MOUNT PLEASANT TEACHERS ASSOCIATION BENEFIT FUND

ELIGIBILITY

The term "Participant" used in this descriptive booklet means:

A. Any Employee for whom contributions are made to the Mount Pleasant Teachers Association Benefit Fund pursuant to any collective bargaining agreement, individual contract of employment or School Board policy.

B. The eligible Employee's lawful spouse.

C. The eligible Employee's dependents:

(1) Unmarried child who has attained the age of two weeks but has not attained the age of 19 years.
(2) Unmarried child who is a full time student at an accredited institution of higher learning and has not attained the age of 25 years. Full-time student is defined as carrying at least 12 credits.
(3) Termination of coverage for a post-secondary student not returning to school is 30 days from the last day of enrollment.
(4) Unmarried child who was handicapped before the age of nineteen years, and is dependent upon his parent or legal guardian for support. The Plan may require written proof of such dependence.

EFFECTIVE DATE OF COVERAGE

Coverage under this Plan becomes effective the first date of the month following the first month of employment. The one year waiting period on certain defined procedures is calculated from the date you are employed.

DENTAL PLAN

DESCRIPTION OF PLAN BENEFITS

The following benefits are payable, subject to the other provisions and limitations of the Plan, for "Covered Dental Services."

A. Amount of Benefits

When an eligible participant and his/her lawful dependents have incurred covered dental charges for services, supplies or treatment furnished, the Fund will pay an amount of benefits up to 100% of the scheduled allowance for the employee and 80% of the scheduled allowance for dependents.

B. Maximum Benefits

Benefits payable to an eligible participant and dependents in any Plan year are limited. **Please see the Schedule of Benefits for the current maximum amount.**

C. New members have a one year waiting period for the following:

(1) Bridge and Crowns;
(2) Orthodontia;
(3) Periodontal (Osseous) Surgery
(4) Dentures

BENEFIT DETERMINATION

The Plan covers treatment performed while covered. Treatment will be considered to have been performed for the listed procedure as follows:

A. Dentures, full or partial – when impression is taken for the appliance.

B. Fixed bridgework, crowns and gold restorations – when the tooth is first prepared.

C. Root canal therapy – when tooth is opened.

D. Orthodontics – when the first appliance is installed.

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LIMITATIONS AND EXCLUSIONS APPLICABLE TO DENTAL PLAN

"Covered Dental Charges" shall in no event be deemed to include expenses incurred for the service, supplies or treatment:

A. Unless such services, supplies or treatment were prescribed as necessary by a dentist or physician.

B. In a Veteran's Administration Hospital, or which in the absence of coverage, would have been furnished without cost, or are furnished under conditions where the covered individual has no legal obligations to pay, or if the expenses are reimbursable by a local or other governmental agency.

C. Covered under any group program or union, employer or association program to the extent that more than 100% recovery by the participant would be made for any charges for which benefits are provided hereunder.

D. Covered under the U.S. Social Security Act (Title XVIII) as amended from time to time.

E. If they were incurred on account of:

   (1) war, declared or undeclared, included armed aggression;
   (2) Services, supplies or treatment received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group;
   (3) Loss or theft of dentures or bridgework;
   (4) Dentistry for cosmetic purposes, inclusive of orthodontia, including alteration or extraction and replacement of sound teeth for the purpose of changing appearance;
   (5) Bodily injury arising out of and in the course of employment by any employer, or disease or defect with respect to which benefits are payable under any Workmen's Compensation or Occupational Disease Act or Law.

F. There are time restrictions indicated in the plan document for certain procedures. All members are expected to adhere to these time restrictions.

G. Crowning of teeth for periodontal support is not covered.

H. Temporary services are not covered expenses.

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SUBMISSION OF PRE-TREATMENT ESTIMATES

A treatment plan, with respect to a course of services or treatment, that is expected to exceed $500.00 (as of July 1, 2002) in cost must be submitted to the Plan within 20 days following the examination which reveals the need for such services or treatment. Such Treatment Plan MUST include appropriate x-rays, a description of services to be furnished, as well as an explanation of the need for such services or treatment. The Pre-Treatment estimate shall be submitted on official claim forms. With the exception of emergency work, failure to obtain **pre-approval** could result in non-payment of claim if need cannot be clearly established.

COVERED DENTAL SERVICES

The Plan covers the following services and supplies, for which a charge is made by a dentist or physician, that are required in connection with the dental care and treatment of any disease, defect or accidental bodily injury.

A. Preventative Treatment

(1) Cleaning of teeth (prophylaxis) is covered twice during each plan year. If a periodontal scaling and a Prophylaxis are performed on the same date, the plan will only pay for the scaling. Additionally, the plan will not cover a prophylaxis within 30 days of a full-month periodontal scaling.

(2) A fluoride treatment will be covered twice each plan year for children up to age 19.

(3) Space maintainers for children only.

B. Emergency Treatment

Emergency visits are covered by the Plan even if no actual dental treatment is provided during the same day. No more than two (2) emergency treatments will be covered in any one plan year.

C. Diagnostic Services

The Plan covers oral examinations, x-rays and laboratory tests that may be necessary to diagnose a specific symptom.

The Plan will cover no more than four (4) x-rays for any one oral examination. However, a full mouth x-ray of all teeth taken as part of a general examination is covered once in a three year period. Allowances for films or other procedures covered by the Plan include the charge for examination and diagnosis. Oral exams are covered twice per plan year.

D. Anesthetics

A separate charge for general anesthesia is only covered in conjunction with partial and full bone extraction, osseous surgery, fractures or dislocation. A charge for local anesthesia is not covered as it is included within the normal charge for the treatment for which the local is given.

E. Drugs

The Plan covers charges for injectable antibiotics administered by a dentist or physician.

F. Extractions and Oral Surgery

The Plan covers all extractions and/or other necessary oral surgery, including fractures and dislocations. Allowances for extractions and oral surgery procedures include routine post-operative care. The Plan covers oral surgery related to the excision of tumors and/or cysts, which are located on the teeth, gum tissue and the alveolus surrounding the teeth. Claims for extraction of wisdom teeth must be accompanied by x-rays of the area in question.

G. Fillings

The Plan covers fillings that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury. This includes all silver (amalgam) and composite fillings. Fillings involving the same surfaces are not covered within two (2) years of date of service. **The Plan will not waive time restriction for any reason.**

H. Crowns/Onlays and Inlays

Crowns that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury and cannot be reconstructed by a filling or other material are covered. This includes gold, porcelain and plastic restorations. Gold onlays and inlays are also covered if the tooth cannot be reconstructed by a filling of other material. Crowning of teeth for periodontal support is not covered. Replacement crowns and onlays or inlays are not covered within (5) years of prior placement. **The Plan will not waive time restriction for any reason.**

NOTE: New members are not covered for crowns for one year.

I. Treatment of Gum Diseases – Periodontics

The Plan covers necessary periodontic treatment of the gums and supporting structure of the teeth. The plan will pay for two (2) periodontal scalings per year. Periodontal maintenance and perio-prophy will be counted as preventive care, which is covered twice per year. The Plan will only pay for periodontic maintenance where the individual has been involved with procedures of periodontal curettage or osseous surgery. (See Preventive Treatment, page 4.)

In the event that the Plan is billed for full-mouth periodontal scaling, full-mouth periodontal curettage and full-mouth periodontal osseous surgery, the plan will not pay for periodontal curettage.

Major periodontal work must be pre-approved with supporting x-rays and charting. Osseous surgery will not be covered within five (5) years of the last treatment. **The Plan will not waive time restrictions for any reason.**

NOTE: New members are not covered for perio-surgery for one year.

J. Root Canal Therapy

The Plan covers root canal and other endodontic treatment. All services provided that are normally associated with root canal therapy are included in the scheduled fee.

K. Orthodontics

There is a maximum life-time orthodontic benefit. **Please see the Schedule of Benefits for the current maximum amount and method of payment.**

Adult orthodontia is covered if one of the following conditions exist:

(1) extreme bucca-lingual version of teeth, either unilateral or bilateral;
(2) a protrusion of maxillary teeth of more than 4 mm.;
(3) a protrusive relation of the maxillary or mandibular arch of at least one cusp;
(4) an arch length discrepancy of 4 or more mm.

Payment will be made for active monthly treatment only. Retainers are considered part of the total treatment plan, and therefore are not a separate expense.

Effective July 1, 2018 - For special appliances like Invisalign, we will make an allowance for comparable standard treatment and the patient is responsible for any additional fee. On claims, submit the total fee and you will be reimbursed on a prorated basis over the term of treatment and post treatment visits. The total amount reimbursed is limited to the plan maximum for orthodontic coverage.

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NOTE: New members are not covered for orthodontics for one year.

If a new member's dependent child is already in orthodontic treatment on The date they become eligible for orthodontic coverage, the following formula will apply. Twenty-four (24) months will be considered a full case. The Plan will subtract the number of months already in treatment from 24 and pay the maintenance allowance for the remaining months.

L. Prosthetics

The Plan covers prosthetic appliances (full denture, partial removable or fixed bridgework). The Plan will not cover the initial placement of appliances involving teeth extracted prior to coverage. However, the Plan will cover dentures or fixed bridges that replace an existing appliance even if the teeth are not extracted while covered, if the prior appliance is more than (5) years old and cannot be made satisfactory. Where teeth are being replaced within the same arch, but not within the same quadrant, an allowance for a partial will be made and not for fixing bridgework. The Plan also includes benefits for repairing damaged dentures or adding teeth to existing dentures or rebasing the denture. If the Plan pays for a new denture, it will not also cover the repair or rebasing of an old denture. Relines are not covered within the first six (6) months from the date of placement, and are not covered more often than once per plan year. The Plan does not cover precision or semi-precision attachments. The plan will not cover replacement of prosthetic appliances in less than (5) years for any reason. **The plan will not waive time restrictions for any reason.**

NOTE: New members are not covered for prosthetics for one year.

M. Implants

Implants are a covered service as long as the tooth which is being replaced was extracted while the member was covered under this plan.

DEFINITIONS

A. DENTIST – The term "dentist" shall be deemed to mean a Doctor of Dental Surgery or Doctor of medical Dentistry.

B. DENTAL SERVICE – The term "dental service" means any service listed in The Schedule of Covered Dental Services when by or under the direction of a licensed dentist.

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C. COVERED DENTAL EXPENSE – means the expense actually incurred for charges made by a dentist for the performance of a dental service when such service is essential for the necessary care of the teeth.

D. PLAN YEAR – July 1st through June 30th.

HOW TO FILE A CLAIM

(1) Request an official claim form from your trustees.
(2) Complete the "Patient" statement in full. (If all questions are not answered it may be necessary to return the claim form, which will delay benefit payment.)
(3) Have your dentist complete his portion of the claim form.
(4) Send to:

Mt. Pleasant Teachers Association
Benefit Fund
C/O Zenith American.
P.O. Box 5817
Wallingford, CT 06492

NOTE: Send all claim forms promptly. Claim forms must be fully completed by all parties called for and submitted within 90 days from the close of the plan year. Improperly completed forms will cause a delay in the payment of a claim.

Proper consideration can only be given to a claim when the completed form is received.

All claim inquiries should be directed to Zenith American. Office hours are 8:00 a.m. to 4:30 p.m. Telephone: (800) 827-1703, FAX: (203) 284-8656.

COMMON CLAIM PROBLEMS

A. Incomplete information regarding whether you or your spouse has other Group insurance coverage, and if so, name or group, name of insurance company, address, policy number, etc.

If there is other group coverage, send a copy of the benefit payment record furnished by the other plan.

B. Incomplete information regarding dates of birth or age.

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CLAIM PROCESSING

Examination – The Trust, at its own expense, shall have the right and opportunity to examine any member information as often as it may reasonably require during the review and processing of the claim.

VISION BENEFIT PROGRAM

COVERED SERVICES

Eye Examination – Check of principal visual functions, ability and condition of vision. If a medical diagnosis exists, the claim should be filed with your medical carrier.

Glasses/Contact Lenses are covered if a visual deficiency exists.

EXAMINATIONS & GLASSES/CONTACT LENSES

The Plan will allow a maximum benefit per individual to be used for an eye examination and glasses or contact lenses. **Please see the Schedule of Benefits for this maximum amount.**

The Plan will only pay amounts up to the actual charge and is not responsible for charges in excess of this schedule.

Eye examinations are covered **once per individual per plan year.**

Employees may receive **one pair of glasses and/or contacts** per plan year.
Dependents may receive **one pair of glasses and/or contacts** per plan year.

PARTICIPATING PROVIDER VISION PROGRAM

The Plan offers the services of a group of participating providers. By using one of these providers you and your eligible dependents will be able to receive a vision examination and glasses/contact lenses with either no out-of-pocket expense or very little. The program offers a selection of frames and lenses from which you may choose. If you decide not to use frames or lenses offered through this program, **you will have to pay the providers charge for the frames and lenses you chose.** However, the claim will be submitted to your vision plan and you will be reimbursed up to the plan's allowance.

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To utilize the participating provider program, you must identify yourself as a member of Mt. Pleasant Teachers Association when you make your appointment. Your Trustees and Insurance Programmers, Inc. have current lists of participating providers.

If you do not use a participating provider you must send the form, which can be obtained from your Trustees or Insurance Programmers, Inc., and submit it completed with your receipts. (Please keep copies of your receipts.) You will be reimbursed the amounts indicated on your Schedule of Benefits.

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GROUP LEGAL SERVICE PLAN

COVERAGE

The Plan covers the Plan member, spouse, children to the age of 19, living at home, or dependent children in school full-time and not gainfully employed to age 25. The Plan is limited to the practice of law in New York State. However, many services, including Wills for non-New York residents, may be provided free of charge. When out-of-office legal services are required under the Plan, such legal services are geographically limited to New York City, Westchester, Nassau, Putnam and Rockland Counties. Please direct specific coverage questions to the Plan attorneys.

INCLUDED SERVICES:

A. Consultation and Advice (in office or by phone)
   (1) Any personal matter
   (2) Any business matter

B. Simple Documentation Preparation or Review (personal non-business Matters), e.g.:
   (1) Loan Agreements
   (2) Contracts to buy or sell personal property, e.g.: automobile
   (3) Installment sale contracts, e.g.: to purchase household furnishings
   (4) Leases

C. Correspondence and Telephone Communications to Third Parties (personal non-business matters), e.g.:
   (1) Property damage claims, e.g.: automobile accidents
   (2) Consumer problems, e.g.: defective products or services
   (3) Negotiation of debt repayment obligation
   (4) Protection against improper debt collection practices
   (5) Landlord/Tenant problems

D. Purchase and sale of house, condominium or cooperative apartment (member's primary residence).

E. Simple Will for member and spouse.

F. Initial appearance at Criminal and Family Court (emergency night telephone number is provided below).

MATTERS NOT COVERED:

A. Anything not specifically included in Plan
B. Claims between members of the Plan
C. Claims against the Union, the School District or arising under the Collective Bargaining Agreement
D. Matters currently with another attorney
E. Unmeritorious or spite claims
F. Litigation before any Court or Administrative Tribunal

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NOTE: Court and filing fees or other disbursements are payable by the client.

The Legal Service Plan is offered through:

HAROLD, SALANT, STRASSFIELD & SPIELBERG
81 Main Street
White Plains, New York 10601
(914) 683-2500

Please consult the Schedule of Benefits for the REDUCED FIXED FEE SCHEDULE FOR NON-INCLUDED SERVICES.

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GENERAL PLAN INFORMATION

TERMINATION OF COVERAGE

Coverage will end on the earliest of the following events:

(1) Your employment ceases;
(2) You cease to be an eligible member or dependent;
(3) You stop making any payments required for your coverage;

or,

(4) The Plan terminates.

LEAVE OF ABSENCE

Any member of the Trust granted a leave of absence by the Board of Education after at least one year of continuous membership in the Trust, may maintain his/her membership through direct personal payment to the Trust. Payment will be required in full within 30 days of last day worked, and will be equal to the amount that would have been due from the Board of Education. In the event payment is not received within 30 days, membership will be terminated. If membership is not maintained the member, upon return, will be subject to all rules affecting new members. The Trust will carry a teacher on leave for a maximum of two years.

COBRA – EXTENSION OF BENEFITS

Under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) certain individuals are given the option of continuing their group health benefits under specified conditions.

You and your dependents are eligible to continue coverage for up to 18 months when termination is due to a reduction in your hours worked, or upon termination of your employment.

A member who (a) elects continuation coverage as the result of termination of employment and (b) is subsequently determined by Social Security to have been disabled

as of the date of termination is entitled to continue coverage for 29 months instead of 18 months.

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Your dependents are eligible to continue their coverage for up to 36 months upon the occurrence of the following events:

(1) The spouse and children upon the death of the covered employee.
(2) The spouse, upon divorce or legal separation from the employee;
(3) The spouse and children of Medicare-eligible employees, when the employee ceases to participate in the plan (dental and vision benefits are not covered by Medicare.)
(4) Dependent children when they cease to be a dependent child under the definition in the Plan.

Coverage cannot be continued beyond any of the following dates.

(1) The date on which the Trust ceases to provide any Plan to any Member.
(2) The date the premium is not paid by the individual.
(3) When the individual becomes covered by any other group health Plan, except if the other group health plan contains a preexisting condition limitation that applies to the person receiving continuation coverage, or when the individual is entitled to Medicare benefits.
(4) In the case of a spouse, when the spouse remarries and becomes covered under another group health plan, except if the other group health plan contains a preexisting condition limitation that applies to the person receiving continuation coverage.

If your coverage terminates, or is about to terminate, you will be provided with a Continuation of Coverage Election Form, which will enable you and your spouse to elect or reject continuation of group health coverage. You are responsible for providing us with current information as to your family status (i.e. separation, divorce or dependent ineligibility for coverage.)

Your election to continue coverage must be completed within 60 days after you receive this Continuation of Coverage Election Form, or your termination date, whichever occurs last. Benefits provided shall be identical to coverage provided for active full-time employees and their dependents who have coverage under the Plan but have not yet terminated their coverage. The cost to continue coverage is paid for by the individual. Within 180 days before the expiration of your continuation of coverage, you shall have a right to convert to a conversion policy if such a policy is part of the group health plan at the time of your termination and is being offered to other active full-time employees under the Plan.

For a complete description of COBRA and questions regarding your right to continue coverage after your termination date, please contact your Trustees or Plan Administrator.

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EXTENDED BENEFITS PROVISION

If a participant's eligibility for coverage under this Plan terminates, benefits are available for up to thirty (30) days following termination of eligibility but only to cover those dental services pre-approved before the termination date. All charges filed for will be applied to the Plan year maximum of the year termination took place.

COORDINATION OF BENEFITS PROVISION

Some individuals have coverage in addition to the benefits provided by this Plan. When this happens, the amount of benefits payable under this Plan will take into account any coverage a Participant has under "other plans" so the combined benefits under this Plan and the "other plans" will not exceed the total expenses involved. For purposes of coordinating benefits of multiple coverage, an "other plan" means any plan of benefits provided by:

A. group insurance or any other arrangement of coverage for individuals in a group which provides benefits or services on an insured or uninsured basis;
B. "no fault" automobile insurance which is required under any law and is provided on other than a group basis; or
C. plans provided by the U. S. Government, State Government or any instrumentalities thereof.

In coordinating the benefits for a Participant having multiple coverage, the "primary" plan pays first and the "secondary" plan pays next to make up the difference, but the total benefit paid by both the primary and the secondary plans will not exceed 100% of the allowable expenses incurred. In addition, no plan will pay more benefits than it would normally provide without this special coordinating provision. In determining which plan is primary and which is secondary, the following order will be used:

A. A Plan without coordination of benefits provision will always be the primary plan; and

B. If all plans have a coordination of benefits provision then:
   (1) The plan covering the participant as an employee is primary;
   (2) The plan covering the participant as a dependent spouse is secondary;

(3) With respect to dependent children, the plan that covers a person as a dependent of an employee whose month and day of birth occur earlier in the calendar year will be considered primary

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****** WHEN SUBMITTING CLAIMS FOR MEMBERS OF THE FAMILY WHO ARE PRIMARY THROUGH ANOTHER CARRIER AND SECONDARY TO THE PARTICIPANT'S PLAN, A COPY OF THE PRIMARY PLAN'S PAYMENT MUST ACCOMPANY THE CLAIM.**

GENERAL INFORMATION CONCERNING PLAN COVERAGE

The Benefits provided by this Plan are for reimbursement of incurred expenses, and payment by the Plan will be made only for those costs actually incurred and paid for by the eligible Participant. Reimbursement will not be made for any amounts for which the Participant is not legally liable in the absence of coverage by this Plan.

This booklet describes the main features of the Plan. The benefits provided may be changed by the Board of Trustees. All provisions of the Plan are subject to such rules and regulations adopted by the Trustees.

PRE-CERTIFICATION/APPEALS

In the event a part or all of a claim is denied due to the enforcement of the Plan document, you may appeal to the Trustees. If an appeal is not made prior to the work being completed on a pre-certified claim, the appeal will not be honored. All appeals must be in writing and directed to our Plan Administrator. Please provide all information needed to support your appeal. The letter should be sent to our administrator so that it can be presented at the next scheduled meeting of the Trust. Appeals must be received no later than 60 days after you receive the determination in question.

RIGHT OF RECOVERY

A. Whenever we have made payments for Covered Services in excess of the maximum amount of payment necessary at the time to satisfy the intent of this provision, irrespective of to whom paid, we have the right to recover the excess payment from one or more of the following: any person to or for who such payments were made, any insurance companies or any other organization.

B. You, personally and on behalf of your enrolled family members will, upon request, execute and deliver such documents as may be required and to

recover excess payments. Your failure to comply will result in a withdrawal of benefits already provided or a denial of benefits requested.