

**Baldwinsville Central School District Group Dental Plan  
Dental Plan Option 2**

**Amended and Restated Effective: September 1, 2020**

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## INTRODUCTION

Baldwinsville Central School District (the “Employer” or “Plan Sponsor”) has adopted the Baldwinsville Central School District Group Dental Plan - Dental Plan Option 2 (the “Plan”), as amended and restated, effective as of September 1, 2020 (the “Effective Date”).

This document serves as both the written Plan document and the Summary Plan Description (SPD). This Plan document and SPD amends and replaces any prior statement of healthcare coverage contained in the Plan or any predecessor to the Plan. You should carefully review this document for a complete understanding of the benefits available to you, as well as your responsibilities under the Plan. The Plan Sponsor has adopted this Plan for the exclusive benefit of its Employees, Retirees, and their eligible Dependents, on the terms and conditions set forth herein. The Plan helps to provide financial security for you and your family by offsetting some of the financial costs that may arise as a result of an illness or injury. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any applicable collective bargaining agreement, as well as a list of Participating Employers, may be obtained, upon request and free of charge, by contacting the Plan Administrator during normal business hours.

The Plan is not a contract of employment between you and the Employer and does not give you the right to be retained in the service of your Employer. The Plan Sponsor has the general right to amend or terminate the Plan, in whole or in part, at any time, subject to the terms and conditions of any relevant collective bargaining agreements.

## DENTAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT (Subject to the Allowed Amount) You Pay
<b>CALENDAR YEAR DEDUCTIBLE</b>	None
<b>DENTAL BENEFITS</b>	
Class I – Preventive and diagnostic services	0% Coinsurance
Class II – Basic services	20% Coinsurance
Class III – Major restorative services	40% Coinsurance
Class IV – Orthodontics	50% Coinsurance
Orthodontic coverage under the Plan is limited to Covered Persons.	
<b>CLASS I, II, AND III COMBINED CALENDAR YEAR MAXIMUM BENEFIT</b>	\$1,250 per Covered Person
<b>CLASS IV – ORTHODONTIA LIFETIME MAXIMUM</b>	\$1,500 per Covered Person
<b>Timely Filing for Claims</b>	180 days from date of Service

***You may be Balance Billed for any charges that exceed the Allowed Amount. The dental benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered by your Employer. You have a separate right to enroll in the dental benefits under this Plan.***

## DEFINITIONS

*The terms defined in this section have been capitalized throughout this document.*

**Allowed Amount.** The Allowed Amount means the maximum amount the Plan will pay to a Health Care Professional for the services or supplies Covered under the Plan, before any applicable Deductible, Copayments and Coinsurance amounts are subtracted. The Allowed Amount for Participating Providers will be the amount the Plan has negotiated with Participating Providers, or the Participating Provider's charge, if less. The Allowed Amount for Non-Participating Providers for services or supplies inside the Service Area or outside the Service Area is based on the 50<sup>th</sup> percentile of the Claims Administrator's fee schedule or the Health Care Professional's actual charge, whichever is less.

**The Non-Participating Provider's actual charge may exceed the Allowed Amount. You must pay the difference between the Allowed Amount and the Non-Participating Provider's charge.**

**Balance Bill, or Balance Billing.** When a Non-Participating Provider bills you for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill you for Covered Services.

**Calendar Year.** The twelve-month period beginning on January 1 and ending on December 31 each year.

**Child.** Your biological Child, legally adopted Child (or a Child placed with you in anticipation of adoption), stepchild, a Child for whom you are a court-appointed legal guardian, and, a Child for whom you are required to provide coverage under the Plan pursuant to the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). Procedures for determining a QMCSO may be obtained from the Plan Administrator, upon request and free of charge.

For purposes of this section "a Child placed with you in anticipation of adoption" means a Child who is under the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the Child in anticipation of adoption of such Child.

**Claims Administrator.** Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield"), administers claims for benefits under the Plan on behalf of the Plan Sponsor and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association.

**COBRA.** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**COBRA Beneficiary.** A Covered Person who is entitled to and elects to continue health coverage under this Plan in accordance with Section 4980B of the Internal Revenue Code. The term will also include a Child who is born or placed for adoption, with the covered Employee during the period of COBRA coverage.

**Coinsurance.** Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that you are required to pay directly to a provider. The amount can vary by the type of Covered Service.

**Copayment.** A predetermined charge, expressed as a fixed amount, which you pay directly to a provider for a Covered Service at the time the service is rendered. The amount can vary by the type of Covered Service.

**Cost-Sharing.** Amounts you must pay for Covered Services, expressed as Coinsurance, Copayments and/or Deductibles.

**Covered Person.** A Covered Employee, Retiree and each of his or her Dependents Covered under the Plan.

**Cover, Covered or Covered Service(s).** The Medically Necessary items or services paid for, arranged, or authorized for a Covered Person under the terms and conditions of this Plan.

**Deductible.** The amount you owe before the Plan begins to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that you owe before the Plan begins to pay for a particular Covered Service. There are special Deductible rules that apply when you have other than individual coverage. See the Deductible provision of the Schedule of Benefits section of this Plan.

**Dependent.** See the Eligibility section of this Plan.

**Employee.** A common-law Employee of the Employer, as determined in accordance with the employment records of the Employer.

**Employer.** Baldwinsville Central School District or any successor thereto.

**FMLA.** The Family and Medical Leave Act of 1993, as may be amended from time to time.

**Genetic Information.** Information about an individual's genetic tests, the genetic tests of that individual's family members, the manifestation of disease or disorder in family members of the individual, an individual's request for, or receipts of, genetic services, or the participating in clinical research that includes genetic services by the individual or a family member of the individual, or Genetic Information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual, and the Genetic Information of any embryo legally held by the individual or family member using an assisted reproductive technology. Genetic Information will not be taken into

account for purposes of determining eligibility for benefits under the Plan or establishing premium or contribution amounts for coverage under the Plan.

**Health Care Professional.** An appropriately licensed, registered or certified dentist or optometrist; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law (or other comparable state law, if applicable) requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of provider in order to be Covered under this Plan.

**HIPAA.** The Health Insurance Portability and Accountability Act of 1996, as amended.

**Lifetime Maximum.** The maximum benefit payable during an individual's lifetime while Covered under this Plan. This Plan may provide for a Lifetime Maximum benefit for a specific type of Covered Service or treatment. Any Lifetime Maximum will be shown in the Schedule of Benefits section of this Plan.

**Medical Necessity or Medically Necessary.** Benefits are Covered as described in this Plan as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary (e.g., inlays/onlays or crowns). The fact that a provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that the Plan has to Cover it.

The Plan may base its decision on a review of:

- Your dental records;
- The dental policies and clinical guidelines of the Claims Administrator;
- Dental opinions of a professional society, peer review committee or other groups of physicians;
- Reports in peer-reviewed dental literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved;
- The opinion of the attending providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;

- They are not primarily for the convenience of you, your family, or your provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

See the Claim and Appeals Procedure section of this Plan for your right to appeal the Plan's determination that a service is not Medically Necessary.

**Medicare.** Title XVIII of the Social Security Act, as amended.

**Non-Participating Provider.** A Health Care Professional that does not have a contract with the Claims Administrator or its agent to provide dental services to you. You will pay higher Cost-Sharing to see a Non-Participating Provider as compared to a Participating Provider.

**Participating Provider.** A Health Care Professional who has a contract with the Claims Administrator to provide services to you. A list of Participating Providers and their locations is available at [www.excellusbcbs.com](http://www.excellusbcbs.com) or upon request by calling the customer service number located on your identification card. The list may be revised from time to time.

**Plan.** Baldwinsville Central School District Group Dental Plan – Dental Plan Option 2.

**Plan Administrator.** The Plan Administrator is the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator.

**Plan Sponsor.** Baldwinsville Central School District or any successor thereto.

**Plan Year.** The 12-month period beginning on September 1 and ending on August 31.

**Retiree.** A former Employee of the Employer who was Covered under the Plan as of the date of his or her retirement.

**Schedule of Benefits.** The section of this Plan that describes the Copayments, Deductibles, Coinsurance and other limits on Covered Services.

**Service Area.** The Service Area is the geographic area in which the Plan will provide benefits to a Covered Person. The Service Area consists of the following counties: Monroe; Wayne; Livingston; Seneca; Yates; Ontario; Steuben; Schuyler; Chemung; Tioga; Tompkins; Cortland; Broome; Cayuga; Onondaga; Oswego; Chenango; Madison; Delaware; Otsego; Herkimer; Montgomery; Fulton; Oneida; Lewis; Hamilton; Essex; Clinton; Franklin; St. Lawrence; and Jefferson.

**Spouse.** A person who is legally married to an Employee (provided marriage is recognized as such for purposes of federal tax laws). A Spouse does not include someone that is legally separated or divorced from the Employee.



**UCR (Usual, Customary and Reasonable).** The cost of a dental service in a geographic area based on what a Health Care Professional in the area usually charges for the same or similar dental service.

**You, Your and Yours.** Throughout this Plan, the words “you”, “your” and “yours” refers to you, the Covered eligible Employee and your Covered eligible Dependents.

## ELIGIBILITY

### **Employee Eligibility**

A full-time or part-time Employee of the Employer that regularly works at minimum 18-20 hours per week (dependent upon bargaining unit) will be eligible to enroll for coverage under the Plan as of the date he/she completes at least one (1) hour of service for the Employer. Participation in the Plan will begin as of the date he/she completes at least one (1) hour of service for the Employer; provided all required election and enrollment forms are properly submitted to your Benefits Office.

### **Dependent Eligibility**

Your Dependents are eligible for coverage under the Plan, provided he/she is:

- (1) Your Spouse.
- (2) Your unmarried Child, until the end of the month of the Child's 19th birthday, or 25<sup>th</sup> birthday if enrolled as a full-time student at an accredited institution of learning and chiefly dependent on you for support.

For purposes of this section, an accredited institution of learning is an institution that: offers courses of study leading to a high school diploma, or to an associate, bachelor or graduate degree; or provides programs for career training and, upon completion of study, credentials the full-time student through licensing, certification or diploma. The term "institution of learning" includes: a business; vocational; technical; trade; or mechanical school. It does not include: an on-the-job training course; or a correspondence school. The term "institution" does not include on-lines degree programs.

- (3) Your unmarried Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation or physical handicap and who became so incapable before reaching the limiting age stated in (2) above. Your Child must have been Covered under the Plan prior to reaching the limiting age stated above, and be chiefly dependent upon you for support and maintenance, must reside with you for more than one-half of the Calendar Year, and not eligible for any other type of health coverage (other than Medicare or Medicaid).

You have 30 days from the end of the month in which your Child attains the limiting age to provide proof of the Child's incapacity and to request continued coverage for such Child under this Plan. The Plan Sponsor may request subsequent proof of your Child's incapacity and eligibility for coverage under the Plan pursuant to this provision.

### **Retiree Eligibility**

You are eligible for coverage under this Plan as a Retiree, if you were Covered under the Plan as of the date of your retirement. You may also elect to continue coverage for any eligible Dependents.

At the time of retirement, you may elect to enroll in COBRA in lieu of Retiree coverage. If you elect COBRA in lieu of Retiree coverage for yourself and any eligible Dependents, or if you fail to make an election under the Plan, you and your Dependents will not be eligible to enroll in Retiree coverage at a later time.

You must be currently enrolled in the Plan to continue yourself and any eligible Dependents under the Retiree coverage under the Plan. You must notify your Benefits Office, in writing, of your intent to continue dental coverage as a Retiree (for yourself and any eligible Dependents) or to cancel your dental election within 30 days after your retirement date. Participation in the Plan for you and your eligible Dependents will begin as of the date of your retirement, provide all written notifications are properly submitted to your Benefits Office.

You may be required to pay for the full or partial cost of Retiree coverage. The amount of any required contribution will be communicated to you prior to the date of your retirement, and thereafter in accordance with the policies and procedures of the Employer.

### **Timely Enrollment**

Once you are eligible to participate in the Plan, you must enroll in coverage under the Plan within 30 days after you satisfy the eligibility requirements. Any required election or enrollment form must be submitted to your Benefits Office no later than the 30-day period described above. If you are required to contribute towards the cost of coverage, you must also complete a payroll deduction authorization form that will allow your Employer to deduct the required contributions from your pay.

If you decline enrollment for you and/or your Dependents because you have other health coverage, you must provide a written notice to your Benefits Office indicating the reason you are declining coverage. If you lose such other coverage it may constitute a special enrollment or a change in status event that gives you and/or your Dependents the right to enroll in the Plan mid-year. If you failed to submit such written statement, you will not be eligible to enroll mid-year and will be required to wait until the next open enrollment period.

If you fail to complete and submit the required election and enrollment forms within the 30-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience an earlier special enrollment or a change in status event (as described below).

### **Open Enrollment Period**

This Plan has an annual open enrollment period. The open enrollment period is the period of time prior to the start of the Plan Year where an eligible Employee and/or eligible Dependent can elect coverage under the Plan or can change coverage under the Plan. The open enrollment period under the Plan will be communicated to you each year by your Benefits Office.

If you fail to complete and submit the required election and enrollment forms within the annual open enrollment period, you will not be eligible to enroll in the Plan until the next

annual open enrollment period, unless you experience an earlier special enrollment or a change in status event (as described below).

### **Special Enrollment Event**

You may make a mid-year change in your election as a result of any of the following special enrollment events:

- (1) **Loss of Other Coverage.** You previously declined coverage for yourself and/or your eligible Dependents because you and/or your Dependents had other health coverage and you submitted a written statement to your Benefits Office when you were initially eligible declining enrollment under the Plan because of such other health coverage, but than that other health coverage was lost as a result of one of the following events:
  - (a) Legal separation, divorce, death, loss of Dependent status, termination of employment, reduction in hours, or any other reason required by HIPAA;
  - (b) The other health coverage was COBRA and the maximum continuation period available under COBRA has been exhausted; or
  - (c) Employer contributions for the other health coverage ended.

If you and/or your Dependent lost the other health coverage for reasons of non-payment of the required contribution or premium, making a fraudulent claim or an intentional misrepresentation of material fact, then you and/or your Dependents will not be eligible to take advantage of this special enrollment right and enroll in the Plan mid-year.

If you are the one that loses the other health coverage, you may enroll yourself and any eligible Dependents in the Plan. If your eligible Dependent loses the other health coverage, and you are already enrolled in the Plan, you may enroll your Dependent in that same benefit option you are already enrolled in or you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must request enrollment in the Plan by submitting any required enrollment and election forms to your Benefits Office no later than 30-days after the date your other health coverage was lost. Coverage under the Plan will begin as of the date you request enrollment. Failure to enroll in the Plan will result in no coverage under the Plan. You may elect to enroll in the Plan again during the Plan's next annual open enrollment period, or in the event you experience another special enrollment or change in status event.

- (2) **Acquisition of a New Dependent.** You declined to enroll, failed to enroll or enrolled in Employee-only coverage under the Plan when you were initially eligible or during the Plan's annual open enrollment period and you acquire a new Dependent mid-year as a result of marriage, birth, adoption or placement for adoption.

You must request enrollment in the Plan by submitting any required enrollment and election forms to your Benefits Office no later than 30 days after the date of the event. Coverage under the Plan will begin as follows:

- (a) For a newborn Child (other than a proposed adopted newborn Child), coverage will begin as of the date of birth, provided you request enrollment within the 30-day period described above.
- (b) For a proposed adopted newborn Child, coverage will begin as of the date of birth, provided you request enrollment within the 30-day period described above; and
  - (i) You take physical custody of the newborn as soon as he/she is released from the Hospital after birth; and
  - (ii) File a petition for adoption within 30 days after the Child's birth.

Coverage under the Plan will not be provided for the proposed adopted newborn Child if a notice of revocation of the adoption has been filed or one of the natural parents revokes consent to the adoption. If the Plan provides coverage of a proposed adopted newborn Child, and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, the Plan will be entitled to recover any sums paid by it for care of the proposed adopted newborn Child.

- (c) For an adopted Child (or Child placed with you in anticipation of adoption), coverage will begin as of the date of adoption (or placement for adoption), provided you request enrollment within the 30-day period described above.
- (d) For a newly acquired Dependent as a result of marriage, coverage will begin as of the date of marriage, provided you request enrollment within the 30-day period described above.

Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan, other than the first 30 days after birth for a newborn Child or a proposed adopted newborn Child. You may elect to enroll in the Plan again during the Plan's next annual open enrollment period, or in the event you experience another special enrollment or change in status event.

(3) **Eligibility Changes in Medicaid and State Child Health Insurance Programs (SCHIP).** You declined or failed to enroll in coverage under the Plan when you were initially eligible because:

- (a) you were covered under Medicaid or a SCHIP at the time you were initially eligible, but now your coverage under Medicaid or a SCHIP has terminated due to loss of eligibility for such coverage; or
- (b) You became eligible for a state premium assistance subsidy under Medicaid or SCHIP to assist with payment of any required Employee contribution under the Plan.

Coverage under the Plan will begin as of the date you request enrollment in the Plan, provided such request is made within 60-days after coverage under Medicaid or SCHIP terminates or you become eligible for a state premium assistance subsidy.

Failure to enroll in the Plan within the 60-day period described above will result in no coverage under the Plan. You may elect to enroll in the Plan again during the Plan's next annual open enrollment period, or in the event you experience another special enrollment or change in status event.

### **Change in Status Event**

Your election under the Plan will remain in effect for the entire Plan Year, unless you experience a special enrollment event (described above) or a change in status event, as defined under Section 125 of the Internal Revenue Code (including any applicable regulations). Any new election made under the Plan due to a change in status event must be consistent with such event. Change in status events include:

- (1) A change in your marital status, including marriage, divorce, legal separation, annulment or death of a Spouse;
- (2) A Dependent loses or gains eligibility under the Plan, such as attainment of a specified age; birth, adoption or placement for adoption of a Dependent; death of a Dependent; or a change in the Plan's Dependent eligibility requirements;
- (3) Change in employment status that causes you, your Spouse or Dependent Child to either gain or lose eligibility under the Plan, including commencement or termination of employment; commencement or return from a leave of absence; or any other employment status change that affects the eligibility status of an individual to participate in the Plan, including a change from part-time to full-time status or vice versa, a change from salaried to hourly or vice versa, or a strike or lockout;
- (4) Gain or loss of eligibility under the Plan or another employer-sponsored welfare benefit plan;
- (5) Significant increase or decrease in the cost of coverage under the Plan, including a new benefit option being added, a benefit option being eliminated or significantly curtailed and a coverage change made under a plan offered by the employer;
- (6) Change in your residence or the residence of your Dependent that is outside the Plan's Service Area;
- (7) Change in election under another employer-sponsored welfare benefit Plan during an open enrollment period under another employer-sponsored welfare benefit Plan that differs from the open enrollment period under this Plan;
- (8) You or your Dependent become covered or lose coverage under Medicare or Medicaid.

Depending on the change in status event, you may be permitted to revoke your existing election or make a new election under the Plan, provided it is consistent with the event and satisfies the regulations under Internal Revenue Code Section 125. For additional information regarding whether or not something constitutes a change in status event, please contact your Benefits Office.

Coverage under the Plan will begin as of the date of the change in status event, provided you request enrollment and submit any required election and enrollment forms no later than 30 days after the event.

Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan. You may elect to enroll in the Plan again during the Plan's next annual open enrollment period, or in the event you experience another special enrollment or change in status event.

### **Change in Election Due to Marketplace Coverage**

If you have an opportunity to enroll in a qualified health plan through an exchange or marketplace established under the Affordable Care Act ("Marketplace Coverage"), you may change your benefit elections under this Plan to cancel medical coverage under this Plan but only if you (and all Dependents whose coverage under this Plan is being cancelled) are also enrolling in Marketplace Coverage. Cancelling coverage under this Plan based on this rule will be permitted only if the Marketplace Coverage (for all Covered Persons whose coverage under this Plan is being cancelled) is effective no later than the next day after coverage under this Plan would terminate because of the cancellation of coverage. The Plan may rely on your reasonable representation that all Covered Persons whose coverage is being cancelled have enrolled in or will enroll in Marketplace Coverage to be effective no later than the deadline indicated in the previous sentence, but the Employer, in its discretion, may also require additional documentation of the Marketplace Coverage. Also, note that you are permitted to enroll in Marketplace Coverage only during the annual Marketplace enrollment period or based on a marketplace special enrollment opportunity. Details about the enrollment periods for Marketplace Coverage are available at: <https://nystateofhealth.ny.gov/>.

## WHEN COVERAGE ENDS

**Employee Coverage Ends:** Your coverage under the Plan ends on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part;
- (2) The last day of the period for which the required contribution has been paid;
- (3) The end of the month your employment ends for any reason, including termination and voluntary resignation. If you are retiring, you may be eligible for retiree coverage. Please see the Retiree Eligibility section of the Plan for further details;
- (4) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA);
- (5) The end of the month you change to an Employee classification that is not benefits-eligible;
- (6) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; or
- (7) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of material fact.

**Dependent Coverage Ends:** Dependent coverage will end on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part;
- (2) The end of the month the Employee's eligibility or coverage under the Plan terminates;
- (3) The end of the month the Dependent Child, or for all other Dependents the end of the month the Dependent, no longer qualifies as a Dependent under the Plan;
- (4) The last day of the period for which the required contribution has been paid;
- (5) The date Dependent coverage under the Plan is terminated;
- (6) The date the Dependent (or any person seeking coverage on behalf of the Dependent) performs an act, practice or omission that constitutes fraud; or
- (7) The date the Dependent (or any person seeking coverage on behalf of the Dependent) makes an intentional misrepresentation of material fact.



**Retiree Coverage Ends:** Retiree coverage for both the Retiree and any eligible Dependents ends on the earliest of the following dates:

- (1) The date the Plan is terminated, in whole or in part;
- (2) The date the Plan no longer provides Retiree coverage;
- (3) The last day of the period for which the required contribution has been paid;
- (4) For the Retiree, date of the Retiree's death. For a your surviving Spouse and your eligible Dependents who are Covered under the Plan at the time of your death will be eligible to continue coverage under the Plan after your death if your surviving Spouse and/or eligible Dependents elect to continue coverage under the Plan. The surviving Spouse and/or eligible Dependent must make the required contribution toward the cost of coverage. The cost of coverage under this survivor benefit will be communicated to your survivor(s) by the Plan Administrator;
- (5) The end of the month in which a Dependent no longer qualifies as a Dependent;
- (6) The date the Retiree or any eligible Dependent (or any person seeking coverage on behalf of the Retiree or any eligible Dependent) performs an act, practice or omission that constitutes fraud; or
- (7) The date the Retiree or any eligible Dependent (or any person seeking coverage on behalf of the Retiree or any eligible Dependent) makes and intentional misrepresentation of material fact.

**Continuation of Coverage due to Layoff, Disability, and Approved Leave of Absence.**

If you are Covered under the Plan and begin an approved leave of absence, suffer a disability or you are laid off, you may be eligible to continue Plan coverage for you and your eligible Dependents. A continuation of Plan coverage pursuant to this provision is subject to the terms and conditions of the applicable collective bargaining between your Employer and the applicable Union. Please refer to your Employer for additional information regarding your eligibility for this provision.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

## DENTAL BENEFITS

**Predetermination of Benefits.** A predetermination of benefits is recommended for any extensive treatment, such as periodontics or prosthetics. A description of planned treatment and expected charges should be sent to the Plan before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be Covered will be determined by the Plan. When there has not been a predetermination of benefits, the Plan will determine what services will be Covered at the time the claim is received. Predetermination of benefits does not guarantee payment and expires one (1) year after the date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a Covered Person qualifies at the time services are completed.

### Covered Dental Benefits

#### Class I - Preventive and Diagnostic Services

- (1) **Clinical Oral Examinations.** The Plan will provide coverage for an oral examination twice in any Calendar Year. Coverage will also be provided for emergency oral examinations to treat pain.
- (2) **Radiographs.**
  - a. **Full Mouth or Panoramic.** The Plan will provide coverage for the following complete intra-oral x-rays once every 36 consecutive months: a full mouth series or a panoramic film.
  - b. **Bitewings.** The Plan will provide coverage for up to a combination of two (2) bitewing films in a Calendar Year.
  - c. **Diagnostic Radiographs and Photographs.** The Plan will provide coverage for diagnostic x-rays and photographs.
- (3) **Dental Prophylaxis, Including Cleaning, Scaling and Polishing.** The Plan will provide coverage for prophylaxis twice in a Calendar Year. The Plan will provide coverage for cleaning or scaling of teeth performed by a licensed dental hygienist if such treatment is rendered under the supervision and direction of a Health Care Professional.
- (4) **Topical Fluoride Treatments (Office Procedure).** The Plan will provide coverage for topical fluoride treatments four (4) times in a Calendar Year for Dependent Children under 19 years of age.
- (5) **Palliative Emergency Treatment.** The Plan will provide coverage for emergency care you receive from a Health Care Professional that is designed only to relieve your dental pain until corrective treatment can be provided.

- (6) **Sealants.** The Plan will provide coverage for the topical application of sealants on posteriors teeth; one (1) per tooth once every 36 consecutive months for Dependent Children under age 19.
- (7) **Periodontal Maintenance.** The Plan will provide coverage for periodontal maintenance (periodontal prophylaxis) twice per Calendar Year after active therapy and/or surgical treatment.
- (8) **Diagnostic Pulp Vitality Test.** The Plan will provide coverage for diagnostic pulp vitality tests.

## **Class II - Basic Services**

- (1) **Amalgam and Composite Restorations.** The Plan will provide coverage for amalgam and composite restorations for treatment of cavities.
- (2) **Oral Surgery.** The Plan will provide coverage for simple extractions. The Plan will provide coverage for oral surgery, consisting of: surgical extractions, including removal of impacted teeth; odontogenic cysts, lesions and biopsies; tooth re-implantation; tooth transplantation and alveoplasty.
- (3) **Space Maintainers.** The Plan will provide coverage for space maintainers for Dependent Children under age 19.
- (4) **Endodontics.**
  - a. **Pulp Caps.** Coverage for direct and indirect pulp caps.
  - b. **Pulpotomy.** The Plan will provide coverage for therapeutic pulpotomy, partial pulpotomy, and pulpal debridement.
  - c. **Root Canal Treatment.** The Plan will provide coverage for root canal therapy, including: anesthesia; opening and drainage of pulp chambers and canals; removal of pulp tissue and instrumentation of canals; application of medications; radiographs taken during the course of active treatment; and culture and sensitivity examinations.
  - d. **Apicoectomy.** The Plan will provide coverage for apicoectomy, including: sutures; suture removal; treatment plan; anesthesia; application of medications; treatment radiographs; and routine post-operative treatment.
  - e. **Hemisection.** The Plan will provide coverage for hemisection, including: sutures; suture removal; treatment plan; anesthesia; application of medications; treatment radiographs; and routine post-operative treatment.
- (5) **Anesthesia.** The Plan will provide coverage for general anesthesia for any Covered Services or procedures under the Plan.

### **Class III - Major Restorative Services**

- (1) **Removable and Fixed Prosthodontics.** Benefits will be provided for the following removable and fixed prosthodontics: full and partial dentures; and fixed bridgework. The following benefit limitations apply:
  - a. The Plan will only provide benefits for the replacement of a denture, partial denture or fixed bridgework for which benefits were provided under this Plan with another denture, partial denture or fixed bridge: when the existing prosthetic was placed more than five (5) years ago and cannot be made serviceable.
  - b. The Plan will not provide coverage for denture replacement made necessary by reason of loss or theft.
  - c. The Plan will only provide benefits for adjustments or repairs to full or partial dentures or bridges when the adjustment or repair is performed more than six (6) months after the initial insertion of the prosthesis.
  - d. The Plan will only provide benefits for re-cementation to full or partial dentures or bridges.
  - e. Benefits for denture relines or rebases are limited to one (1) in a 36-month period and must occur at least six months after initial placement.
  - f. Benefits for temporary partial stayplate dentures (flipper) are limited to the replacement of extracted anterior teeth.
  - g. Removal of part of a root (hemisection) does not qualify as a tooth extraction when determining benefits in connection with installation of removable or fixed prosthetics.
  
- (2) **Periodontic Services.**
  - a. **Periodontic Surgical Services.** The Plan will provide coverage for the following periodontic surgical services: gingivectomy; gingivoplasty, osseous surgery; and gingival flap procedures.
  - b. **Periodontic Adjunctive Services.** The Plan will provide coverage for periodontic adjunctive services consisting of periodontal scaling and root planing (per quadrant).
  
- (3) **Inlays/Onlays and/or Crowns.** The Plan will provide coverage for inlays/onlays and/or crowns to treat a tooth due to severe decay and/or fracture and when teeth cannot be restored by a filling. Coverage for these restorations includes all necessary: bases; pulp medications; liners; gingival preparation; impressions; and finishing. The following benefit limitations apply:

- a. The Plan will only provide benefits for the replacement of an inlay/onlay or crown with another inlay/onlay or crown if more than five (5) years have elapsed since the last placement.
  - b. The Plan will provide coverage for stainless steel crowns.
  - c. The Plan will provide benefits for repair or re-cementation of crowns.
- (4) **Dental Implants (Tooth Implantation).** The Plan will provide coverage for dental implants to replace missing teeth, including:
- Single implant crowns; and
  - Abutment.
- The Plan will only provide benefits for replacement of an implant when more than five (5) years have elapsed since the last placement. A pre-determination of benefits for implant services is recommended. A description of planned treatment and expected charge should be sent to the Plan before treatment is started. The expenses that will be Covered will be determined by the Plan. When there has not been a pre-determination of benefits, the Plan will determine what services will be Covered at the time the claim is received. Pre-determination of benefits does not guarantee payment and expires one year after the date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a Covered Person qualifies at the time services are completed.
- (5) **Tissue Conditioners.** The Plan will provide coverage for tissue conditioners.

#### **Class IV - Orthodontics**

- (1) **Orthodontic Services.** The Plan will provide coverage for orthodontic services for handicapping malocclusion, consisting of: the initial and subsequent installations of orthodontic appliances; and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and its attendant sequelae through the correction of malposed teeth; including harmful habit services. Coverage is subject to the following conditions, limitations and exclusions:
- a. The Plan reserves the right to review your dental records, including necessary x-rays, photographs and models, to determine whether orthodontic needs and treatment are within the limitations and exclusions of this Plan.
  - b. For purposes of determining benefits available for treatment in progress at the commencement or termination of a Covered Person's coverage, all orthodontic services shall be deemed to have been rendered on the date performed.
  - c. The Plan will provide coverage for diagnostic photography/facial images; included an additional panoramic x-ray once every 36 consecutive month period.

- d. The Plan will not provide coverage for: appliances or restorations specifically to increase vertical dimensions or restore the occlusion; or for the replacement and/or repair of any orthodontic appliance.

## EXCLUSIONS

In addition to the exclusions and limitations described in other sections of this Plan, the Plan will not provide coverage for the following:

- (1) **Anesthesia.** The Plan will not provide coverage for the following forms of anesthesia: local; regional block; Trigem division block; local analgesia; and non-intravenous conscious sedation.
- (2) **Bonding.** The Plan will not provide coverage for bonding and/or splinting of teeth.
- (3) **Care by more than One Provider.** In the event a Covered Person transfers from the care of one Health Care Professional to that of another Health Care Professional during the course of treatment, or if more than one Dentist renders services for one dental procedure, the Plan will not provide coverage for more than the amount it would have provided if one Health Care Professional rendered the service.
- (4) **Cosmetic Services.** The Plan will not provide coverage for any services in connection with elective cosmetic surgery that is primarily intended to improve your appearance and is not Medically Necessary.
- (5) **Court Ordered Services.** The Plan will not provide coverage for any service or care (including evaluation, testing, and/or treatment) that is ordered by a court, or that is required by a court as a condition of parole or probation, unless:
  - A. The service or care would be Covered under this Plan in the absence of a court order;
  - B. The service or care has been pre-authorized by the Plan, if required; and
  - C. It is determined, in advance, that the service or care is Medically Necessary and Covered under the terms of this Plan.

This exclusion applies to special dental reports, including those not directly related to treatment, e.g., reports on certification examinations and reports prepared in connection with litigation.

- (6) **Criminal Behavior.** The Plan will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred. To the extent required by law, this exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).

- (7) **Dental Charges- Drugs.** The Plan will not provide coverage for medications provided for the care and treatment of dental cares.
- (8) **Dental Consultation.** The Plan will not provide coverage for dental consultations.
- (9) **Dental Veneers.** The Plan will not provide coverage for dental veneers.
- (10) **Diagnostic Caries Susceptibility Test.** The Plan will not provide coverage for diagnostic caries susceptibility test.
- (11) **Diagnostic Cast.** The Plan will not provide coverage for diagnostic casts.
- (12) **Diagnostic Oral Pathology and Labs.** The Plan will not provide coverage for diagnostic oral pathology and labs.
- (13) **Diagnostic Tests and Examinations.** The Plan will not provide coverage for diagnostic tests and examinations.
- (14) **Experimental and Investigational Services.** Unless otherwise required by law, the Plan will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, "Service"); an inpatient stay in connection with a Service; or treatment of a complication related to a Service; if the Service is experimental or investigational.

"Experimental or investigational" means that the Claims Administrator determines the Service is:

- A. not of proven benefit for a particular diagnosis or for treatment of a particular condition;
- B. not generally recognized by the medical community, as reflected in published, peer-reviewed, medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or
- C. not of proven safety for a person with a particular diagnosis or a particular condition, e.g., is currently being evaluated in research studies to ascertain the safety and effectiveness of the treatment on the well-being of a person with the particular diagnosis or in the particular condition.

Governmental approval of a Service will be considered in determining whether a Service is experimental or investigational, but the fact that a Service has received governmental approval does not necessarily mean that it is of proven benefit, or appropriate or effective treatment for a particular diagnosis or for a particular condition.



In determining whether a Service is experimental or investigational, the Claims Administrator may require that any or all of the following five criteria be met:

- A. A Service that is a medical device, drug, or biological product must have received final approval of the United States Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once final FDA approval has been granted for a particular diagnosis or for your particular condition, use of the Service (medical device, drug, or biological product) for another diagnosis or condition may require that any or all of the five criteria be met.
  - B. Published, peer-reviewed, medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.
  - C. Published, peer-reviewed, medical literature must provide demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.
  - D. Published, peer-reviewed, medical literature must provide proof that the Service is at least as effective in improving health outcomes as established services or technology, or is usable in appropriate clinical contexts in which an established service or technology is not employable.
  - E. Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in subparagraph C above, is possible in standard conditions of medical practice, outside of clinical investigatory settings.
- (15) **Free Care.** The Plan will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not Covered under this Plan. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter, or the spouse of any of them, it will be presumed that the service or care would have been furnished without charge. You must prove that a service or care would not have been furnished without charge.
- (16) **Government Hospitals.** Except as otherwise required by law, the Plan will not provide coverage for any service or care you receive in a Facility or institution which is owned, operated or maintained by: the Veterans Administration (VA); a

federal, state, or local government, unless the Facility is a Participating Provider. However, coverage will be provided for services or care in such a Facility to treat an Emergency Condition. In this case, coverage will continue to be provided only for as long as emergency care is Medically Necessary and it is not possible for you to be transferred to another Facility.

- (17) **Government Programs.** The Plan will not provide coverage for any service or care for which benefits are payable under Medicare or any other federal, state, or local government program, except when required by state or federal law. When you are eligible for Medicare, benefits will be reduced by the amount Medicare would have paid for the services. Except as otherwise required by law, this reduction is made even if: you fail to enroll in Medicare; you do not pay the charges for Medicare; or you receive services at a Facility that cannot bill Medicare.

However, this exclusion will not apply to you if one of the following applies:

- A. **Eligibility for Medicare By Reason of Age.** You are entitled to benefits under Medicare by reason of your age, and the following conditions are met:
- i You are in “current employment status” (working actively and not retired) with the Employer; and
  - ii The Employer maintains or participates in an Employer group health plan that is required by law to have this Plan pay its benefits before Medicare.
- B. **Eligibility for Medicare By Reason of Disability Other than End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:
- i You are in “current employment status” (working actively and not retired) with the Employer; and
  - ii The Employer maintains or participates in a large group health plan, as defined by law, that is required by law to have this Plan pay its benefits before Medicare pays.
- C. **Eligibility for Medicare By Reason of End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Plan will not reduce its benefits, and will provide benefits before Medicare pays, during the waiting period. The Plan will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before the benefits under this Plan are provided.

- (18) **Military Service-Connected Conditions.** The Plan will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.
- (19) **No-Fault Automobile Insurance.** The Plan will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all of the benefits of the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy. The Plan will provide benefits for services Covered under this Plan when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a deductible, the Plan will provide coverage for the services Covered under this Plan, up to the amount of the deductible. The Plan will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.
- (20) **Non-Covered Service.** The Plan will not provide coverage for any service or care that is not specifically described in this Plan as a Covered Service; or that is related to service or care not Covered under this Plan; even when a Participating Provider considers the service or care to be Medically Necessary and appropriate.
- (21) **Occlusal Adjustments.** The Plan will not provide coverage for occlusal adjustments.
- (22) **Occlusal Guards.** The Plan will not provide coverage for occlusal guards.
- (23) **Oral Hygiene Programs.** The Plan will not provide coverage for training or supplies used for: dietary counseling; tobacco counseling; oral hygiene; or plaque control programs.
- (24) **Procedures to Increase Vertical Dimension.** The Plan will not provide coverage for procedures, restorations and appliances to increase vertical dimension or to restore occlusion.
- (25) **Prosthetic Appliances.** The Plan will not provide coverage for prosthetic appliances.
- (26) **Replacement of Prosthetic Devices.** The Plan will not provide coverage for replacement of a lost, missing or stolen prosthetic device. Coverage will not be provided for replacement of a prosthetic device for which benefits were provided under this Plan unless the existing prosthetic was placed more than five (5) years ago and cannot be made serviceable.
- (27) **Restorative- Gold Foil.** The Plan will not provide coverage for restorative services related to gold foil.

- (28) **Services Charged by other Providers.** The Plan will not provide coverage for services of Health Care Professionals if fees or charges therefore are claimed by Hospitals, clinical laboratories or other institutions.
- (29) **Services Starting Before Coverage Begins.** The Plan will not provide coverage for any service or care you receive prior to the effective date of your coverage under this Plan.
- (30) **Services Starting or Continuing After Coverage Terms** The Plan will not provide coverage for any service or care you received after the termination date of your coverage under this Plan.
- (31) **Temporomandibular Joint.** The Plan will not provide coverage for appliances, therapy, surgery or any services rendered for the dental or medical treatment of the temporomandibular joint.
- (32) **Unlicensed Provider.** The Plan will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider; or that is outside the scope of licensure of the duly licensed provider rendering the service or care.
- (33) **Workers' Compensation.** The Plan will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.

## CONTINUATION OF COVERAGE

Consolidated Omnibus Budget Reconciliation Act of 1985 - COBRA  
Family and Medical Leave Act of 1993 (FMLA)  
Uniformed Services Employment and Reemployment Rights Act of 1994

This section contains a brief explanation of the Federal laws that permit you and/or your Dependents to continue coverage under the Plan. If you lose coverage under the Plan, contact your Benefits Office. The Benefits Office is available to provide a complete description of your right to continue coverage under COBRA, FMLA, or USERRA. Coverage will be identical to that provided by the Plan for active Employees.

**Eligible COBRA Beneficiaries:** You and/or your Dependents that lose coverage under the Plan due to a “qualifying event” will be considered an eligible COBRA Beneficiary unless you, the Employee, were terminated due to gross misconduct. If you are terminated due to gross misconduct and lose coverage under the Plan, you and any of your eligible Dependents will not be entitled to elect to continue coverage under COBRA. An eligible COBRA Beneficiary also includes a new Dependent Child who is born or placed for adoption with a COBRA Beneficiary.

If the “qualifying event” is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, a Covered Retiree and his/her Spouse and his/her eligible Dependents will also be considered a COBRA Beneficiary, provided such bankruptcy results in loss of coverage under the Plan.

**Note:** *You may have other coverage options available to you, other than continuing coverage under COBRA, when you lose coverage under this Plan.* Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for Medicaid or other group health plan coverage (such as a Spouse’s plan) through what is called a “special enrollment period”. Some of these options may cost less than COBRA coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **When an Employee is Eligible for COBRA.**

If you are an Employee and lose Plan coverage due to termination of employment or a reduction in hours, you and/or your Dependents may continue coverage for up to 18 months, provided you elect to enroll in coverage within 60 days after the later of the date (1) you lose coverage under the Plan; or (2) the date you are given notice of your right to elect COBRA.

**When a Dependent is Eligible for COBRA:** A Dependent becomes a COBRA Beneficiary if they lose coverage under the Plan due to any one of the qualifying events described below. A Dependent can continue coverage for up to 36 months.

- (1) You are a Dependent Child of an Employee and you are no longer eligible for coverage under the Plan as a Dependent Child.
- (2) You are a Spouse or Dependent Child of an Employee and you (or your parents in the case of a Dependent Child) become legally divorced, legally separated, or the marriage is legally annulled.
- (3) The Employee (your Spouse, or in the case of a Dependent Child, your parent) dies.
- (4) The Employee (your Spouse, or in the case of a Dependent Child, your parent) becomes enrolled in Medicare while covered by COBRA.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan, provided he/she notifies the Benefits Office within 60 days following the date of the qualifying event. Such notification must be provided in accordance with the Notification Requirement provision below.

#### **Extension of COBRA Coverage Due to Disability**

A COBRA Beneficiary may be determined totally disabled under Title II or Title XVI of the Social Security Act (SSA) after enrolling for COBRA coverage. If the SSA determines that a COBRA Beneficiary was disabled on the date of the qualifying event or within the first 60 days of COBRA coverage, the disabled COBRA Beneficiary, plus all other COBRA Beneficiaries who are receiving COBRA coverage in connection with the same qualifying event may continue coverage for up to 29 months. The disabled COBRA Beneficiary must apply for and be approved for SSA disability benefits. COBRA Beneficiaries that are not disabled may elect to extend coverage even if the disabled COBRA Beneficiary declines to do so. You must notify your Benefits Office within 60 days after the date of the SSA determination and before the end of the 18-month COBRA period. If the disabled COBRA Beneficiary is no longer determined disabled by SSA, you must notify your Benefits Office within 30 days after the date of the SSA determination. Any Such notification must be provided in accordance with the Notification Requirement provision below.

#### **Extension of COBRA Coverage Due to another Qualifying Event**

If a second qualifying event occurs during the first 18 months of COBRA coverage, your Spouse and any Dependent Child may continue coverage for up to 36 months from the date of the original qualifying event. You must notify the Benefits Office within 60 days of a qualifying event that causes a Dependent to lose coverage under the Plan. Such notification must be provided in accordance with the Notification Requirement provision below.

**When Continued Coverage Ends:** Continued coverage will end for any COBRA Beneficiary on the earliest of the following dates:

- (1) The date cost of continued coverage is not paid when it is due.
- (2) The date the COBRA Beneficiary becomes enrolled in Medicare after their COBRA election date under this Plan.

- (3) The date the person becomes covered under any other health plan after their COBRA election date under this Plan.
- (4) The date the Plan terminates and the Plan Sponsor ceases to provide group health plan coverage.
- (5) The maximum period of extension under COBRA ends (18, 29, or 36 months).
- (6) The first of the month beginning 30 days after the date of the SSA's determination that a COBRA Beneficiary is no longer disabled.

**Notice Requirements:** Each COBRA Beneficiary has an independent right to elect COBRA coverage, even if an Employee rejects COBRA coverage. The COBRA Beneficiary must request continued coverage by providing written notice to the Benefits Office that is postmarked within the time frames listed above. Failure to elect COBRA during the timeframes described above will result in the loss of all rights to continue coverage for the benefits available under this Plan.

It is very important to keep the Plan Administrator informed of the current address of all Covered Persons who are or may become qualified COBRA Beneficiaries. You may notify the Plan Administrator at the address in the section entitled "General Plan Information".

For qualifying events such as divorce, annulment or legal separation of the Employee and Spouse, death of an Employee or former Employee, or a Dependent Child's loss of eligibility under the Plan, the notification must contain the following information:

- (1) Name of the Plan;
- (2) Name and address of the Employee or former Employee who is or was Covered under the Plan;
- (3) Name and address of all COBRA Beneficiaries who lost coverage due to the qualifying event;
- (4) A detailed description of the qualifying event;
- (5) Date of the qualifying event; and
- (6) Include any documentation providing proof of the event (e.g. divorce decree).

For second qualifying events, in addition to all of the required information stated in (1) through (6) above, the notice must also include the following information:

- (1) Name and address of all COBRA Beneficiaries who lost coverage due to the initial qualifying event and who are receiving COBRA coverage at the time of this notice; and
- (2) Describe the nature and date of the initial qualifying event.

For a determination by SSA that you, your Spouse or Dependent Child is determined to be disabled within 60-days after your COBRA coverage begins, the notice must contain the information stated in (1) through (6) above, in addition to the following:

- (1) Name of the disabled COBRA Beneficiary;
- (2) Date upon which the disabled COBRA Beneficiary became disabled;

- (3) Date upon which the SSA made its determination of disability; and
- (4) A copy of the determination of the SSA.

If you, your Spouse or Dependent Child is later determined by SSA to be not disabled, the notification to the Benefits Office must include all of the above stated information, in addition to the following:

- (1) Date upon which the COBRA Beneficiary is considered no longer disabled; and
- (2) Date upon which the SSA made its determination of non-disability status.

If the notice does not contain all of the required information, the Benefits Office may request additional information from you. If you fail to provide the required information within the timeframe specified in the request, your notice may be rejected and no continuation of coverage under this provision or extension of coverage (if applicable) will be provided.

Notification must be sent to the Benefits Office at the following address:

Baldwinsville Central School District  
Benefits Office  
29 East Oneida Street  
Baldwinsville, New York 13027  
Phone: (315) 635-4545  
Fax: (315) 638-6141

**Cost of COBRA Coverage:** Any person who elects to continue coverage under the Plan must pay 102% of the actual cost of coverage you elect, unless you qualify for the 11-month disability extension. Any person that elects the 11-month disability extension will be required to pay 150% of the actual cost of coverage for the 11-month extension period. If election is made after the Covered Person becomes eligible for COBRA, the first payment must be paid within 45 days of the election. It must cover the entire period prior to the election. Payments are then due on the first day of each month to continue coverage for that month. If payment is not received by the due date, coverage will be cancelled and cannot be reinstated. The cost of the continued coverage will be determined by a method defined by law. Calculation of COBRA premiums is made annually and may increase or decrease based on Plan experience.

**FMLA and USERRA Continuation Coverage:** If an Employee is on a leave of absence because of the Family and Medical Leave Act of 1993 (FMLA) or if an Employee is absent from active service by reason of "service in the uniformed services," within the meaning of Section 4303(13) of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Employee may elect continued coverage for a specified period of time. For more information on FMLA or USERRA continuation coverage contact your Employer.

### **COORDINATION OF BENEFITS**



This section applies only if you also have other group health benefits coverage with another plan.

- (1) **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans, or policies (“plans”) providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be Covered by both plans, the Plan will coordinate benefit payments with any payment made under the other plan. One plan will pay its full benefit as the primary plan. The other plan will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:
  - (a) Any group or blanket insurance contract, plan, or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;
  - (b) Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization or Employee benefit organization;
  - (c) Any Blue Cross, Blue Shield or other service type group plan;
  - (d) Any coverage under governmental programs or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and
  - (e) Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.
  
- (2) **Rules to Determine Payment.** In order to determine which plan is primary, certain rules have been established. The first of the rules listed below which applies shall determine which plan shall be primary:
  - (a) If the other plan does not have a provision similar to this one, then it will be primary;
  - (b) If you are covered under one plan as an employee, subscriber, or primary member and you are only covered as a Dependent under the other plan, the plan which covers you as an employee, subscriber, or primary member will be primary; or

- (c) Subject to the provisions regarding separated or unmarried parents below, if you are covered as a Child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan that covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.
  - (d) There are special rules for a Child of separated or unmarried parents:
    - i. If the terms of a court decree specify which parent is responsible for the health care expenses of the Child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.
    - ii. If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the Child's health care expenses does not have actual knowledge of the court decree, benefits for the Child are determined in the following order:
      - a. First, the plan of the parent with custody of the Child;
      - b. Then, the plan of the spouse of the parent with custody of the Child;
      - c. Finally, the plan of the parent not having custody of the Child.
  - (e) If you are covered under one of the plans as an active Employee, neither laid-off nor retired, or as the Dependent of such an active Employee, and you are covered as a laid-off or retired Employee or a laid-off or retired Employee's Dependent under the other plan, the plan covering you as an active Employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.
  - (f) If none of the above rules determine which plan shall be primary, then the plan that has covered you for the longest time will be primary.
- (3) **Payment of the Benefit When This Plan Is Secondary.** When this Plan is secondary, the benefits of this Plan will be reduced so that the total benefits payable under the other plan and this Plan do not exceed your expenses for an item of service. However, the Plan will not pay more than it would have paid if it were primary.

The Plan counts as actually paid by the primary plan any items of expense that would have been paid if you had made the proper and timely claim. The Employer and/or the Claims Administrator will request information from that plan so the Claims Administrator can process your claims. If the primary plan does not respond within 30 days, the Claims Administrator may assume that the

primary plan's benefits are the same as the Plan's. If the primary plan sends the information after 30 days, the Plan will adjust its payment, if necessary.

Although it is not a requirement of this section, when you have coverage under more than one health plan, you can help to maximize the benefits available to you by following the rules and protocols of both the primary and secondary plans.

- (4) **Right to Receive and Release Necessary Information.** The Plan, the Employer and the Claims Administrator have the right to release or obtain information that they believe necessary to carry out the purpose of this section. The Plan, the Employer and the Claims Administrator need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. The Plan, the Employer and the Claims Administrator will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish any information that the Plan, the Employer and the Claims Administrator request. If you do not furnish the information, the Plan has the right to deny payments.
- (5) **Payments to Others.** The Plan may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which the Employer and/or the Claims Administrator decide the Plan should have paid. These payments are the same as benefits paid.
- (6) **The Plan's Right to Recover Overpayment.** In some cases the Plan may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to the Plan the amount by which it should have reduced the payment it made. The Plan also has the right to recover the overpayment from the other health benefits plan if the Plan has not already received payment from that other plan. You must sign any document that the Employer and/or the Claims Administrator deems necessary to help the Plan recover any overpayment.

## **SUBROGATION/REIMBURSEMENT PROVISION**

The purpose of this Plan is to provide benefits for expenses that are not Covered by another party. All payments made under this Plan are conditioned on the understanding that the Plan will be repaid (either through reimbursement or subrogation) for benefits that related to an illness, injury or health condition for which you (or your estate, legal guardian or legal representative), may have or assert for a tort or contractual recovery. Recovery rights apply to any sums you receive by settlement, verdict, or otherwise for the illness, injury or health condition.

This Plan is always secondary to any recovery you make from Worker's Compensation (no matter how the settlement or award is characterized for damages) and is always secondary to any automobile coverage for first party benefits.

If you assert a claim against or receive money from another responsible person or insurance company or other party in connection with an illness, injury or health condition for which you have received benefits under this Plan, you must contact the Employer immediately.

The Plan will be subrogated to all claims, demands, actions and rights of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including your own). The amount of such subrogation will equal the total amount paid under the Plan arising out of the illness, injury or health condition that is the basis for any claim you (or your estate, legal guardian or legal representative) may have or assert. The Plan may assert its subrogation rights independently of you or it may choose to assert its reimbursement rights against your recovery.

The Plan has the right to reimbursement to the extent of benefits paid related to the illness, injury or health condition from any recovery you may receive from these sources regardless of how your recovery is characterized or regardless of whether medical expenses are specifically included in your recovery. The Plan shall recover the full amount of benefits advanced and paid for the illness, accident, or injury without regard to any claim or fault on your part.

The Plan's subrogation and reimbursement rights are a first priority lien on any recovery meaning the Plan is entitled to recover up to the full amount of benefits it has paid without regard to whether you (or your estate, legal guardian or legal representative) have been made whole or received full compensation for your other damages and without regard to any legal fees or costs that you (or your estate, legal guardian or legal representative) have paid or owe. In other words, the Plan's right of recovery shall not be reduced due to the "Double Recovery Rule", "Made Whole Rule", "Common Fund Rule" or any other legal or equitable doctrine. The Plan's right of recovery takes preference over any other claims against the recovery and is enforceable regardless of how settlement proceeds are characterized.

You (or your estate, legal guardian or legal representative or other person acting on your behalf) must hold recovery funds from any person or party in constructive trust for the benefit of the Plan.

You agree to cooperate with the Plan's reimbursement and subrogation rights as the Plan may request and you agree not to prejudice the Plan's rights under this provision in any manner.

## CLAIM AND APPEAL PROCEDURES

You or your provider must submit a claim form before reimbursement for an eligible expense can be paid. Claim forms are available from the Plan Administrator or the Claims Administrator.

When submitting a claim form, include:

- (1) The name of the patient;
- (2) The name, address, telephone number and tax identification number of the provider;
- (3) The name of the Employee;
- (4) The place where the services were rendered;
- (5) The diagnosis and procedure codes;
- (6) The amount of charges;
- (7) The name of the Plan; and
- (8) The date of service.

Payments will be made directly to Participating Providers. Payments for services rendered by a Non-Participating Provider may be payable directly to the Non-Participating Provider or the Employee. Submit claim forms to the Claims Administrator at:

Excellus Health Plan, Inc.  
P.O. Box 21146  
Eagan, MN 55121

### **Timely Claim Filing Requirement**

All claims must be filed with the Plan within 180 days after you receive the services for which payment is being requested. Claims filed after this time period will be denied.

### **Procedures for all Claims**

The Plan's claim procedures are intended to reflect the U.S. Department of Labor's claims procedure regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those regulations, those regulations will control. In addition, any changes in those regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, you or your authorized representative must follow the procedures outlined in this section. There are four (4) different types of claims: (1) Post-service claims; (2) Pre-service claims; (3) Concurrent care claims; and (4) Urgent care claims.

## **Post-Service Claims**

Post-service claims are those claims that are filed for payment of benefits after health care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. This 30-day period may be extended by the Claims Administrator for up to 15 days. In addition, the Claims Administrator will notify you within the initial 30-day period if additional information is required to process the claim, and will put your claim on hold until all information is received.

Once notified of the extension and the additional information required to process the claim, you have 45 days to provide the required information. If all of the required information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

## **Pre-Service Claims**

Pre-service claims are those claims that require notification or approval prior to receiving health care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision (whether or not adverse) from the Claims Administrator within 15 days of receipt of the claim.

If the Claims Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision shall be furnished to you prior to the end of the initial 15-day period. Such an extension generally will not exceed 15 days. However, if the extension is necessary because of your failure to provide required information you shall have 45 days to provide the information.

If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

## **Urgent Care Claims**

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- (1) You will receive notice of the benefit determination (whether or not adverse) in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.

- (2) However, if your urgent care claim is missing required information, the Claims Administrator will notify you of the omission and how to correct it within 24 hours after the urgent care claim was received. You will then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the earlier of:

- (1) The Claims Administrator's receipt of the requested information; or
- (2) The end of the 48-hour period within which you were to provide the additional information requested.

### **Concurrent Care Claims**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided by the Claims Administrator within 24 hours of the receipt of your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time frames described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the Claims Administrator reduces or terminates such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the Claims Administrator shall notify you (sufficiently in advance of the termination or reduction to appeal the decision and obtain a determination upon review of the decision) before the course of treatment is reduced or terminated.

### **Notice of Adverse Benefit Determination**

If a claim is wholly or partially denied, or if a rescission of coverage occurs, the Claims Administrator will furnish the Plan participant with a written notice of the adverse benefit determination. The written notice will contain the following information:

- (1) the specific reason or reasons for the adverse benefit determination;
- (2) specific reference to those Plan provisions on which the adverse benefit determination is based;
- (3) a description of any additional information or material necessary to complete the claim and an explanation of why such material or information is necessary;



- (4) notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
- (5) A statement describing your right to bring an action for judicial review;
- (6) In the case of an adverse benefit determination by the Plan:
  - (a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;
  - (b) If the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.
- (7) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

### **Appealing a Denied Claim**

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. In your appeal, you may submit written comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

The review of your claims shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial benefit determination. With respect to a claim for benefits under a group health plan, the Plan will identify, upon request to the Claims Administrator, any medical experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the appeal relates to a claim for payment, your request should include:

- (1) The patient's name and the identification number from the ID card,
- (2) The date(s) of service(s),

- (3) The provider's name,
- (4) The reason you believe the claim should be paid, and
- (5) Any documentation or other written information to support your request for claim payment.

You have 180 days after you receive notice of the initial denial of your claim in which to request an appeal of that denial. This Plan offers two levels of appeal. You have 60 days after you receive notice of the denial of your first level appeal to request a second level appeal of that denial. You (or your authorized representative) must submit a written request for review to the following:

**Excellus Health Plan, Inc.**  
P.O. Box 4717  
Syracuse, NY 13221.  
Fax Number: 1-315-671-6656

The review of your appeal shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Plan will provide the claimant (i.e. you and your Covered Dependents), free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

Before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided (see Timing of Notification of Benefit Determination on Review, below) to give the claimant a reasonable opportunity to respond prior to that date.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which:

- (1) You may submit a request for an expedited appeal of an adverse benefit determination orally or in writing; and
- (2) All necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

### **Timing of Notification of Benefit Determination on Review**

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended as permitted below due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be counted from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

### **Appeal Process**

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Health Care Professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Your participation in the Plan includes your consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

### **Appeal Determinations**

#### **(1) Pre-Service and Post-Service Claim Appeals**

You will be provided with written notification of the decision on your appeal as follows:

For appeals of pre-service claims (as defined above), your appeal will be conducted and you will be notified of the decision, for each level of appeal, within 15 days from receipt of a request for appeal of a denied claim (or of the first-level appeal adverse determination).

For appeals of post-service claims (as defined above), your appeal will be conducted and you will be notified of the decision, for each level of appeal, within 30 days from receipt of a request for appeal of a denied claim (or of the first-level appeal adverse determination).

#### **(2) Urgent Claim Appeals**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

### **Manner of Notification of Final Internal Adverse Benefit Determination**

The Claims Administrator shall provide a participant with written notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the participant:

- (1) The specific reason or reasons for the adverse benefit determination;
- (2) Reference to the specific Plan provisions on which the adverse benefit determination is based;
- (3) A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;
- (4) A statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain information about such procedures;
- (5) A statement of the participant's right to bring an action for judicial review; and
- (6) The following information:
  - (a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the participant upon request;
  - (b) If the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request; and
  - (c) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

**Adverse Benefit Determination**

For purposes of the Plan's claim procedures, an "adverse benefit determination" is a denial, reduction or termination of, or a failure to provide or make payment (in whole, or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction of termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to Cover an item or service for which benefits are otherwise provided because it is determined be experimental and/or investigation or not medically necessary or appropriate.

**Time to Sue**

No action at law or in equity may be maintained against the Plan or the Claims Administrator to recover benefits under the Plan prior to the expiration of 60 days after written submission of a claim for such benefits has been furnished to the Plan as required in this Plan. In addition, no legal action may be commenced or maintained to recover benefits under the Plan more than three (3) years after the date you received the service for which you want the Plan to pay.

**Appointment of Authorized Representative**

An authorized representative is a person you authorize, in writing, to act on your behalf with respect to a benefit claim and/or appeal a denial of benefits. It also means a person authorized by a court order to submit a benefit claim and/or appeal a denial of benefits on your behalf. An assignment of benefits by you to a provider will not constitute appointment of that provider as your authorized representative. To appoint an authorized representative, you must complete a form that can be obtained from the Plan Administrator or the Claims Administrator. However, for a claim involving urgent care, a Health Care Professional with knowledge of your condition may always act as your authorized representative without completion of this form.

## TEMPORARY TOLLING OF CERTAIN TIMEFRAMES

Effective as of March 1, 2020, the Plan will disregard days occurring during the “Outbreak Period” (as defined below), for purposes of determining the date by which an individual (e.g., a Participant, claimant, dependent, qualified beneficiary) has to:

- (1) elect to initially enroll in COBRA continuation coverage if the 60-day initial election period otherwise would include any day of the Outbreak Period;
- (2) make an initial or any subsequent COBRA premium payment if the time period (or the grace period) for making the COBRA premium payment otherwise would include any day of the Outbreak Period;
- (3) provide a required notice to the Plan of a COBRA qualifying event, if the time period for providing the notice otherwise would include any day of the Outbreak Period;
- (4) file an initial claim for benefits under the Plan if the timely filing period otherwise would include any day of the Outbreak Period; or
- (5) file an internal appeal in response to an adverse benefit determination if the time period for filing an internal appeal otherwise would include any day of the Outbreak Period.

In all cases where a time period referred to in (1)-(5) above began before March 1, 2020, in determining the extended time period based on the above rule, any period of time prior to March 1, 2020 will be subtracted from the time period that would apply without the extension to determine the remaining time frame in which a covered person has to act after the end of the Outbreak Period. For example, for a request to initially enroll in COBRA that is subject to a 60-day initial election period, if the initial election period started on February 15, 2020, (i) the period from February 15 through February 29 will count as the first 14 days of the 60-day period (leaving 46 days in the initial COBRA election period), (ii) the entire Outbreak Period will be disregarded and (iii) the initial COBRA election period will end 46 days after the end of the Outbreak Period.

Coverage with respect to (1), (2), and (3) above, may be retroactive to the date of the qualifying event; provided the Covered Person makes any required premium payments prior to the end of the extended time period provided for above.

For purposes of this section, the “Outbreak Period” is the period beginning March 1, 2020 and ending 60 days after the announced end of the “National Emergency” described in the next sentence (or on a different date announced by the Internal Revenue Service and the Employee Benefits Security Administration (the “Agencies”)) and will be interpreted to be consistent with the meaning of that term under the Notice issued by the Agencies and published in the Federal Register on May 4, 2020. The “National Emergency” for this purpose is the National Emergency declared on March 13, 2020 (with a March 1, 2020 effective date) as a result of the COVID-19 outbreak. If the National Emergency is determined by the Agencies to end on different dates in different parts of the country, the Outbreak Period will be interpreted to end on the date that is determined by the Plan Administrator to be appropriate for the Plan.

## RESPONSIBILITIES OF THE PLAN ADMINISTRATION

### **Named Fiduciary**

The named fiduciary of this Plan is the Plan Sponsor.

The Plan Sponsor has full discretionary authority to control and manage the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan. The Plan Sponsor delegates its responsibility with respect to the payment of claims to the Claims Administrator. The Claims Administrator is the named fiduciary with respect to the determination of claims and first level appeals under the Plan.

### **Appointment of Plan Administrator**

The Plan Administrator is appointed by the Plan Sponsor. The Plan is administered by the Plan Administrator. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonable possible. If no Plan Administrator is appointed, then the Plan Administrator is the Plan Sponsor.

### **Authority to Make Decisions**

The Plan Administrator has full discretionary authority to administer and interpret the Plan, including discretionary authority to interpret its terms, make determinations of fact, and determine eligibility for participation and benefits under the Plan. The Plan Administrator may, however, delegate its discretionary authority and such duties and responsibilities as the Plan Administrator deems appropriate to facilitate the day-to-day administration of the Plan. Any determination of the Plan Administrator or its delegate is binding, final and conclusive upon all persons. In carrying out its duties with respect to the general administration of the Plan, the Plan Administrator has, in addition to the foregoing powers and any other powers conferred by this Plan, or by law, the following powers:

- (1) to construe the terms of the Plan and to determine all questions arising in its administration, interpretation, application or operation;
- (2) to decide all questions relating to the eligibility of individuals to participate in the Plan;
- (3) to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed items;
- (4) to determine the benefits under the Plan to which any person may be entitled;
- (5) to keep records of all acts and determinations of the Plan Administrator and to keep all such records, books, accounts, data and other documents as may be necessary for the proper administration of the Plan;

- (6) to prepare and distribute to all participants information concerning the Plan, and the rights of the participants under the Plan, including, but not limited to, all information which is required to be distributed under state or federal law;
- (7) to perform all necessary reporting as required by state or federal law;
- (8) to employ counsel, accountants and other consultants to aid in exercising its powers and carrying out its duties under the Plan; and
- (9) to perform any other acts necessary and proper for the administration of the Plan.

**Amendment or Termination of the Plan**

The Plan Sponsor has the general right to amend or terminate the Plan, in whole or in part, at any time, subject to the terms and conditions of any relevant collective bargaining agreements.

If the Plan is terminated, the rights of a Covered Person are limited to expenses incurred before the termination date. All amendments to the Plan shall become effective as of the date established by the Plan Sponsor.



## GENERAL PROVISIONS

### **Assignment of Benefits**

You cannot assign any benefits or monies due under the Plan to any person, corporation or other organization. Any assignment by you will be void. Assignment means the transfer to another person or to an organization of your right to the services provided under this Plan or your right to collect money from it for those services.

**Notice.** Any notice that the Employer or the Claims Administrator give to you under this Plan will be mailed to your address as it appears on the such entities records or to the address of the Employer. If you have to give the Employer or Claims Administrator any notice, it should be mailed to the address listed in the General Plan Information section.

**Your Medical Records.** In order to provide your coverage under this Plan, it may be necessary for the Employer and/or the Claims Administrator to obtain your medical records and information from Facilities, Health Care Professionals, Providers of Additional Health Services, and pharmacy who provided services to you. Actions to provide that coverage include processing your claims, reviewing grievances or complaints involving your care, and quality assurance reviews of your care, whether based on a specific complaint or a routine audit of randomly selected cases. When you become covered under this Plan, you automatically give the Employer and/or the Claims Administrator permission to obtain and use those records for those purposes.

The Employer and the Claims Administrator agree to maintain that information in accordance with state and federal confidentiality requirements. However, you automatically give the Employer and the Claims Administrator permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which the Employer and the Claims Administrator contract to assist them in administering this Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

**Who Receives Payment under this Plan.** Payments under this Plan for service provided by a Participating Provider will be made directly by the Plan (or by the Claims Administrator on behalf of the Plan) to the provider. If you receive services from a Non-Participating Provider, payment may be made to either you or the provider at the option of the Employer or the Claims Administrator.

**Venue for Legal Action.** If a dispute arises under this Plan, it must be resolved in Federal court, or a court located in the State of New York. You agree not to start a lawsuit against the Plan or the Claims Administrator in a court anywhere else. You also consent to these courts having personal jurisdiction over you. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order you to defend any action the Plan or Claims Administrator brings against you.

**Choice of Law.** All disputes relating to this Plan shall be governed by Federal law and, as applicable, the laws of the State of New York.

**Recovery of Overpayments.** On occasion a payment will be made when you are not Covered, for a service that is not Covered, or which is more than is proper. When this happens the Employer and/or the Claims Administrator will explain the problem to you and you must return the amount of the overpayment within 60 days after receiving notification.

**Right to Offset.** If the Plan makes a claim payment to you or on your behalf in error or you owe the Plan any money, you must repay the amount you owe. If the Plan owes you a payment for other claims received, the Plan has the right to subtract any amount you owe to the Plan from any payment the Plan owes you.

**Agreements between the Claims Administrator and Participating Providers.** Any agreement between the Claims Administrator and Participating Providers may only be terminated by the Claims Administrator or the providers. This Plan and the Claims Administrator do not require any provider to accept a Covered Person as a patient. Neither the Plan, nor the Employer nor the Claims Administrator guarantees a Covered Person's admission to any Participating Provider or any health benefits program.

**Identification Cards.** Identification cards are issued for identification only. Possession of any identification card confers no right to services or benefits under this Plan. To be entitled to such services or benefits the Covered Person's contributions must be paid in full at the time that the services are sought to be received. Coverage under this Plan may be terminated if the Covered Person allows another person to wrongfully use the identification cards.

**Right to Develop Guidelines and Administrative Rules.** The Employer and/or the Claims Administrator may develop or adopt standards that describe in more detail when payment will or will not be made under this Plan. Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether emergency care in the outpatient department of a Facility was necessary; or whether certain services are Skilled Care. Those standards will not be contrary to the descriptions in this Plan. If you have a question about the standards that apply to a particular benefit, you may contact the Claims Administrator and it will explain the standards or send you a copy of the standards. The Employer and/or the Claims Administrator may also develop administrative rules pertaining to enrollment and other administrative matters. The Employer and/or the Claims Administrator shall have all the powers necessary or appropriate to enable them to carry out their duties in connection with the administration of their respective duties under this Plan. Any actions or decisions made by the Employer and/or the Claims Administrator are binding unless arbitrary, capricious or made in bad faith.

**Furnishing Information and Audit.** All persons Covered under this Plan will promptly furnish the Employer and/or the Claims Administrator with all information and records that they may require from time to time to perform their obligations under this Plan. You must provide the Employer and/or the Claims Administrator with information over the telephone for reasons such as the following: to allow the Employer and/or the Claims Administrator to determine the level of care you need; so that the Employer and/or the Claims Administrator may certify care authorized by your physician; or to make decisions regarding the Medical Necessity of your care.

**Enrollment.** The Employer will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all Covered Persons Covered under this Plan, and any other information required to confirm their eligibility for coverage. The Employer will provide the Claims Administrator with the enrollment information including your name, address, age and social security number and advise the Claims Administrator in writing when you are to be added to or subtracted from the list of Covered Persons, on a monthly basis. In no event will retroactive additions to or deletions from coverage be made for periods in excess of 30 days.

**Reports and Records.** The Employer and the Claims Administrator are entitled to receive from any provider of services to Covered Persons, information reasonably necessary to administer this Plan subject to all applicable confidentiality requirements as defined in the General Provisions section of this Plan. By accepting coverage under this Plan, the Employee of the Employer, for himself or herself, and for all Covered Dependents Covered hereunder, authorizes each and every provider who renders services to a Covered Person hereunder to:

- (1) Disclose all facts pertaining to the care, treatment and physical condition of the Covered Person to the Employer and/or the Claims Administrator, or a medical, dental, or mental health professional that the Employer and/or the Claims Administrator may engage to assist the Employer and the Claims Administrator in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- (2) Render reports pertaining to the care, treatment and physical condition of the Covered Person to the Employer and/or the Claims Administrator, or a medical, dental, or mental health professional, that the Employer and/or the Claims Administrator may engage to assist the Employer and the Claims Administrator in reviewing a treatment or claim; and
- (3) Permit copying of the Covered Person's records by the Employer and the Claims Administrator.

**Service Marks.** Excellus Health Plan, Inc. ("Excellus") is an independent corporation organized under the Insurance Law of New York State. Excellus also operates under licenses with the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross and Blue Shield Association. Excellus is solely responsible for its obligations created under the Administrative Service Contract between the Employer and Excellus.

**Qualified Medical Child Support Orders:** The Plan provides medical benefits in accordance with the applicable requirements of any "Qualified Medical Child Support Order". A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of competent jurisdiction or through an administrative ruling that has the force and effect of state law which:

- (1) Relates to the provision of Child support with respect to the Child of an Employee or COBRA Beneficiary under this Plan or provides for health benefit coverage to such a Child, and is made pursuant to a state domestic relations law (including a community property law), and relates to such coverage under this Plan, or
- (2) Enforces a law relating to medical Child support described in Section 1908 of the Social Security Act with respect to this Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a beneficiary under this Plan. For purposes of this section, an "alternate recipient" shall mean any Child of an Employee or COBRA Beneficiary who is recognized by a Qualified Medical Child Support Order as having a right to enrollment under a group health plan with respect to such an Employee or COBRA Beneficiary.

A procedure has been established to determine if a Qualified Medical Child Support Order exists. You may obtain a copy of the procedure at no charge from your Employer.

**The Genetic Information Nondiscrimination Act of 2008 (GINA).** GINA is a federal law that prohibits discrimination in group health plan coverage based on Genetic Information. This Plan is maintained and operated in a manner consistent with GINA.

**Certification of Compliance with Privacy Regulations:** A Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information that is maintained or received by the Plan. Such information is referred to as Protected Health Information (PHI) in this section. A complete description of your privacy rights under HIPAA can be found in the Notice of Privacy Practices (Privacy Notice) you received when you enrolled. A copy of the Privacy Notice is available upon request from the Employer.

Under HIPAA you have certain rights with respect to your PHI, including but not limited to, the right to see and copy the information, receive an accounting of certain disclosures of the information and to amend the PHI under certain circumstances.

The Plan may disclose PHI to the Employer only as follows:

**Summary Health Information.** The Plan may disclose PHI that is summary health information to the Employer, if the Employer requests the summary health information for the purpose of obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan or amending the Plan. "Summary health information" is Plan information that summarizes claims information for the Plan from which most individual identifying information has been removed.

**Enrollment Information.** The Plan may disclose to the Employer information on whether an individual is participating in the Plan.

**Other Disclosures to Employer.** Except as provided above or under the terms of an applicable individual authorization, the Plan may disclose PHI to the

Employer only if the Employer requires the PHI to administer the Plan. The Employer, by signing this Plan document, certifies that it:

- (1) will not use or further disclose PHI other than as permitted by the Plan or as required by law;
- (2) will ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;
- (4) will report to the Plan any use or disclosure, of which it becomes aware, of PHI that is inconsistent with the uses or disclosures permitted under the Plan;
- (5) will make PHI available to the individual who is the subject of that information in accordance with the Privacy Regulations;
- (6) will consider requested amendments to an individual's PHI in accordance with the Privacy Regulations;
- (7) will make available the information required to provide an accounting of disclosures of PHI in accordance with the Privacy Regulations;
- (8) will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;
- (9) if feasible, will return or destroy all PHI received from the Plan that the Employer still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (10) will ensure that the adequate separation of the Plan and the Employer as required in this Section is established.

**Prohibited Disclosures.** The Plan will not disclose PHI to the Employer for purposes of employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Employer.

**Separation of Health Plan and the Employer.** The Employer has designated and trained certain Employees to be the only Employees of the Employer who will have access to PHI. Only those trained and authorized Employees will use or disclose PHI

on behalf of the Plan and only to the extent appropriate for performing administrative services that the Employer provides for the Plan.

The Employer will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that Employees of the Employer who have access to PHI use that PHI only for the purposes specified in this Section.

**Privacy Notice.** The Plan will comply with the applicable requirements of the Plan's Privacy Notice, which is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan. You may request a copy of the Notice of Privacy Practices from the Employer or the Privacy Officer.

**Security Regulations.** The Plan will comply with all applicable requirements of the HIPAA Security Regulations.

In addition, the Employer, by adopting this document, certifies that it will

- (1) Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan;
- (2) Implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
- (3) Ensure that the adequate separation of the Employer and the Plan required by the Privacy Regulations is supported by reasonable and appropriate security measures;
- (4) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect that information; and
- (5) Report to the Plan any security incident of which it becomes aware.

**Breach Reporting.** The Employer will promptly report to the Plan any breach of unsecured PHI of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HIPAA Security Breach Regulations.

## GENERAL PLAN INFORMATION

PLAN NAME: Baldwinsville Central School District Group  
Dental Plan - Dental Plan Option 2

PLAN NUMBER: N/A

PLAN SPONSOR: Baldwinsville Central School District  
29 East Oneida Street  
Baldwinsville, New York 13027

PLAN SPONSOR EIN: 15-6002126

TYPE OF PLAN: Welfare benefit plan providing dental  
benefits

PLAN ADMINISTRATOR Baldwinsville Central School District  
29 East Oneida Street  
Baldwinsville, New York 13027  
(315) 635-4545

SOURCES OF CONTRIBUTIONS: Baldwinsville Central School District  
(Employer) and its Employees contribute  
funds

CLAIMS ADMINISTRATOR: Excellus Health Plan, Inc.  
P.O. Box 21146  
Eagan, MN 55121

UTILIZATION REVIEW MANAGER: Excellus Health Plan, Inc.  
165 Court Street  
Rochester, NY 14647

PLAN YEAR: September 1- August 31.

SOURCE OF FUNDING: The Plan is self-funded and all benefits are  
paid from the general assets of the Employer

AGENT FOR SERVICE OF LEGAL  
PROCESS Baldwinsville Central School District  
29 East Oneida Street  
Baldwinsville, New York 13027  
(315) 635-4545

PRIVACY OFFICER: Karen Delpriore  
Baldwinsville Central School District  
29 East Oneida Street  
Baldwinsville, New York 13027  
(315) 635-4545

Baldwinsville Central School District has adopted the Plan Document and Summary Plan Description for the dental benefits under the Baldwinsville Central School District Group Dental Plan - Dental Plan Option 2 effective as of September 1, 2020.

**Baldwinsville Central School District**

Dated: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_