calendar year per covered individual).
- Topical application of fluoride limited to two treatments per year per covered individual children under age 18.
- Bitewing X-rays (limited to 2 per calendar year per covered individual).
- Full-mouth series of X-rays, including bitewings (limited to once every 3 years per covered individual).
- Panoramic survey (considered full mouth series).
- Pit and fissure sealants

What Are Basic Dental Expenses?

Basic Dental Expenses are for the following services:

- ORAL SURGERY–Charges for surgery performed on the gums, alveolar processes and teeth. This includes removal of impacted or erupted teeth and preparation of the gums for dentures.
- EXTRACTIONS–Charges for extractions, including those in connection with orthodontic treatment. (Includes local anesthetic and post-operative care.)
- ANESTHESIA–Charges for general anesthesia administered in connection with covered surgical procedures.
- PERIODONTICS–Charges for treatment of periodontal and other diseases of the gums and tissues of the mouth.
- ENDODONTICS–Charges for root canal therapy, includes necessary X-rays.
- FILLINGS–Charges for fillings, other than gold fillings.
- SPACE MAINTAINERS–Charges for space maintainers for missing primary teeth.
- PRESCRIPTIONS–Charges for medication expenses when dentists' prescriptions are denied by member's hospitalization plan.

Dental Care Benefits (Continued)

What Are Major Dental Expenses?

Major Dental Expenses are for the following services:

- RESTORATIONS–Charges for inlays, crowns and gold fillings.
- BRIDGES AND DENTURES–Charges for initial installation of dentures or fixed bridge work to replace at least one natural tooth extracted while the family member is covered under the Plan's Dental Care Program.
- IMPLANT SERVICES-Charges for implant support prosthetics and surgical implants.
- REPLACEMENT WORK–Charges for replacement of existing crowns, dentures or fixed bridgework if the existing crown, denture or fixed bridgework was installed at least five years prior to its replacement and cannot be made serviceable. The replacement must not be needed because of the loss or theft of the dentures or fixed bridgework.
- REPAIR WORK–Charges for repair and re-cementing of crowns, inlays and fixed bridgework.

Also, charges for replacement of existing dentures or fixed bridgework, or for the addition of teeth to existing dentures or fixed bridgework, if needed to replace at least one natural tooth extracted while the family member is covered under the Plan's Dental Care Program.

Orthodontic Benefits for Your Qualified Dependent Children

Orthodontic benefits pay for some of the charges incurred for Orthodontic Procedures performed on your Qualified Dependent children who are age 19 or less on the date the Orthodontic Procedure starts. Protection under this coverage is not extended after the date a person ceases to be a Covered Person for the benefits of this Coverage Supplement.

How Are Orthodontic Benefits Paid?

Payments will be made for 50% of the covered orthodontic charges described below which are incurred while the dependent child is eligible, up to the maximum lifetime benefit of $2,200 (Effective 02/01/2011).

Covered orthodontic charges will be paid upon insertion of the appliances in the following manner:

a. As primary coverage, one lump payment.

-OR

b. As secondary coverage, we will coordinate the benefits in the same manner as the primary.

All claims must be presented within 180 days of insertion.

Effect of Prior Plan Coverage

The Lifetime Orthodontic Maximum will be reduced by any benefits provided by the Trust or Wallkill Central School District.

Dental Care Benefits (Continued)

What Expenses Are Not Covered?

The following charges are **not** covered or are covered only to the extent stated.

- OCCUPATIONAL INJURY–Charges due to an on-the-job injury are not covered. However, this exclusion will not apply if the law does not permit a family member's employer (or the family member) to obtain coverage for the family member under a Workers' Compensation Act or similar act. Nor will it apply if the law permits but does not require a family member who is a partner or an individual proprietor to have coverage under a Workers' Compensation Act or similar act and that person does not have such coverage.
- OCCUPATIONAL SICKNESS–Charges due to any sickness which would entitle the family member to benefit under a Workers' Compensation Act or similar act are not covered.
- GOVERNMENT SERVICES–Charges for dental services furnished by or paid for by any government or government agencies are not covered. Charges for dental services are not covered if the family member would not have been required to pay for the services in the absence of insurance for dental care. However, this exclusion will not apply where prohibited by law.
- COSMETIC DENTISTRY–Charges in connection with dental services primarily for the purpose of improving appearance are not covered. For example, the following are **not** covered:
    - Alteration or extraction and replacement of sound teeth
    - Porcelain or other veneer facings on crowns or pontics to replace molar teeth
- Any charges for an Orthodontic Procedure if an active appliance for that Orthodontic Procedure has been installed before the first day on which the person became a Covered Person for the benefits of this Coverage Supplement

The following are also **not** covered:

- Any treatment of the teeth to remove or lessen discoloration except in connection with endodontic treatment; replacement of congenitally missing teeth; and all appliances and restorations for the purpose of splinting teeth, except A-splinting and provisional splinting in connection with periodontal treatment.
- Replacement of existing crowns, dentures or fixed bridgework, or addition of teeth to existing dentures or fixed bridgework, unless:
    - The replacement or addition is needed to replace at least one natural tooth extracted while the family member is covered under the Dental Plan.

      -OR-

    - The existing crowns, denture or fixed bridgework was installed at least five years prior to the replacement and cannot be made serviceable.
- Replacement of lost or stolen dentures or fixed bridgework.
- The Trust will not consider requests for the replacement of occlusal guards due to wear within the first two years of the guard's initial installation.
- Appliances, restorations, or procedures for altering vertical dimension, restoring or maintaining occlusion, splinting, replacement of tooth surface lost by abrasion or attrition, treatment and or diagnostic procedures for dysfunction of the temporomandibular joint (TMJ), unless specifically included in your handbook.

Dental Care Benefits (Continued)

What Expenses Are Not Covered? (Continued)

Treatment Started Before Coverage Begins

Charges for the following are **not** covered:

- DENTURES–if the impression for the denture was taken before the family member became covered under the Dental Care Plan.
- CROWNS, BRIDGES OR GOLD RESTORATIONS–if preparation of the teeth was begun before the family member became covered under the Dental Care Plan.
- ROOT CANAL THERAPY–if begun before the family member became covered under the Dental Care Plan.

Additional Exclusions

- MISCELLANEOUS SERVICES–Charges for oral hygiene instruction, plaque control, and dietary instructions are not covered.
- SERVICES BY RELATIVES–Charges for dental care furnished by any person related by blood or marriage.

Coordination of Benefits

Coordination of Benefits Within the Plan

If both individuals of a married couple or domestic partnership are members of the Benefit Trust, the Trust will allow reimbursement of claims at the Reasonable and Customary amount under each member, not to exceed 100% of the total amount billed. (Revised 02-01-08)

How Do Other Group-Type Plans Affect Benefits?

If a person has dental coverage under another group-type plan we will coordinate our benefits with those of that plan. One plan is primary. One plan is secondary. The primary plan pays regular benefits in full. The secondary plan pays a reduced amount which, when added to the benefits paid by the primary plan, can equal up to 100% of ALLOWABLE EXPENSES.

COVERED AMOUNT is defined as the **reasonable or customary amount** for an item of care at least part of which is covered by one of the plans.

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

1) The plan that covers the patient as an employee, rather than as dependent, is primary.
2) If both plans cover the patient as a dependent child, the following will determine which plan is primary:
    a. The primary plan will be the plan of the parent whose birthday occurs earlier in the calendar year, except that:
        - If both parents have the same birthday, the primary plan will be the plan that has covered the parent for the longer period of time. ***Birthday*** refers only to month and day in a calendar year, not the year in which the parent was born.
        - If either parent's plan is issued in another state and does not have this rule for determining which plan is primary, but instead has a rule based upon the gender of the parent, the plan with the gender rule shall determine which plan is primary.
    b. If the child's parents are legally separated or divorced, the primary plan will be the plan of the parent with custody of the child, except that:
        - If the parent with custody is covered as the spouse of the child's stepparent, the primary plan will be the plan of the stepparent if that plan also covers the child.
        - If a court decree has said which parent has financial responsibility for the child's covered expenses, the primary plan will be the plan of the parent who has that responsibility if the insurer of that plan has actual knowledge of the terms of the decree. This does not apply to any claim determination period or plan year during which benefits are paid before the insurer had that actual knowledge.
3) If neither 1 nor 2 applies, the primary plan will be the plan which has covered the patient for the longer period of time, except that:
    a. If the coverage of one plan is based on present employment, and the coverage of the other plan is based on prior employment, the primary plan will be the plan which is based on present employment.

    -AND-

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

Coordination of Benefits with Other Plans (Continued)

Health Maintenance Organizations (HMO)

There are several types of HMOs that provide dental benefits for members and/or their dependents. The HMO is to be the primary plan and then the Benefit Trust secondary.

Dental Claims as the Result of an Accident or an Injury

All claims that are the result of an accident or an injury must first be submitted to the member's health insurance carrier. Once the member receives an Explanation of Benefits (EOB) from the insurance carrier, he or she may then submit the original claim with the EOB to the Benefit Trust for processing. (Effective 07/16/09)

How Does No-Fault Auto Insurance Affect Benefits?

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

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

Members' Responsibilities

When You Have a Claim

To insure that you receive reimbursement for your claims you must adhere to the following:

1) All dental claims must be **submitted within 90 days** from the date of service or within 90 days from the point another primary plan processes the original claim, whichever is later.

   The date of service is determined by the date on which treatment is initiated regardless of the date of billing. (Effective 07/01/11)

2) All orthodontic claims must be **submitted within 180 days** from the date of service.

3) Claims must be submitted on Delta Dental's Claim Forms, however **members' original signature and date of signature will continue to be required**.

4) Only claims that reference **ADA codes** will be processed.

5) When a claim is returned to a member for correction or added information, the member shall have **35 calendar days** from the date of the notice to resubmit the revised claim form. Should the correct information not be supplied within the 35-day period, the claim will be denied.

Record Keeping

It is the members' responsibility to keep records of all dental expenses. You should save all bills and receipts for dental expenses. We need them as proof of your claim. When you are reimbursed, make sure you keep the top portion with the description and payment explanation for your own personal records.

To help preserve the assets of the Benefit Trust, you are strongly urged NOT to turn over the top portion with the description and payment explanation of your reimbursement to your dentist.

Re-issuing Lost Checks

Members should contact Delta Dental customer service (800-932-0783) for information regarding the re-issuing of lost or stolen checks. Any fees charged by Delta for reissuing checks are the sole responsibility of the member.

Claims Overpayment

When the Trust pays a claim to a member in error, the Trust reserves the right to request repayment in full of the overpaid amount from the member. If the member fails to make repayment, the outstanding amount will be deducted from future claim payments to the member.

Proof of Claim

On receipt of due proof of claim, **Dental Benefits are payable to you**.

1) Written proof of claim must be furnished to Delta Dental within **90 days** after the date of service for which the claim is made, or within **90 days** from the point another primary plan processes the original claim, whichever is later.

   The date of service is determined by the day on which treatment is initiated regardless of date of date of billing. (Effective 07/01/11)

2) Orthodontic claims must be submitted within **180 days** of initial placement of the appliance. If proof is not furnished within the time period, claim will be denied.
3) Appeal of denial can be made to the Board of Trustees of the Benefit Trust. The appeal must be provided in writing with satisfactory evidence indicating the reasons for Late Filing, Itemized bills will be required for the appeal process. See-*Appeals (Page 19)*
4) All submitted claims must be signed and dated by the member or the claim will be returned, unprocessed.

Additional Proof of Claim

Before paying benefits, the Benefit Trust/Delta Dental may require any of the following:

1) A dental chart showing work done before the treatment for which claim is made.
2) X-rays, lab, hospital records, or dentists' records. (Revised 07-30-08)
3) Cast molds or other evidence of the dental condition of treatment.
4) An examination at our expense, when we deem it reasonably necessary, by a dentist we select, of any patient while that patient has a claim pending under the Plan.

Termination of Benefits

When Does Your Coverage End?

Your coverage will end on the last day of the Plan month during which **ANY** of the following events occur:

1) Your employment ceases; i.e., you cease active full-time work in the eligible classes.
2) You cease to be an eligible member of the Benefit Trust.
3) You stop making any payments required for your coverage.
4) The Plan terminates.

Leaves of Absence

When a member is on a Board of Education approved leave of absence, all benefits provided by the Trust will cease on the last day on which the member is the employee of record.

When Does Your Dependents' Coverage End?

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

1) When your coverage ends.
2) The last day of the month in which a dependent reaches his/her 26th birthday.
3) When you stop making any payments required for dependents coverage.
4) If the Plan is changed to terminate coverage for all dependents.

What Benefits Are Paid After Coverage Ends?

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

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

-AND-

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

-AND-

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

COBRA–Continuation of Coverage Notice

What is COBRA?

(Applicable to employees of employers who have 20 or more employees on a typical business day during the preceding calendar year.)

On August 21, 1996, a new Federal law, the Health Insurance Portability and Accountability Act of1996, ("HIPAA"), [Public Law 104-191], was enacted. HIPAA changed some of the continuation coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA), [Public Law 99-272, Title X], that apply to the Employer's group dental plan. COBRA offers employees and their families the opportunity for a temporary extension of health coverage, at group rates, in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the new law. Both you and your spouse should take time to read this notice carefully.

Who is Eligible for COBRA?

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

If you are the spouse of an employee covered by a group health plan, you have the right to choose continuation coverage, (COBRA), for yourself if you lose group health coverage under the group health plan for any of the following reasons:

1) The death of your spouse *
2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment
3) Divorce or legal separation from your spouse
4) Your spouse becomes eligible for Medicare.

In the case of a dependent child, a child who is born to or placed for adoption with an employee covered by a group health plan, he or she has the right to continuation coverage, (COBRA), if group health coverage is lost for any of the following reasons:

1) The death of a parent *
2) The termination of a parent's employment (for other reasons other than gross misconduct) or reduction in parent's hours of employment
3) Parent's divorce or legal separation
4) A parent becomes eligible for Medicare

-OR-

5) The dependent ceases to be a dependent child under the group health plan.

In the event of Chapter 11 Bankruptcy, certain retirees and their dependents also have rights of continuation.

*Coverage will continue for the deceased's covered dependents for six months from the date of the active member's death. Thereafter the surviving dependents will be offered the opportunity to COBRA indefinitely. (Effective10/4/06)

COBRA–Continuation of Coverage Notice (Continued)

Under the law, the employee or a family member has 60 days to inform the Benefit Trust of a divorce, legal separation, the birth or adoption of a child, or a child losing dependent status under the group health plan.

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

When the Benefit Trust is notified that one of these events has happened, the Benefit Trust will in turn notify you that you have the right to choose continuation coverage, (COBRA).

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

If you do not choose continuation coverage, (COBRA), your group health insurance coverage will end.

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

In that case, the required continuation coverage period is 18 months. If a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at anytime during the first 60 days of continuation coverage, (COBRA), the 11 month extension, (for a total COBRA coverage period of up to 29 months from the initial qualifying event), is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements in a timely fashion.

However, the law also provides that your continuation coverage may be terminated for any of the following reasons:

1) Your former employer no longer provides group health coverage to any of its employees
2) The premium for your continuation coverage, (COBRA), is not paid
3) You become eligible for Medicare
4) You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's group health plan.

You do not have to show that you are insurable to choose continuation coverage, (COBRA). However, under the law, you may have to pay all or part of the premium plus 2% administration fee for your continuation coverage, (COBRA).

Effective 9/18/02, members electing COBRA coverage must purchase all services offered by the Benefit Trust. The individual's cost will be equal to the District's annual contribution as per the collective bargaining agreement between the Wallkill Teachers' Association and the Wallkill Central School District plus a 2% administration fee.

COBRA–Continuation of Coverage Notice (Continued)

All COBRA payments will be due on the 1st of each month. There will be a 30-day grace period for late payments. All COBRA benefits will be terminated and claims will not be processed if payment is not received during the 30-day grace period.

The COBRA rate will be adjusted October 1st of each year to equal 102% of the District's current contribution.

COBRA rates for grandfathered members making direct payments will increase at the same rate as the District's contribution.

The law also states that, at the end of the 18th month, 29th month or 3 year continuation coverage, (COBRA), period, your dental coverage will be terminated.

This law applies to employer group health plans beginning on or after July, 1986. Any questions about this law should be addressed to your Benefit Trust.

Also, if you have changed marital status, you or your spouse have changed addresses, please notify the Benefit Trust Office.

Dental Claims Appeals Procedure

The following policy was revised by the WTA Benefit Trust Fund Board of Trustees on September 8, 2016.

Stage 1: A covered member who is aggrieved by the denial of a dental claim, in whole or in part, may request a review of the action taken by the Delta Dental Claims Office. The notice of appeal must be submitted in writing to the Board of Trustees within 60 days after the action taken by the Delta Dental Claims Office.

Stage 2: The reason for the appeal and/or the rationale of the appeal must be submitted in writing, with the notice of appeal.

Stage 3: The member will be informed, by written notice, of the date and time of said hearing.

Stage 4: The member will present the appeal to the Board of Trustees in executive session, prior to its scheduled meeting; or the member may present his/her appeal in writing. Failure of the member to appear or send a written appeal within the specified time, without just cause, may result in the dismissal of the appeal.

Stage 5: The Board of Trustees shall act on the appeal within a reasonable period of time and render their decision in writing to the member.

Stage 6: A member or his/her dependent claimant who considers himself/herself aggrieved by the denial of the appeal may, at his/her discretion, submit the appeal to one (1) arbitrator selected from the panels of arbitrators of the American Arbitration Association and will abide by the commercial rules of the American Arbitration Association. A judgment of the Court having jurisdiction may be entered upon the award. Where such aggrieved member or his/her dependent claimant elects to have the appeal submitted to arbitration, as described above, such an election of procedure shall be exclusive and the member or his/her dependent may not resort to any judicial proceeding except to enforce such award. The fees and charges of the American Arbitration Association shall be shared equally by the grievant and the WTA Benefit Fund.

Important Notices

Who We Are

The Wallkill Teachers' Association established the Benefit Trust in February 1991 to administer benefits for its members and other eligible individuals. Its Board of Trustees consists of seven active-member trustees, plus a retired-member trustee. Each member of the Board is appointed for a two-year term by the Wallkill Teachers' Association's Representative Assembly. The Trust meets monthly in the offices of the Wallkill Teachers' Association.

Any questions regarding the content of this handbook should be addressed to:

Board of Trustees
WTA Benefit Trust
PO Box 305
Gardiner, NY 12525

845-256-1234, ext. 104

Where to Submit Claims

Submit all signed and dated claims within 90 days of service to the following address:

Delta Dental Claims Office
PO Box 17055
Mechanicsburg, PA 17055-6999

Legal Actions

No one may sue for payment of claim less than 60 days after due proof of claim is furnished or more than two (2) years after the date that proof of claim is required by the Plan.

All terms and conditions in this handbook are subject to review and may be changed at any time.

WTA Benefit Trust

Benefits Handbook Amendment: Confidentiality of Protected Health Information

In accordance with Article IV, section 4.4 of the Agreement and Declaration of Trust of the WTA Benefit Trust, the Benefits Handbook is hereby amended as follows:

The Section entitled "Confidentiality of Protected Health Information," **is hereby added as follows:**

"**CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION"**

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of an Individual's Protected Health Information ("PHI") effective April 14, 2004.A summary of rights under HIPAA can be found in the Plan's privacy notice, which *was* distributed to Individuals in accordance with HIPAA and which is available from the Plan's Privacy Official.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Wallkill Teachers' Association) will not use or disclose PHI except as necessary for treatment, payment, health care operations and plan administration, as defined by HIPAA, or as permitted or required by law.

"Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a participant's claim);

b) coordination of benefits;

c) adjudication of health benefit claims (including appeals and other payment disputes);

d) subrogation of health benefit claims;

e) establishing employee contributions;

f) risk adjusting amounts due based on enrollee health status and demographic characteristics;

g) billing, collection activities and related health care data processing;

h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

i) obtaining payment under a contract for reinsurance(including stop-loss and excess of loss insurance);

j) medical necessity reviews or reviews of appropriateness of care or justification of charges;

k) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

m) reimbursement to the plan.

"Health Care Operations" include, but are not limited to, the following activities:

a) quality assessment;

b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

c) rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

d) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance);

e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

g) business management and general administrative activities of the Plan ,including, but not limited to:

   i. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements

   ii. customer service, including the provision of data analyses for policy holders, Plan sponsors, or other customers

h) resolution of internal grievances; and

i) due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity.

Confidentiality of Protected Health Information (Continued)

Only those employees processing dental claims who assist in the Plan's administration will have access to PHI. These individuals may only have access to use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan. The Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Plan will not, without authorization, use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions and decisions unless authorized by the Individual; (d) not use or disclosure the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the Individuals; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available

Confidentiality of Protected Health Information (Continued)

in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan's Privacy Official.

Under HIPAA, an Individual has certain rights with respect to his or her PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. An Individual also has the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if he or she believes his or her rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of an Individual's rights under HIPAA's privacy rules. An Individual should contact The Benefit Trust Office at (845) 256-1234 (x104) if the Individual" (a) wishes to obtain a copy of the

notice; (b) has questions about the privacy of his or her PHI; or (c) wants to file a complaint under HIPAA.

Effective April 20, 2006, the Plan Sponsor will:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to Plan any security incident of which it becomes aware concerning electronic protected health information."

THIS IS TO CERTIFY that the above Amendment to the Benefits Booklet of the WTA Benefit Trust was duly adopted by the Board of Trustees at a meeting held on the 17 day of July, 2006, effective on or after April 20, 2006.

DATED: 7/17/06

David Thompson, Trustee

Quick Reference of Dental Information (10/01/16)

I - When you go to the dentist office:

1) When asked if you have dental coverage: Answer **YES**. Your dental benefits are provided by the WTA Benefit Trust through **Delta Dental.**
2) If your dentist is a Participating Provider, he or she may be able to file your claim electronically. If not, fill out a Delta Dental claim form and have your dentists office submit it to Delta Dental.
3) For Non-Participating Providers you must use the Delta Dental Claim Form Make sure the includes the following information:
    a) Member's Name
    b) Patient's Name
    c) Dentist's Name – (the dentist who performed the services – we do not accept group names such as the Hudson Valley Dentists Group.)
    d) Date of Service - clearly visible
    e) Current ADA/CDT codes must be used for each service performed
    f) Teeth numbers must be included when necessary

    *** Information on the claim form must either be **all typed** or **all handwritten**. If it is a combination of the two, it will be considered an altered document and returned to you.

4) You, the member, must sign and date all forms that are submitted. All dental claims **MUST** be submitted **within 90 days** of service or you will receive **$0 benefit.**

4) Claims should be submitted to:

Delta Dental Claims Office
PO Box 17055
Mechanicsburg, PA 17055-6999

II. Coordination of Benefits:

1) If your spouse has dental coverage:
    a. We are secondary for your spouse – which means that any claims must be processed with your spouse's coverage first. Then, if the claim was not totally paid for by the primary, you may submit the original claim with the Explanation of Benefits (EOB). Again, you the member must sign both forms.
    b. We are always primary for you, the member – ALWAYS.
    c. If you have dependents: Then we must follow the birthday rule to see who is primary. Birthday rule states that the parent whose birthday comes first in a calendar year is primary. (age does not matter.)
2) If you have MVP health insurance.
    a. MVP provides preventative dental care for dependents under the age of 19. Therefore, all regular cleanings and x-rays must be submitted to MVP first. Then submit the dental claim and a copy of the EOB from MVP and we will reimburse the co-pay for the claim. (Reminder: **ALL** claims must be **signed and dated by the member**.)IV – Submission of claims:
1) Make sure you the member has signed and dated the forms.
2) Submit your dental claim within 90 days of the date of service.
3) Submit your orthodontia claim within 180 days of the date of service.

III – Dental Benefits Handbook:

1) Updated versions with more detailed lists of information may be found on line at:

http://locals.nysut.org/wallkill/sept2010updatedDental%20Benefits%20bk.pdf

DELTA DENTAL

Delta Dental of New York

SUBSCRIBER INFORMATION

1. Policyholder / Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

2. Date of Birth (MMDDCCYY) | 3. Gender ◯M ◯F | 4. Policyholder / Subscriber ID (SSN or ID#)

5. Plan or Group Number | 6. Employer Name

PATIENT INFORMATION

7. Relationship to Policyholder/Subscriber in #1 Above
◯ Self ◯ Spouse ◯ Dependent Child ◯ Other

8. Patient Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code

9. Date of Birth (MMDDCCYY) | 10. Gender ◯M ◯F | 11. Patient ID/Account # (Assigned by Dentist)

12. Remarks

TRANSACTION AND PREDETERMINATION INFORMATION

13. Type of Transaction (Mark all Applicable Boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Pre-treatment Estimate
☐ EPSDT/ Title XIX ☐ Encounter

14. Predetermination/ Pre-treatment Estimate Number

TREATMENT INFORMATION

15. Treatment Resulting From
☐ Occupational Illness/injury ☐ Auto accident ☐ Other accident

16. Date of Accident (MMDDCCYY) | 17. Auto Accident State

18. Place of Treatment
◯ Provider's Office ◯ Hospital ◯ ECF ◯ Other

19. Number of Enclosures (00 to 99)
Radiograph(s) | Oral Image(s) | Model(s)

20. Is Treatment for Orthodontics?
◯ No (Skip 21-22) ◯ Yes (Complete 21-22)

21. Date Appliance Placed (MMDDCCYY)

22. Months of Treatment Remaining | 23. Replacement of Prosthesis? ◯ No ◯ Yes (Complete 44) | 24. Date of Prior Placement (MMDDCCYY)

OTHER INSURANCE COVERAGE

25. Other Coverage? ◯ None ◯ Dental (Complete 26-32) ◯ Medical (Complete 26-32)

26. Name of Other Coverage Policyholder / Subscriber (Last, First, Middle Initial, Suffix)

27. Date of Birth (MMDDCCYY) | 28. Gender ◯M ◯F | 29. Policyholder / Subscriber ID (SSN or ID#)

30. Plan or Group Number | 31. Patient's Relationship to Person Named in #26
◯ Self ◯ Spouse ◯ Dependent ◯ Other

32. Other Insurance Company / Dental Benefit Plan Name, Address, City, State, ZIP Code

33. Diagnosis Codes | A. | B. | C. | D.

RECORD OF SERVICES PROVIDED

	34. Procedure Date (MMDDCCYY)	35. Area of Oral Cavity	36. Tooth Number(s) or Letter(s)	37. Tooth Surface	38. Quantity	39. Procedure Code	40. Diagnosis Pointer (A, B, etc.)	41. Description	42. Fee
1									
2									
3									
4									
5									
6									
7									
8									

MISSING TEETH INFORMATION

44. (Place an 'X' on each missing tooth)

Permanent																Primary										43. Total Fee	0.00
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		

AUTHORIZATION - RELEASE OF INFORMATION

45. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

AUTHORIZATION - ASSIGNMENT OF BENEFITS

46. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY

47. Dentist or Entity Name, Address, City, State, ZIP Code

48. NPI

49. License Number | 50. SSN or TIN

51. Phone Number | 52. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed

X _____
Signed (Treating Dentist) Date

54. Treatment Location Address, City, State, ZIP Code -

55. NPI

56. License Number | 57. Provider Specialty Code

58. Phone Number | 59. Additional Provider ID

Delta Dental Enterprise Claim Form
Version 1, Rev 0 10/12/2011