GREAT NECK TEACHERS ASSOCIATION BENEFIT TRUST FUND

Comprehensive Benefits Booklet for SAGES

January 2020

Dear Member:

The Trustees are pleased to provide you with this Comprehensive Benefits Booklet which describes your benefits through the Great Neck Teachers Association Benefit Trust Fund.

This booklet contains details of these benefits including enrollment, eligibility, coverage for dependents, and other general information concerning Trust Fund procedures. To the extent that this booklet describes an insured benefit the group insurance contract specifies the exact benefits provided, and the language of the insurance contract will govern in the event of inconsistency between it and the language of this booklet.

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

If you have any questions, please contact the Trust Fund Office (516) 829-9086.

Sincerely,

Board of Trustees
James Daszenski (GNTA)
Patti Crisafulli (GNTA)
Ana Tavares (GNTA)
Jennifer Snyder (GNTA)
Matt Trinkwald (GNTA)
Maria Steck (OSA)
Catherine Davidson (SAGES)

GREAT NECK TEACHERS ASSOCIATION BENEFIT TRUST FUND

The Cottage
343 Lakeville Road Great Neck, New York 11020
(516) 829-9086
Fax (516) 829-0724

Board of Trustees

James Daszenski (GNTA)
Patti Crisafulli (GNTA)
Ana Tavares (GNTA)
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Maria Steck (OSA)
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Fund Counsel

Mirkin & Gordon, P.C.

Fund Accountant

Buchbinder Tunick & Co. LLP

Fund Self-Insured Benefits Consultant

Dickinson Group, LLC

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Legal Benefit, Dental Fee Schedule and Dental Participating Provider List are located at the back of this book.

GENERAL INFORMATION

Are you eligible for coverage under this fund?

Sage's may elect coverage in GNTA Benefit Trust Benefits which include an Excess Medical Plan, Dental Plan and Legal Plan. When filling out your Enrollment Form please designated which plan(s) in which you would like to enroll.

Are your dependents eligible for coverage under this Fund?

Your eligible dependents will receive certain benefits from the Fund. Your eligible dependents include:

- your spouse to whom you are legally married,
- your domestic partner,

- A domestic partner is defined as a person, eighteen years of age or older, who is not married or related by blood to the employee or retiree in a manner that would bar marriage in the State of New York, who has a close and committed personal relationship with the employee or retiree, who lives with the employee or retiree and has been living with same on a continuous basis, and who, together with the employee or retiree, has registered as a domestic partner of the employee or retiree and has not terminated the domestic partnership."

your unmarried dependent children until the end of the month in which they reach age 19,

- your unmarried dependent children who are full time students in an educational institution and are wholly dependent upon you for

financial support until the earlier of the last day of the month in which:

- they reach age 25, or
- they are no longer full-time students (unless they are under an approved medical leave of absence from the educational institution for less than one year),

as long as you provide proof of enrollment for each semester. Coverage will be extended for two months after the graduation date.

- your unmarried children over age 19 who are unable to do any work to support themselves because of physical handicap or mental illness, developmental disability or mental retardation. The incapacity must have started before the child reached age 19, must be certified by a doctor, and may have to be recertified periodically. You must submit written proof of the disability to the Fund Office. Coverage under this provision will end if the dependent child marries, becomes eligible for Medicare, or becomes able to earn a living.

Dependent children are your natural children, stepchildren, legally adopted children, including children in a waiting period prior to finalization of adoption, children of domestic partners, and any other children related to you by blood or marriage who are living in a regular parent child relationship with you and are dependent upon you for financial support and maintenance.

To establish eligibility of a member's stepchild or a domestic partner's child, you may be required to complete an affidavit of dependency verifying that the child resides with you full-time and provide proof of financial dependency as shown on income tax returns.

If your dependent is eligible for benefits as a member, then he or she is only eligible for member benefits and not for benefits as your dependent.

When does your eligibility for coverage end?

Your eligibility for coverage under the benefits described in this booklet will end when the first of these events occurs:

- you are no longer eligible for coverage,
- the Fund no longer provides benefits for your class of employee,
- contributions made on your behalf stop, or
- the last day of the second month after
  - your employment with a contributing employer stops,
  - you enter military service,
  - your employer is no longer a contributing employer,
  - you work less than the required hours for eligibility, or
  - the group insurance policy is terminated.

When does coverage end for your dependents?
Coverage under the Fund for your dependents will end when the first of these events occurs:

- your coverage ends,
- your dependent is no longer considered an eligible dependent as defined
- your dependent enters the Armed Forces of any country,
- your death, or
- the Fund no longer provides coverage for any dependents.

Under certain circumstances when coverage for your dependents would otherwise end, they may be eligible to continue their coverage under the Fund or, for those benefits provided by an insurance carrier, convert to an individual policy directly with the carrier.

What Happens If There Is a Change in Your Family Status?

You must immediately notify the Fund Office of any change in your family status (marriage, divorce, separation, birth or adoption of a child, death of an eligible dependent) and of any change of address. When a change in family status has occurred, you must provide the Fund Office with proof of same (i.e. original or certified copied of birth certificates, marriage certificate, Judgment of divorce, separation agreement, etc.) Failure to do so could result in loss or delay of benefits.

Continuation Coverage Rights Under COBRA

The following is important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Fund.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
COBRA continuation coverage can become available to you when you would otherwise lose your coverage with the Great Neck Teachers
Association Benefit Trust Fund ("Fund"). It can also become available to other members of your family who are covered under by the Fund when they would otherwise lose their coverage. For additional information about your rights and obligations under the Fund you should contact the Fund Administrator.

COBRA continuation coverage for the Fund is administered by the Fund Office located at The Cottage, 343 Lakeville Road Great Neck, New York 11020, tel. (516) 829-9086.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Fund coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation

coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Fund is lost because of the qualifying event. You or your dependents will be required to pay the necessary premiums to continue coverage for the following Fund benefits:

- Dental benefits;
- Excess Medical Expense benefits;
- Optical benefits; and
- Hearing Aid benefits.

If you are a Fund member, you will become a qualified beneficiary if you lose your coverage under the Fund because either one of the following qualifying events happens:

- Your hours of employment with the Great Neck Union Free School District ("District") are reduced, or
- Your employment with the District ends for any reason other than your gross misconduct.

If you are the spouse of a Fund member, you will become a qualified beneficiary if you lose your coverage under the Fund because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment with the District are reduced;
- Your spouse's employment with the School District ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The Parent-Fund member dies;
- The Parent-Fund member's hours of employment with the District are reduced;
- The Parent-Fund member's employment with the District ends for any reason other than his or her gross misconduct;
- The Parent-Fund member becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Fund as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the member's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Fund Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the member and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Fund Administrator within 60 days after the qualifying event occurs.
You must provide this notice to the Fund Administrator at The Cottage, 343 Lakeville Road Great Neck, New York 11020, tel. (516) 829-9086.

How is COBRA Coverage Provided?

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered members may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the member, the member's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the member's hours of employment, and the member became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiary's other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Fund is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Fund Administrator is notified of the Social Security Administrator's determination by sending a copy of the Determination letter within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Fund Administrator at the Fund office.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Fund. This extension may be available to the spouse and any dependent children receiving continuation coverage if the member or former member dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Fund as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred.

If You Have Questions
Questions concerning your COBRA continuation coverage rights should be addressed to the Fund Administrator at The Cottage, 343 Lakeville Road Great Neck, New York 11020, tel. (516) 829-9086.

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

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Fund Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

CONTINUATION OF COVERAGE DURING LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (FMLA). If you take a FMLA leave, your employer must continue to contribute to the Fund on your behalf and certain health-related benefits through the Fund must continue. However, if you do not return to work after your FMLA leave ends, you may be required to repay the amount your employer paid toward your coverage during your leave unless you do not return because of a serious health condition of yourself or a family member or other circumstances beyond your control. If you do not return to work after the end of your FMLA leave, you may be eligible for COBRA continuation coverage. Contact the Fund Administrator for more information about your rights and your dependents' rights to continuation coverage.

CONVERSION PRIVILEGE INSURANCE COMPANY COVERAGE ONLY
When your eligibility for group coverage ends, you or your dependents may convert to non-group policies provided by the insurance companies. Benefits under the non-group policies may be different from your coverage under the group contracts through the Fund. Contact the Fund Administrator for additional information about continuing coverage.

What is coordination of benefits and how does it work?
When benefits would be payable under more than one group plan, benefit payments will be coordinated so that the total benefits paid under all Group Plans will not exceed 100% of the total amounts charged. If you and your spouse are both employed by the District, and eligible for benefits, your benefit payments will also be coordinated not to exceed 100% of the total amounts charged.

Claim Procedures Under the Coordination of Benefits Provision
If you are a covered member of the Fund and are eligible for benefits from another group plan:
- Submit your claim to the Great Neck Teachers Association Benefit Trust Fund Office first.
- After you have received payment from the Fund, you may submit a claim for the unpaid balance to the other group plan under which you are eligible for benefits.
- You will receive any additional benefits which may be due for this claim under the second plan.

The total amount you receive for each claim from this Fund and from any other group plan cannot exceed 100% of the total amount charged.

If your spouse/domestic partner has a claim and is eligible for benefits under another group plan:
• Your spouse/domestic partner must submit a claim to his or her plan first.
• After the claim is paid by your spouse's/domestic partner's plan, a claim for the unpaid balance may be submitted to this Fund along with an explanation of benefits received from the other plan.
• Any additional benefits which may be due for this claim will be paid by this Fund according to plan limitations.

The total amount paid for each claim from any group plan under which your spouse/domestic partner is eligible and from this Fund cannot exceed 100% of the total amount charged.

If a claim is submitted for a child when one parent is a covered member of the Fund and the other parent is a covered member of another plan:
• Submit this claim to the plan of the parent whose birthday (month and day only) occurs first in a calendar year.
• After the claim has been paid by the first plan, it may be submitted to the second plan along with an explanation of benefits received from the first plan.
• The payment you receive for each claim from both plans cannot exceed 100% of the total amount charged.

If the claim is submitted for a child whose parents are divorced when one parent is a covered member of this Fund and the other parent is a covered member of another plan:
• If the parent with custody has not remarried,
- submit the claim to the plan which covers the parent with custody first.
- after the claim has been paid by the first plan then it may be submitted to the second plan with an explanation of benefits received from the first plan.
• If the parent with custody has remarried,
- submit the claim to the plan which covers the parent with custody first.
- submit the claim to the plan which covers the stepparent second.
- submit the claim to the plan which covers the parent without custody last.
• If there is a court order which establishes financial responsibility for the medical, dental or other health care expenses of the child, submit the claim to the plan which covers the parent with the court ordered responsibility first. A copy of such court order must be submitted with your claim.

CLAIMS INFORMATION

Filing Claims
You must file claims to receive your Great Neck Teachers Association Benefit Trust Fund benefits. Claim forms are available from the Fund Office, on the GNPS website: greatneck.k12.ny.us. and on www.gnteachers.net All claims should be sent to the Fund Office at Dickinson Group, LLC, 50 Charles Lindbergh Blvd Suit 207 Uniondale, NY 11553

Appeal Procedure
The benefits provided by this Fund may be changed by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust Indenture which established and governs the Fund operations. All rules are uniformly applied by the Fund Office. The action of the Fund Office is subject to review only by the Board of Trustees. A covered member, eligible dependent or beneficiary may request a review of action by submitting notice in writing to the Board of Trustees, Great Neck Teachers Association Benefit Trust Fund, The Cottage, 343 Lakeville Road, Great Neck, NY 11020. The Trustees shall act on the appeal within a reasonable

period of time and render their decision in writing, which shall be final and conclusive and binding on all persons.

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")

A federal law, the Health Insurance Portability and Accountability Act, ("HIPAA"), requires the Benefit Fund to protect the confidentiality
of your private health information. A complete description of your rights under HIPAA can be found in the Fund's privacy notice, which was distributed to all current members of the Fund prior to April 14, 2004 and is distributed to all new members upon enrollment, a copy of which is available from the Fund Chairman.

The Fund will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary
for treatment, payment, operations of the Fund, or as permitted or required by law. By law, the Fund has required all business associates

to also observe HIPAA's privacy rules. In particular, the Fund will not, without authorization, use or disclose protected health information for employment-related actions and decisions.

Under HIPAA, you have certain rights with respect to your protected health information, 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. You also have the right to file a complaint with the Fund or with the
U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

AMENDMENT OR TERMINATION OF BENEFITS

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

Your coverage and your dependent's coverage will stop on the earliest of the following dates:

- When the Fund is terminated;
- When you are no longer eligible;
- When there is a non-payment of the direct payments; or

Your dependents' coverage will also terminate when they are no longer your eligible dependents.

Active and retired benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits either before or after his or her retirement. The Trustees may expand, modify or cancel the benefits for active and retired members; change eligibility requirements or the amount of the direct payments; and otherwise exercise their prudent discretion at any time without legal right or recourse by an active or retired member or any other person.

THIRD-PARTY REIMBURSEMENT/SUBROGATION

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

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

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

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

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

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

If the Fund finds it has overpaid you, or an otherwise ineligible dependent, for a particular benefit, it has the right to recoup the excess amount from you. The Fund may bill you for overpayments made, and/ or, it may also reduce future benefit payments to offset the overpaid amounts or it may suspend your benefits until the overpayment is recouped.

EXCESS MEDICAL BENEFIT

The Excess Medical Benefit is a supplemental benefit. It does NOT provide basic hospital, basic medical, major medical or Medicare supplements. It is designed to reimburse you for some "Out of Pocket" costs not covered by your major medical.

** Spouse and dependents are only eligible if you pay for member/spouse or family coverage.*

The following benefits are provided with purchase:

OUT OF NETWORK DEDUCTIBLE BENEFIT

Who is eligible?: Member and participating eligible dependents.
What is the Plan Year?: Calendar Year
Benefit Description
The benefit pays up to $1000 with an additional 1% of costs of your Out-of-Network Deductible for each Member claiming for self and eligible dependents.

OUT PATIENT PSYCHIATRIC BENEFIT

Who is eligible?: Member and participating eligible dependents.
What is the Plan Year?: Calendar Year
Benefit Description
The Fund will pay up to $25 per visit for out-of-network providers/ or will reimburse co-payment up to $25 per visit for in-network providers with a family maximum of $600 per calendar year, plus 1% thereafter.

VISION CARE BENEFIT

Who is eligible?: Member and participating eligible dependents.
What is the Plan Year?: Every Other Calendar Year
Benefit Description
This benefit pays up to $150 for glasses, exams, and/or contacts to all eligible participants once every two years.

IN HOSPITAL/IN PATIENT REHABILITATION CASH BENEFIT

Who is eligible?: Member and eligible spouse only.
What is the Plan Year?: A rolling 52 weeks
Benefit Description
For each day the member is confined to a Hospital/Rehab this benefit will provide $50.00 per day up to 26 weeks (in hospital only). For each day the member is confined to a Hospital/Rehab this benefit will provide $10.00 per day up to 26 weeks (in hospital only).

IN-HOSPITAL PRIVATE DUTY NURSING

Who is eligible?: Member and participating eligible dependents.
What is the Plan Year?: Calendar Year
Benefit Description
For medically necessary in-hospital private duty nursing during the first 48 hours of confinement in an acute care general hospital, 50% of reasonable and customary charges will be reimbursed.

The claim must include the nurse's itemized bill, a doctor's statement indicating the necessity of care and proof that the Empire Plan did not pay the expense.

OUT-PATIENT REHABILITATION BENEFIT

Who is eligible?: Member and participating eligible dependents.

Benefit Description

Out-patient rehabilitation therapy in a Comprehensive out-patient rehabilitation facility (CORF) is provided on a first dollar basis and coordinated with the underlying Blue Cross/Metropolitan Life Insurance Company's medical program up to $1000 with an additional 1% of costs per calendar year per eligible participant.

Specific areas of out-patient rehabilitation services are:

1. Occupational therapy
2. Physical therapy
3. Speech therapy
4. Inhalation therapy
5. Psychiatric diagnostic Evaluation (excluding treatment
6. Coordination of medical services
7. Audio logical Evaluation
8. Loan of various rehabilitation equipment on the prescription of (CORF) physician
9. Acupuncture used for rehabilitation purposes **
10. Chiropractic used for rehabilitation purposes.**

**These services must be covered under the underlying Empire Plan Program before they may be submitted to the Fund

* Spouse and dependents are only eligible if you pay for member/spouse or family coverage.

PRESCRIPTION DRUG BENEFIT

Who is eligible?: Each member claiming for self and eligible participating dependents.

Benefit Description

Once annually, up to a maximum of $250.00, with $1 per additional copayment, the Fund reimburses to a member the co-payment costs which have been paid within the calendar year for drugs prescribed by a medical doctor, osteopath or dentist. Prescription must be dispensed by a licensed pharmacist.

RESTRICTIONS:

- Only one claim per year is eligible.
- Individual prescriptions not covered by a pharmacy printout or copy of receipt. Do not submit original receipts. (The Fund is not responsible for loss of originals if submitted.)
- The Fund prescription drug coverage is secondary to your primary prescription drug coverage.

CLAIMING:

Your prescription drug claim MUST be submitted before the first quarter ending following the year charges were made in order to be eligible for coverage. (Example: Covered expenses incurred from 1/1/17 through 12/31/17 MUST be submitted by March 31, 2018.

BENEFIT TRUST FUND
THE COTTAGE
343 LAKEVILLE ROAD
GREAT NECK, NY 11020
Tel: 516-829-9086

SUBMIT ALL CLAIMS TO:
Dickinson Group, LLC
50 Charles Lindbergh Blvd Suit 207
Uniondale, NY 11553
877-347-7225
FAX: 516-740-5417

CLAIM FORMS ARE AVAILABLE ONLINE AT:

https://www.gnteachers.net/forms.html

-and-

GREATNECK.K12.NY.US
From the Left Column
Select: FORMS
Select: GNTA

Dental Benefits

This section of your booklet describes dental benefits available to you and your participating eligible dependents.

The Great Neck Teachers Association Benefit Trust Fund provides Comprehensive Dental Expense Benefits. This benefit is self-insured and is administered by a third party administrator. Comprehensive Dental Expense Benefits are available to purchase for you and your eligible participating dependents.

How Comprehensive Dental Expense Benefits Work

Comprehensive Dental Expense Benefits provide scheduled reimbursement for expenses you have for preventive, basic and major non-orthodontic dental services with no deductible requirement. Benefits are also provided for orthodontic services up to plan maximums.

Pre-Authorization

When a dentist's charges for a course of treatment involving any crown and bridgework, such dental services must be authorized by the Fund before treatment is provided. The covered member's or eligible dependent's dentist is required to submit x rays and a treatment plan to the Fund Office (Dickinson Group, LLC) for review by the Fund's Dental Consultant. The dentist may proceed to provide dental services as soon as the treatment plan has been authorized by the Fund. The Fund reserves the right to modify or deny claims involving crown and bridgework which have not been approved by the Fund before the beginning of treatment.

The Schedule of Benefits

Your Comprehensive Dental Expense Benefits program pays a set amount for covered expenses you incur for preventive, basic and major dental services up to a maximum benefit of $2,250 per calendar year for each covered person. There is no annual deductible for you or your dependents. The maximum amounts the plan will pay for specific services are given in the Schedule of Dental Benefits.

Reimbursement of Orthodontia

Orthodontic services are reimbursed according to a fee schedule up to a lifetime maximum of $4,005 per eligible person. A period of orthodontic treatment starts on the first day you or your dependent
incurs a covered expense for orthodontia and extends for a period of 24 consecutive months or less if the treatment is completed in less time. The orthodontic benefit is not included in the yearly dental maximum.

What Are Your Orthodontic Dental Benefits?

- Up to $125 for the initial work-up.
- Diagnosis and insertion of the initial appliance: once, up to $854.
- Up to $103 per active monthly visit with a maximum of 24 consecutive visits. If you or your dependent misses a monthly visit, the Fund will not reimburse for that month, but it will be counted toward the 24 consecutive months maximum.

Please note that the initial work-up and the initial appliance are reimbursed only once during a period of orthodontic treatment.

Dental Implants

- A lifetime maximum of up to $2,000 will be provided for dental implants per eligible person. This maximum will not be included in the yearly dental maximum.
- Reimbursement for dental implants will only be made under the following ADA procedure codes: 6010, 6040, and 6050.
- ADA codes 6053-6077 (crowns and abutments over implants) are included in the regular $2250.00 yearly dental maximum.

Charges for specialized techniques involving precision attachments, personalization or characterization and additional charge adjustments within six months from installation are not included as covered dental charges.

Alternate Benefit Provisions
When more than one dental service would provide suitable treatment, your benefits will be based on the treatment determined by the plan to be best suited to your condition by accepted standards of dental practice. If two services would each provide satisfactory results according to accepted standards of dental practice and one service is less expensive than the other, the Plan will reimburse up to the maximum allowance for the less expensive treatment.

Participating Dental Panel

A list of participating dentists is available from the Fund Office. All dentists have been checked for proper credentials before being invited to join the PPO. You may select any dentist from the list. All members and their dependents will be able to receive appointments during usual office hours without restrictions. Should you choose a provider not included on the Participating Dental Provider list the Fund will cover the amounts per service as listed on the Dental Fee Schedule. Any cost incurred over the amount listed will be the responsibility of the member.

EXCLUSIONS

Benefits will not be paid for charges for:
- treatment from anyone other than a licensed dentist or physician, except routine cleaning of teeth and fluoride application which is performed by a licensed dental hygienist under the direct supervision of, and billed by, a dentist or physician
- facings, veneers, or similar material placed on molar crowns or pontics
- services performed by a member of your or your spouse's immediate family
- services or supplies that are cosmetic in nature or directed toward a cosmetic end
- any service or supplies incurred, installed, or delivered before you or your dependents become eligible for benefits under this Plan
- replacing a lost, missing or stolen prosthetic appliance
- a broken appointment
- any services received from a medical department, clinic or any facility provided or furnished by your or your dependent's employer
- any service that is not necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending dentist
- services or supplies that do not meet accepted standards of dental practice including experimental services or supplies

- services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared
- any duplicate prosthetic appliance except as specifically provided
- completing claim forms
- oral hygiene, or dietary instruction or plaque control programs
- wiring or bonding teeth or crowns to act as a splint for any reason
- an injury arising from employment
- illness covered by Workers' Compensation
- services or supplies for which you are not required to pay
- expenses incurred outside of the United States or Canada unless you or your dependents are residents of one or the other and the charges are incurred while traveling on business or for pleasure
- appliances, restorations, or any procedure to alter vertical dimension or restore occlusion
- services or supplies not specifically listed under covered expenses
- full mouth debridement

Extension of Dental Benefits

If your dental coverage terminates, benefits will be extended for expenses you have for dentures, fixed bridgework, crowns and inlays, or endodontic treatment, including root canal therapy, if:

- treatment was begun before coverage ended
- appliances, where appropriate, were ordered before coverage ended, and
- treatment is completed within 60 days after the date your coverage ends.