FALLSBURG TEACHERS ASSOCIATION TRUST

Description of Dental Benefits

IMPORTANT INFORMATION

This is not an insured benefit plan. The benefits described in this booklet or any rider attached hereto are self-insured by the company which is responsible for their payment. Meridian Administrators Corp provides claims administration services to the plan, but Meridian Administrators Corp does not insure the benefits described. Because the plan is not insured by Meridian Administrators Corp, all references to insurance shall be read to indicate that the plan is self-insured. For example, references to "Meridian Administrators Corp" and Policyholder" shall be deemed to mean your "Employer". "Policy" to mean "Plan" and "Insured" to mean "Covered" and "Insurance" shall be deemed to mean “Coverage”.

July 2016

TABLE OF CONTENTS

VISION REIMBURSEMENT

In conjunction with the dental plan, members are eligible for the following reimbursement for vision services:

Active employees: Reimbursement of $200.00 every two years

Retired employees: Reimbursement of $100.00 every two years

THE SCHEDULE DENTAL BENEFITS FOR YOU AND YOUR DEPENDENTS
Indemnity Plan

How your dental plan works

CLASS Preventive Care	Plan pays 100%
CLASS II Basic Restorative	Plan pays 85%
CLASS III Major Restorative	Plan pays 50%
Class IV Orthodontia	Plan pays 50%

PLAN YEAR MAXIMUM OF **$1,500.00** PER INDIVIDUAL

CLASS IV LIFE TIME MAXIMUM OF **$1,250.00**

HOW TO FILE YOUR CLAIM

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to**: Meridian Administrators Corp, 1050 University Ave Suite A, Rochester, New York 14607.**

DENTAL EXPENSES

The first dental claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

ELIGIBILITY- EFFECTIVE DATE

ELIGIBILITY FOR EMPLOYEE INSURANCE

You will become eligible for insurance on the day you complete the waiting period if you:

• Are a permanent full-time employee and

• Normally work at least 30 hours per week

ELIGIBILITY FOR DEPENDENT INSURANCE

You will become eligible for Dependent Insurance on the later of:

• The day you become eligible yourself, or

• The day you acquire your first dependent

DENTAL BENEFITS

COVERED EXPENSES

The term covered expenses means expenses incurred by or on behalf of you or anyone of your dependents for charges made by a dentist for the performance of a dental service listed in the Dental Services Schedule.

Covered expenses will include only those expenses incurred for such charges when the dental service is:

• Performed by or under the direction of a dentist;

• Essential for the necessary care of the teeth; and starts and is completed while the person is insured.

Any portion of charges for a dental service that exceeds the covered expense shown for that service in the dental services schedule is not included in the reasonable and customary charges for the dental service in your area.

A dental service is deemed to start when the actual performance of the service starts except for the following:

• Fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared.

• A crown, inlay or onlay, it starts on the first date of the participation of the tooth involved.

• Root canal therapy; it starts when the pulp chamber of the tooth is opened.

ALTERNATE BENEFIT PROVISIONS

When more than one dental service could provide suitable treatment based on common dental standards, Meridian Administrators Corp will determine the dental service on which payment will be based and the expenses that will be included as covered expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your dentist are free to apply this benefit payment to the treatment of your choice, however you are responsible for the expenses incurred which exceed covered expenses, for this reason, Meridian Administrators Corp strongly recommends the use of predetermination of benefits when major dental services are needed, so that you and your dentist know in advance what the benefit plan will cover before any treatment begins.

PREDETERMINATION OF BENEFITS

The term “Predetermination of Benefits” means a review by Meridian Administrators Corp of the Dentist's description of planned treatment and expected charges. This review should be made whenever extensive dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to the Meridian Administrators Corp.

When there has not been a predetermination of benefits, Meridian Administrators Corp will determine the expenses that will be included as covered expenses at the time the claim is received.

Predetermination of Benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any for which a person qualifies at the time services are completed.

DENTAL SERVICES SCHEDULE

Covered Dental Expenses will include expenses incurred for Dental Services listed in this schedule. Meridian Administrators Corp may agree to accept, as covered dental expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/ or by description and submitted to Meridian Administrators Corp. Meridian Administrators Corp will determine the Maximum Covered Expense for services that it accepts. The Maximum Covered Expense so determined will be consistent with the maximums listed.

CLASS I SERVICES - DIAGNOSTIC AND PREVENTATIVE	
Clinical Oral Examination	Only two per person per calendar year
Palliative (emergency)	Treatment of dental pain, minor procedures, when no other definitive Dental Services are performed (Any X-Ray taken in connection with such treatment is a separate Dental service)
Prophylaxis (cleaning)	Only two per person per calendar year
Topical Application of Fluoride (excluding Prophylaxis)	Limited to persons less than 19 years old. Only one per person, per calendar year.
Topical Application of Sealant (per tooth)	On a posterior tooth for a person less than 14 Years old- only one treatment per tooth in Any three calendar years.
Space Maintainers	Fixed Unilateral, limited to non-orthodontic treatment.

CLASS II SERVICES - BASIC RESTORATIONS, ENDODONTICS, PERIODONTICS, PROSTHODONTIC MAINTENANCE AND ORAL SURGERY	
X-Rays (complete series)	Only one per person, including panoramic Film, in any 3 calendar years.
Bitewing X-Rays	Only two charges per person, per calendar year
Panoramic X-Ray	Only one per person, per 3 calendar years.
Amalgam Filling	Primary (baby) teeth, one surface.
Amalgam Filling	Permanent teeth, one Surface
Composite/Resin Filling	One Surface
Root Canal Therapy	Any X-Ray, test, laboratory exam, or follow-up care is part of the allowance for root canal therapy and not a separate dental service
Osseous Surgery	Flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate dental service.
Periodontal Maintenance Procedures (following active therapy)	Periodontal Prophylaxis
Periodontal Scaling and Root Planning	Entire mouth

Simple Extractions	Surgical removal of erupted tooth requiring Elevation of Mucoperiosteal flap and removal of bone and/or section of tooth. Removal of impacted tooth, soft tissue. Removal of impacted tooth, partially bony. Removal of impacted tooth, completely bony.
Local Anesthetic	Analgesic and routine post-operative care for Extractions and other oral surgery are part of the allowance for each Dental Service.
General Anesthesia	The administration of general anesthetic is a Dental service covered in conjunction by this schedule only: a) when medically necessary in conjunction with oral or dental surgery; b) if the anesthetic agent produces a state of unconsciousness with absence of pain sensation over the whole body.

CLASS III SERVICES - MAJOR RESTORATIONS, DENTURES AND BRIDGEWORK

Bridgework	High Noble Metal (gold) or Crown restoration are Dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate or plastic restoration
Replacement Bridge	
Crowns	Porcelain fused to High Noble Metal Full Cast, High Noble Metal
Dentures	Fixed or Removable Appliance Complete (full) dentures, upper or lower Lower, Cast Metal Base with Resin saddles (including any conventional clasps, rests and teeth). Upper, Cast Metal Base with Resin saddles (including any conventional clasps, rests and teeth) Bridge Pontics - Cast High Noble Metal Bridge Pontics - Porcelain fused to High Noble Metal Bridge Pontics - Resin with High Noble Metal Abutment Crowns - Resin with High Noble Metal Abutment Crowns - Porcelain fused to High Noble Metal Abutment Crowns - Resin with High Noble Metal Complete or Partial - Any adjustment or repair to a denture Within 6 months of its installation is not a separate Dental Service.
Implants	A surgical implant of any type including any prosthetic device attached to it.

CLASS IV SERVICES ORTHODONTIA - Orthodontics Diagnostics

Appliance Therapy	(Braces) Including related oral exams, surgery and extractions.

EXPENSES NOT COVERED

Covered Expenses will not include, and no payment will be made for expenses incurred for:

• Service performed solely for cosmetic reasons.

• Replacement of a lost or stolen appliance.

• Replacement of a bridge, crown or denture within five years after the date it was originally installed unless:

a) such replacement is made necessary by the placement of an original opposing denture or the necessary extraction of natural teeth

b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.

• Any replacement of a bridge, crown or denture which can be made usable according to common dental standards.

• Procedures, appliances or restorations (except full dentures) whose main purpose is to a) change vertical dimension; b) diagnose or treat conditions or dysfunction of the temporomandibular joint; c) stabilize periodontally involved teeth; or d) restore occlusion.

• Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars.

• Bite registrations; precision or semi-precision attachments; or splinting.

• Instruction for plaque control, oral hygiene and diet.

• Dental services that do not meet common dental standards.

• Services that are deemed to be medical services.

• Services and supplies received from a hospital.

• Services for which benefits are not payable according to the "General Limitations" sections.

GENERAL LIMITATIONS

No payment will be made for expenses incurred by you or any one of your dependents for or in connection with:

- An injury arising out of, or in the course of, any employment for wage or profit.
- A sickness which is covered under any workers compensation or similar law.
- Charges made by a Hospital owned or operated by the United States Government; a) unless there is a legal obligation to pay such charges whether or not there is insurance; or b) such charges are directly related to a military service connected sickness or injury.
- Charges which the person is not legally required to pay.
- Charges for unnecessary care, treatment, or surgery.
- Experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society. Or to the extent that:
- Payment is unlawful where the person resides when the expenses are incurred.
- Charges are more than reasonable and customary.
- You or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

No payment will be made for expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory plan of any auto insurance policy written to comply with:

- A "no-fault" insurance law; or
- An uninsured motorist insurance law

COORDINATION OF BENEFITS

If you or any one of your dependents are covered under more than one plan, benefits payable from all such plans will be coordinated. Coordination of benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the allowable expenses incurred in that period, the sum of the following would exceed such allowable expenses:

• The benefits that would be payable from this Plan in the absence of coordination; and

•The benefits that would be payable from all other plans without coordination of benefits provisions in those plans.

The benefits that would be payable from this plan for allowable expenses incurred in any Claim Determination period, in the absence of coordination of benefits will be reduced to the extent required so that the sum of the following will not exceed the total of such allowable expenses:

• Those reduced benefits; and

• All the benefits payable for those allowable expenses from all other plans.

Benefits payable from all other plans include the benefits that would have been payable had the proper claim been made for them. However, the benefits under another plan will be ignored when the benefits of this plan are determined if a) the benefit determination rules would require this plan to determine its benefits before that plan; and b) the other plan has a provision that coordinates its benefits with those of this plan and would, based on its rules, determine its benefits after this plan.

Meridian Administrators Corp reserves the right to release to, or obtain from any other insurance company or other organization or person any information which, in its opinion, it needs for the purpose of coordination of benefits.

When payments which should have been made under this plan based on the terms of this section, have been made under any other plan, Meridian Administrators Corp will have the right to pay to any organization making these payments the amount it determines to be warranted.

Amounts paid in this manner will be considered to be benefits paid under this plan. Meridian Administrators Corp will be released from all liability under this plan to the extent of these payments. When an overpayment has been made by Meridian Administrators Corp at any time, it will have the right to recover that payment to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as it may determine.

PLAN
Plan means any of the following which provides medical or dental benefits or services: 1) group or blanket insurance coverage, other than blanket group school accident

policies; 2) service plan contracts, group or individual practice, or other prepayment plans; or 3) coverage under any labor-management trusted plans; union welfare plans; employer organization plans; or employee benefit organization plans. The plan does not include coverage under individual or family policies or contracts. Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan.

ALLOWABLE EXPENSE

Allowable Expense means any necessary, reasonable and customary item of expense at least a part of which is covered by any one of the plans that covers the person for whom the claim is made. When the benefits from the plan are in the form of services, not cash payments, the reasonable cash value of each service is both an allowable expense and a benefit paid.

CLAIM DETERMINATION PERIOD

Claim determination period means a plan year or that part of a plan year which the person has been covered under this plan.

BENEFIT DETERMINATION RULES

The rules below establish the order in which benefits will be determined:

1. The benefits of a plan which covers the person for whom claim is made, other than as a dependent, will be determined before a plan which covers that person as a dependent.

2. The benefits of a plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in the calendar year, will be determined before a plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: a) if the other plan does not have this rule, its alternate rule will govern; and b) in the case of a dependent child of divorced or separated parents, the rule of item (3) will apply.

3. If there is a court degree which established financial responsibility for medical, dental and other health care of the child, the benefits of the plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

a) The benefits of a plan which covers a child as a dependent of the parent with custody will be determined before a plan which covers the child as a dependent of a stepparent or a parent without custody.

b) The benefits of a plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of a parent without custody.

4. When the above rules do not establish an order, the benefits of the plan which has covered the person for whom a claim is made for the longer period of time will be determined before a plan which has covered the person for the shorter period of time; except that:

a) The benefits of a plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent

b) If the other plan does not have the rule in item (4a) which results in each plan determining its benefits after the other, then (4a) will not apply.

PAYMENT OF BENEFITS

TO WHOM PAYABLE
All dental benefits are payable to you. However, at the option of Meridian Administrators Corp with the consent of the policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of Meridian Administrators Corp is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Meridian Administrators Corp may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, Meridian Administrators Corp may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters, or to the executors or administrators of your estate.

Payments as described above will release Meridian Administrators Corp from all liability to the extent of any payment made.

TIME OF PAYMENT
Benefits will be paid by Meridian Administrators Corp when it receives due proof of loss.

RECOVERY OF OVERPAYMENT
When an overpayment has been made by Meridian Administrators Corp, Meridian Administrators Corp will have the right at any time to: a) recover that overpayment from the person to whom amount of that overpayment was made from a future claim, or on whose behalf it was made; or b) offset the amount of that overpayment from a future claim.

TERMINATION OF INSURANCE- EMPLOYEES

Your insurance will cease on the earliest data below:

• The date you cease to be in a class of eligible employees or to qualify for the insurance.

• The last day for which you have made any required contribution for the insurance.

• The date the policy is canceled.

• The date your active service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

TEMPORARY LAYOFF OR LEAVE OF ABSENCE
If your active service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your active service ends.

INJURY OR SICKNESS
If your active service ends due to an injury or sickness, your insurance will be continued while you remain totally and continuously disabled as a result of injury or sickness. However, your insurance will not continue past the date your employer stops paying premium for you or otherwise cancels the insurance.

TERMINATION OF INSURANCE- DEPENDENTS
Your insurance for all dependents will cease on the earliest date below:

• The date your insurance ceases

• The date you cease to be eligible for dependent insurance.

• The last day for which you have, made any required contribution for the insurance

• The date dependent insurance is canceled.

The insurance for any one of your dependents will cease on the date that dependent no longer qualifies as a dependent.

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS

The continuation required by federal law does not apply to any benefits for loss of life, dismemberment, or loss of income.

Federal law enables you or your dependents to continue health insurance if coverage would cease due to a reduction in your work hours or your termination of employment (other than gross misconduct). Federal law also enables your dependents to continue insurance if their coverage ceases due to your death, divorce, or legal separation, or with respect to a dependent child, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your employer's group plan and is subject to federal law, regulation and interpretations.

EMPLOYEES AND DEPENDENTS CONTINUATION PROVISION

If you and your dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment, other than gross misconduct, you or your dependent may continue health insurance upon payment of the required premium to the employer. You and your dependents must elect to continue insurance within 60 days from the later of: a) the date of a reduction of your work hours or your termination of employment: or b) the date notice of the right to continue insurance is sent. Such insurance will not be continued by Meridian Administrators Corp for you and/or your dependents, as applicable, beyond the earliest of the following dates:

- 36 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- The date the policy cancels;
- The date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- The date your dependent ceases to qualify as an eligible dependent.
- The date you become entitled to Medicare, following your enrollment for Medicare.
- The effective date of coverage under another group plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

  If after you have continued your dependent's coverage due to your loss of employment or reduction in work hours, your dependent would lose coverage because you became entitled to (enrolled in) Medicare, your dependent may continue coverage for up to 36 hours from the date you became entitled to Medicare.

DISABLED INDIVIDUALS CONTINUATION PROVISIONS

If you or your dependent is disabled on the date of the termination of the employment or a reduction in work hours you may continue insurance for up to an additional11 months beyond the 18 months period.

To be eligible you or your dependent must:

- Be declared disabled under Title II or XVI by the Social Security Administration; and
- Notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial18 months continuation period, and provide the plan administrator with a copy of the determination.

Termination of coverage during a 29 month period will occur if you or your dependents are found by the Social Security Administration to be no longer disabled. Termination will occur on the first day of the month beginning more than 30 days after the date of the final determination all reasons for termination which apply to the initial18 months will also apply for an additional months of coverage.

INTERACTION WITH OTHER CONTINUATION OF BENEFITS

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of 1) the continuations required by federal law; or 2) any other continuation of insurance provided in this certificate.

NEWLY ACQUIRED DEPENDENTS

If, while your insurance is being continued under the continuation required by federal law provisions, and you acquire a new dependent, such dependent will be eligible for this continuation provided:

- The required premium is paid; and
- Meridian Administrators Corp is notified of your newly acquired dependent in accordance with the terms of the policy.

However, such newly acquired dependents will not be entitled to continue their insurance if items, (1), (2), (3), or (4) in the Dependent Continuation Provision section should subsequently occur.

DENTAL BENEFIT EXCLUSIONS

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- For a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay, or onlay installed within 3 calendar months after his insurance ceases.
- For root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

DEFINITIONS

ACTIVE SERVICE

You will be considered in Active Service:

- On any of your employer's scheduled work days if you are performing the regular duties of your work on a full time basis on that day either at your employer's place of business or at some location to which you are required to ravel for your employer's business

- On a day which is not one of your employer's work days if you were in active service on the preceding scheduled work day.

COINSURANCE

The term coinsurance means the percentage of charges for covered expenses that an insured person is required to pay under the plan.

DENTIST

The term dentist means any person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the dental services described in the policy.

DEPENDENTS

Dependents are:

- Your lawful spouse; and

- Any unmarried child of yours who is

- Less than 19 years old;

- 19 years but less than 25 years old enrolled in school as a fulltime student and primarily supported by you;

- 19 or more years old and primarily supported by you and incapable of self- sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Meridian Administrators Corp may, from time to time, require proof of the continuation of such condition and dependence. After that Meridian Administrators Corp may require proof no more than once a year.

  A child includes a legally adopted child from the start of any waiting period prior to the finalization of the child’s adoption. It also includes a stepchild who lives with you.

  Anyone who is eligible as an Employee will not be considered a dependent.

  No one may be considered as a dependent of more than one employee.

EMPLOYEE
The term employee means a full- time employee of the employer. The term does not include employees who are part-time or temporary or who normally work less 30 hours a week for the employer.

EMPLOYER
The term employer means a policyholder and all affiliated employers.

MEDICAID
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

REASONABLE AND CUSTOMARY CHARGE
A charge will be considered reasonable and customary if:
- It is the normal charge made by the provider for a similar service or supply; and
- It does not exceed the normal charge made by most providers of such service or supply in the geographical are where the service is received, as determined by Meridian Administrators Corp.

To determine if a charge is reasonable and customary, the nature and severity of the injury or sickness being treated will be considered.

HIPPA STATEMENT

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, and its implementing regulation, the Standards for Privacy of Individually Identifiable Health Information, 6a5 Fed. Reg. 82,462, et seq. (December 28, 2000) (hereinafter the "HIPPA Privacy Rule", Fallsburg Schools ("Covered Entity") and Meridian Administrators Corp ("Business Associate") (jointly "the Parties") have entered into an Agreement that addresses the requirements of the HIPAA Privacy Rule with respect to “Business Associates”, as that term is defined in the HIPAA Privacy Rule.

Specifically, this Agreement is intended to ensure that "Business Associates" (such as Meridian Administrators Corp) will establish and implement appropriate safeguards (including certain administrative requirements) for "Protected Health Information" the "Business Associate" may create, receive, use or disclose in connection with certain functions, activities, or services (collectively "services") to be provided by "Business Associate" to covered entity. The services to be provided by "Business Associate" are identified in a separate agreement between the Parties.

The Parties acknowledge and agree that in connection with the services provided, "Business Associate" will create, receive, use or disclose Protected Health Information. As set forth in the HIPAA Privacy Rule and as used herein, Protected Health Information ("PHI") is defined as individually identifiable health information maintained or transmitted in any form or medium including, without limitation, all information (including demographic, medical and financial information) date, documentation and materials that relate to: (i) the past, present or future physical or mental health condition of an individual; (ii) the provision of health care to an individual; or (iii) the past, present or future payment for the provision of health care to an individual. "PHI" does not include health information that has been de-identified in accordance with the standards for de-identification provided for in the HIPAA Privacy Rule.

Fallsburg Central School District
PO Box 124, 115 Brickman Road
Fallsburg, NY 12733
(845) 434-6800
FAX: (845) 434-0418
Website: www.fallsburgcsd.net