

**SUMMARY PLAN DESCRIPTION
FOR
*BEDFORD CENTRAL SCHOOL DISTRICT
GROUP DENTAL BENEFITS PLAN***

**(A self-funded dental benefits plan for employees
of Bedford Central School District)**

RESTATED APRIL 1, 2000

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INTRODUCTION

Bedford Central School District (also shown hereafter as District), is pleased to give you a copy of the Summary Plan Description (also shown hereafter as SPD) for the Bedford Central School District Group Dental Benefits Plan (also shown hereafter as the Plan). You should read this SPD carefully to acquaint yourself with its provisions for eligibility, coverage, filing a claim, and other important information. Please refer to **Section X - Definitions** for description of terms used in this SPD.

PLAN IDENTIFICATION

Plan Name:	Bedford Central School District Group Dental Benefits Plan
Plan Administrator:	Bedford Central School District
Plan Sponsor:	Bedford Central School District
Plan Effective Date:	July 1, 1993
Plan Restatement Date:	April 1, 2000
Plan Year:	Twelve consecutive months beginning July 1 and ending June 30.
Claims Administrator:	POMCO

Please Note

The pronoun you or your means an eligible and enrolled employee of the District. It also means a COBRA participant enrolled for individual coverage, or a COBRA participant whose social security number is used for family coverage enrollment. This is a restatement of the Plan showing benefits in effect since July 1, 1993.

The District has designed a plan that gives you benefits for a broad range of dental services. A number of features have been included in the Plan to manage costs for both you and the Plan and to ensure that the dental care you receive is within Plan guidelines. The Dental Expense Benefits shown in this SPD are available to eligible enrolled active employees and their dependents.

This SPD is a summary of the health benefits available for covered Plan services and supplies. It shows your rights, obligations, and benefits under the Plan. The Master Plan Document of the Bedford Central School District Group Dental Benefits Plan, consisting of this SPD, the terms of the Plan, and any Amendments to the Plan, is maintained and on file with the Plan Administrator. This SPD is not intended to interpret, extend, or change the provisions of the Plan in any way. Due to negotiated changes or other changes, the SPD may not be fully current. Any Plan Amendments or changes shall become part of the Master Plan Document. The provisions of this Plan may only be determined accurately by reading the Master Plan Document. To the extent the SPD is inconsistent with the provisions of the Master Plan Document, the terms of the Master Plan Document will govern.

A. DENTAL CLAIMS ADMINISTRATOR

POMCO has been selected by the Plan Administrator to administer the Plan dental claims. Dental claims should be mailed to POMCO for benefit determination. If you have any questions or concerns about this coverage, you should phone POMCO. Claim forms may be obtained from the District Benefits Office or from POMCO. Refer to **Section VIII - Claim Submission and Review Procedures** for details on how to submit your claims.

**POMCO, P. O. Box 6329,
Syracuse, NY 13217-6329
Phone Toll-free: 1-800-234-9862**

SECTION I –SUMMARY OF PLAN BENEFITS

The information in this section shows the Plan benefits for covered expenses. However, Plan payment is based on all the terms and limitations of the Plan. Please read this entire SPD to find out the full details for Plan coverage, limitations and exclusions. Plan benefits are self-funded by the District.

The Dental Expense Benefits shown below are available to eligible enrolled full-time employees and their eligible enrolled dependents (Covered Persons). Please refer to **Section II - Eligibility and Enrollment** for details on Plan enrollment, eligibility and effective dates for Plan coverage. For detailed covered service descriptions, please refer to **Section III - Covered Services, Section IV - Plan Exclusions and Section IX - Definitions**.

A. ALLOWABLE FEES

Allowable Fees mean the Usual, Customary and Reasonable (UCR) charges for covered services billed by a qualified provider. You will be responsible for the payment of charges that are more than the UCR allowance plus applicable deductibles and percentage copayment amounts. See **Section VIII - Definitions** under *Usual Customary and Reasonable Charges (UCR)*.

B. SERVICES BY MORE THAN ONE PROVIDER

The covered services or supplies will be used to decide the Plan benefits, not the number of providers doing the services. If dental care is transferred from one dentist or physician to another provider during treatment, total Plan payment will not be more than the Plan would have been paid had one provider given the covered service.

C. PRETREATMENT ESTIMATE

If you or your dentist anticipates that your dental expenses will exceed \$100.00, you may wish to ask your dentist to submit a pretreatment estimate to POMCO before the actual services are rendered. This pretreatment estimate must be sent for pre-approval of orthodontic coverage. POMCO will complete the pretreatment estimate showing which services are covered and the available allowance for each service. The completed form will be returned to your dentist. Pretreatment estimates will help you or your dependent to make informed decisions concerning your dental costs and availability of Plan benefits.

The Pretreatment Estimate is not a guarantee of benefits. Plan benefits will be payable at the time of claim submission based on Plan limitations and exclusions in effect at the time services were incurred.

Please Note

There may be occasions when differences of opinion regarding the dental care arise. In these situations, the Plan Administrator will rely on the findings of the Claim Administrator's dental consultant. The dental Plan excludes services covered under medical plans sponsored by the District. Claims for these services should be submitted to the medical Claims Administrator. Examples of claims that should be considered by the medical plan are excision of tumors, removal of cysts and neoplasm, excision of bone tissue and accidental injury to natural teeth. If the medical plan denies benefits, submit a copy of their denial with your claim submission to the Dental Claims Administrator.

D. BENEFIT MAXIMUMS

Calendar Year Maximum	\$1500.00 per calendar year is the most the Plan will pay for each Covered Person for any combination of dental covered expenses in a calendar year. Also, see orthodontic maximum
Orthodontic Maximum	\$500.00 per course of orthodontic treatment for each Covered Person for covered orthodontic expenses. Orthodontic benefits also count toward the calendar year maximum. No more than \$1500.00 will be paid by the Plan for any combination of orthodontic or non-orthodontic expenses incurred in the same calendar year for each Covered Person.

E. CALENDAR YEAR DEDUCTIBLE

The Plan reduces Allowable Fees by the deductible amount, then the Claim Administrator determines benefits based on the balance. You are responsible for payment of the deductible. Non-covered dental expenses cannot be used to reduce the deductible.	
Individual Deductible	\$25.00 per Covered Person each calendar year.
Family Limit	When three covered family members each satisfy their individual \$25.00 deductible, using covered dental expenses, no further cash deductible will be applied to family members for the remainder of the calendar year (on or after the date the third deductible was satisfied.)
Common Accident Limit	When two or more covered family members are involved in the same accident, deductible expenses related to that accident are limited to one deductible of \$25.00 for that calendar year and the next calendar year.
Carry-over Deductible Credit	Covered expenses incurred during the last three months of a calendar year that are used to reduce the individual deductible will count toward that individual's deductible for the next following calendar year. This is based on the date incurred, not the date the expenses were received or processed.

F. SCHEDULE OF ALLOWANCES/COVERED EXPENSES

Percentage Copayment. After the deductible is satisfied, the Plan pays the applicable percentage copayment shown below for each class of dental services. You are responsible for payment of the deductible, the percentage copayment balance and charges more than the UCR allowance. Benefits count toward the calendar year benefit maximum. The following schedules show the covered services and the applicable percentage copayments and other limits that apply based on Type 1 Dental Expenses, Type 2 Dental Expenses, Type 3 Dental Expenses, and Orthodontic Expenses.

1. Type 1 Dental Expenses - Diagnostic and Preventive

After the Deductible, Plan pays 80% of Allowable Fees for covered services. The Limits shown below are for each Covered Person. Benefits apply to the Calendar Year Maximum.

Covered Dental Services	Limits
Clinical Oral Examinations	Limited to twice per calendar year.
Prophylaxis (Scaling and cleaning of teeth and gums)	Limited to twice per calendar year.
Full-mouth X-rays/complete series	Limited to once per 36 consecutive months.
Bitewing X-rays	Limited to twice per calendar year.
Panoramic X-rays	Limited to once per 36 consecutive months with or without full-mouth x-rays/complete series.
Other X-rays	As needed for dental treatment.
Topical fluoride (Covered Person up to age 19)	Limited to once per calendar year. Not a benefit for Covered Persons age 19 or older.
Space Maintainer	When used in place of prematurely lost teeth. Limited to once in three consecutive years.
Sealants (Covered Person up to age 15)	Limited to once per tooth in three consecutive years. Not a benefit for Covered Persons age 15 or older.

2. Type 2 Dental Expenses - General Therapeutic. Palliative Care, Prescribed Medicines, Basic restorations (resin, silicate, plastic, amalgam or composite fillings) crown and prosthetic repairs, endodontics, periodontics, oral surgery, prosthetic repairs, and general anesthesia.

After Deductible, Plan pays 80% of Allowable Fees. Benefits apply toward calendar year benefit maximum. Plan allowance includes local anesthetic, analgesic and routine follow-up care. Sometimes, a service will be considered part of another procedure. Separate benefits will not be payable for inclusive procedures.

3. Type 3 Dental Services - Major Restorations. (Precious metal fillings, crowns, inlays, onlays, etc.), Dentures and Bridgework

After Deductible, Plan pays 60% of Allowable Fees. Benefits apply toward calendar year benefit maximum. Plan allowance includes local anesthetic, analgesic and routine follow-up care. Sometimes, a service will be considered part of another procedure. Separate benefits will not be payable for inclusive procedures.

4. Orthodontic Expenses

<p><i>After the Deductible, Plan pays 60% of allowable fees up to per course of orthodontic treatment maximum and the calendar year maximum for combination of orthodontic or non-orthodontic dental expenses. You are responsible for payment of the deductible, the percentage copayment balance, charges more than the allowable fees and expenses more than the benefit maximums. Limits are based on individual patient care.</i></p>	
<p><i>The amount of Plan payment for one course of orthodontic treatment will be 60% of the case fee allowance to be paid as shown below. After initial benefit payment, benefits will be paid in quarterly portions (every three months) during the remainder of the treatment course. Benefits are available only for services that are incurred while the participant is covered under the Plan.</i></p>	
Initial Diagnosis, Evaluation, pre-care and appliances.	Initial Plan Payment will be 15% of the total benefit allowance for the course of treatment.
Monthly Treatment	A monthly benefit for each month, payable at the end of each three month period during the remainder of the orthodontic treatment course will be determined by dividing 45% of the total benefit allowance for the course of treatment by the total number of months needed to complete the treatment course.

G. POTENTIAL CAUSES FOR BENEFIT REDUCTION

1. **Alternate Benefit/Standard Procedures Effect on Plan Benefits.** If the patient or the dentist selects nonstandard treatment, benefits could be based on Allowable Fees for the alternate standard procedure that adequately treats the dental condition. Please refer to **Section III - Covered Dental Services** under **Alternate Benefits/Standard Procedures** for further details. You can obtain a pretreatment estimate before treatment starts to assist you in making dental care decisions. Please refer to **Section III - Covered Dental Services** under **Pretreatment Estimate**.

2. **Coordination of Benefits Effect on Plan Benefits.** Your benefits could be reduced if you or your dependents are covered by more than one health/dental plan, including plans sponsored by the District. Please refer to **Section IV - Coordination of Benefits**.

Please Note

All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions. You must comply with requests for additional dental or medical documentation as deemed necessary by the Claims Administrator to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all dental or medical documents. Treatment decisions are independent from payment decisions. The patient's dentist or physician is responsible for determining whether treatment should be rendered despite whether the charges are totally or partially included in, or excluded from, coverage under the Plan.

SECTION II - ELIGIBILITY AND ENROLLMENT

Plan coverage for you and your dependents will be according to the eligibility, effective dates, and cancellation provisions of the Plan. The rules concerning eligibility for Plan enrollment are based on established policies, agreements and/or by established policies of the Bedford Central School District Board of Education, as amended. The following section provides a description of eligibility rules in effect at the time this SPD is published. However, the content in this section is not intended to constitute, or be validated as, the origin or basis for Plan

eligibility requirements. The District Benefits Office can provide full details of the District's current eligibility requirements for Plan enrollment.

A. ELIGIBILITY FOR PLAN ENROLLMENT

1. Employees. An active Employee is eligible for Plan enrollment when meeting the minimum requirements established by the District and/or negotiated bargaining agreements. Retirees are not eligible.

2. Dependents. The following dependents are considered eligible as dependents for enrollment in family coverage:

a. Your Legal Spouse. (A legally separated spouse may be enrolled in the Plan, but a divorced spouse is not eligible). The District may require proof of marriage.

b. Your Unmarried Children who are:

1) Under 19 years of age. Your newborn child is eligible from the moment of birth **if** enrolled in family coverage within **30 days** after date of birth. An unmarried child whose 19th birthday occurs during the school vacation period will continue to be eligible for benefits, provided the child is enrolled in a school and is anticipating full-time student status at the end of the vacation period.

2) Over 19 years of age but under age 25 who receive more than half their support from the employee and are full-time matriculating students at an accredited secondary school, college or university. Time spent in the U.S. Military service, not to exceed four years, may be deducted from the dependent's age for the purposes of establishing eligibility.

In the event your dependent child, who is a full-time student, is disabled and is granted a medical leave by the school he or she is attending, benefits will continue for a maximum of 12 calendar months following the month in which the child withdraws from school. If the end of the 12 calendar months occurs during a vacation period, coverage will be extended to the beginning of the next regular semester.

In the event your unmarried dependent child between the ages of 19 and 25 who previously was not eligible for benefits or had benefits ended and returns to a full-time student status, may be reinstated to family coverage effective the actual date the student commenced full-time attendance at the high school or an accredited institute of higher learning.

3) Age 19 years or older and incapable of self-support because of mental or physical disability and became so disabled before reaching age 19. The eligibility of such a dependent should be established as early as possible. This should be done at the time of your initial enrollment if the child is age 19 or older at that time. If the child has not yet attained age 19 at the time you first enroll in the program, eligibility for continued benefits should be established at the time of his or her 19th birthday.

To obtain Plan coverage for incapacitated dependents or full-time students, you may be required to document, at least annually, appropriate certification of this fact to the District Benefits Office. Failure to provide the required information when requested will result in that child being removed from enrollment and eligibility for benefits until proof is provided which supports continued eligibility for Plan enrollment.

c. Child Definition - Child or children mean:

- 1) The employee's own child or legally adopted child, whatever the child's place of residence or support provided;
- 2) Any stepchild of the employee who permanently resides in the employee's home.
- 3) Any other child supported by the employee or the spouse of the employee and permanently residing in the employee's home, provided the support and residence commenced before the child reached age 19; or
- 4) Any unmarried child placed for adoption before the child reaches age 18. The term placed for adoption means a child placed in the employee's home and the employee's assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child. This eligibility ends when such legal obligation terminates. Proof of pre-adoption status will be required by the District Benefits Office to establish eligibility. Once the child is legally adopted, he or she retains eligibility as a legally adopted child as shown above.
- 5) Pre-adoptive newborn from the moment of birth under a family Plan when all of the following conditions are met:
 - a) You enroll the child, you intend to adopt, in a family Plan within 30 days of the birth and applicable family contribution is made;
 - b) You take physical custody of the child upon discharge from the hospital or birthing center; and
 - c) Within 30 days of the child's birth, you file a petition to adopt or for temporary legal guardianship under New York State or Domestic Relations Law or similar state laws when filed outside NY state.

Coverage will not be provided for initial inpatient treatment of a pre-adoptive newborn, if the child's biological parent has health coverage for that care. Also, if a notice of revocation of the adoption has been filed, or a biological parent revokes consent to the adoption, coverage will not be provided. If Plan benefits were paid for a pre-adoptive newborn, whose adoption was revoked, the employee may be requested to reimburse those Plan payments.

Please Note

Documentation of the dependent status with the District Benefits Office will be required. Criteria of support will be deemed to have been met if the employee contributes at least 50 percent to the support of the dependent and that dependent qualifies as an exemption on the most recent Federal income tax return filed by the employee.

3. **Qualified Medical Child Support Orders.** Federal Law requires the Plan, under certain circumstances, to provide coverage for your children when you or your spouse divorce or separate. The law also provides for children born out of wedlock. The Plan must comply with qualified medical child support orders (QMCSO) that relate to Plan benefits. QMCSO means orders, judgement, settlement, or a decree issued from a court of competent jurisdiction, magistrates or other officials with the power to issue a QMCSO, pursuant to a state's domestic laws, that requires the Plan to provide coverage for your child. This coverage is provided even if you no longer have custody and even if you would not have chosen to cover the child under your health Plan. The child's custodial parent, legal guardian or state agency can apply for coverage even if you don't. If the Plan receives a QMCSO, it will provide immediate enrollment. This means the child identified will be included under your coverage, as required according to the QMCSO requirements. You will be required to pay any added monthly participation costs for the child's enrollment. You will receive written notification and be provided with further information about the QMCSO rules if the Plan receives an order that applies to you.

4. Leave of Absence

The District Benefits Office can provide full details concerning your rights for Plan coverage during an

approved leave of absence.

You may retain your individual coverage or family coverage under the Plan while you are absent from work for an approved leave of absence. This continuation is not automatic. You must apply for continuation before your leave of absence starts. To remain eligible during a leave of absence without pay, you must remit your designated participation contribution, if any, to the District Benefits Office each month on a timely basis. The District Benefits Office can answer questions concerning their requirements and provide details on your participation payments for leave of absence Plan continuation. You could be required to pay the total premium equivalent for Plan participation.

If you continue to be absent from work at the end of the approved leave of absence, your coverage under the Plan will end. However, you will be eligible to elect continuation of the Plan coverage under COBRA. See ***Continuing Coverage Under COBRA*** shown later in this section. If your coverage under the Plan ends while you are absent from work, it cannot be reinstated until you return to active employment. When you return to work, you must once more enroll in the Plan. The District Benefits Office can provide details on your effective dates of coverage following Plan enrollment as a returning employee.

Please Note

Under the Family and Medical Leave Act (FMLA) of 1993, a federal law, eligible employees are entitled to receive up to 12 weeks of unpaid leave in a 12 consecutive month period for certain family and medical reasons. If you are on an FMLA leave of absence, you may continue Plan coverage by paying your monthly designated participation contribution, if any, for Individual or Family Coverage. Plan continuation will be according to the FMLA law, as amended. The District Benefits Office can provide details of your rights under the FMLA and your costs to continue coverage while on FMLA leave of absence.

B. ENROLLMENT

The District Benefits Office can provide forms and details for enrollment options and your participation costs. Failure to report enrollment changes could result in Plan benefit overpayment. Should this happen, the District could request that you reimburse the Plan up to the benefit overpayments. ***No person may be eligible for enrollment both as an employee and a dependent or as a dependent of more than one employee***

Enrollment in the Plan is not automatic. You are required to enroll yourself and your dependents. You must meet the District's eligibility requirements. Employees must be actively employed at the time of enrollment. Plan participation costs are based on the type of coverage you choose. Plan coverage options are as follows:

1. **Individual Coverage.** Only the employee or a COBRA participant is enrolled. Benefits will be paid only for the person enrolled even if other family members meet eligibility requirements.
2. **Family Coverage.** Employee and one or more of his or her eligible dependents are enrolled. (Includes COBRA participants enrolled in family coverage). Benefits are paid only for family members enrolled in the Plan even if other family members meet eligibility requirements.
3. **Enrollment Changes.** It is your responsibility to apply for any enrollment changes including:
 - a. Adding a newly acquired spouse or dependent child;
 - b. Adding an existing spouse previously enrolled as an employee;
 - c. Adding a previously eligible but non-enrolled spouse or dependent child;
 - d. Changing from individual coverage to family coverage any time you acquire a spouse or dependent child or elect to enroll a previously eligible but non-enrolled spouse or dependent child;
 - e. Changing from family coverage to individual coverage when you no longer have eligible dependents or

- any time you no longer wish to provide coverage for eligible dependents;
- f. Changing from two individual enrollments to one family coverage or from one family coverage to two individual enrollments when you or your spouse are both eligible as employees under this health Plan;
 - g. Changing or adding a new dependent or removing an existing dependent from family coverage; or
 - h. Reporting other health plan(s) and Medicare coverage information and changes.

C. EFFECTIVE DATES OF BENEFITS

You should consult with the District Benefits Office for full details concerning how the effective date of benefits will be established for you or your eligible dependents. The following are the general rules for effective dates of benefits:

1. Employee General Rules

- a. Each employee in an eligible class, whose employment commenced on or before the effective date of the Plan, shall be covered on the effective date of the Plan or shall be eligible for any amended changes of the Plan. **The eligible employee must be actively employed on such effective dates and enrolled in the Plan. However, Plan coverage begins no sooner than the first day of the month after the date of eligible employment.**
- b. If you enroll at the time of active employment, Plan coverage begins on the first day of the month following the date of eligible employment; or
- c. If you fail to enroll within 30 days of eligible employment, coverage begins no sooner than the first day of the month following the date the District Benefits Office accepts your late enrollment application. Exception: See *Special Enrollment Effective Dates* shown later in this section.

- 2. Dependent.** Coverage for an eligible dependent will become effective on the date the employee becomes covered if the employee applies for such dependent coverage when enrolling in the Plan. If you fail to enroll an existing covered dependent at the time of your initial enrollment, coverage begins no earlier than the first day of the month following the date the late dependent(s) enrollment is accepted by the District Benefits Office. Exception: See *Special Enrollment Effective Dates* shown below.

3. Special Enrollment Effective Dates

- a. **Adding New Dependents.** Your biological newborn child is covered for the first 30 days under your individual or family coverage for the first 30 days without Plan enrollment. However, you must enroll the child under the following rules for that child to be covered beyond the first 30 days.
 - 1) If you are enrolled in the Plan and acquire new dependents, after your initial enrollment, and enroll the new dependents within 30 days after the date the eligible dependents are acquired, Plan coverage for the new dependent will begin on the date you acquired the dependent, but no sooner than the applicable employment waiting periods.
 - 2) If you are not enrolled in the Plan when you acquire a spouse you may enroll yourself and your spouse under family coverage. If you acquire a newborn child, or a newly placed or adopted child (under Age 18), you may enroll yourself and/or your spouse and the newly acquired newborn child, newly placed for adoption or adopted child under family coverage. For coverage to be effective on the date you acquired the new dependent, you must enroll within 30 days after the date of marriage, birth, placement for or adoption, whichever applies. This immediate coverage rule does not apply to children existing at the time of your initial eligibility.

- 3) If you have individual or no coverage at the time you enroll your new dependents in family coverage, you will be required to pay the full monthly participation costs, if any, for family coverage beginning with the month in which the dependent was acquired.
- 4) If you fail to enroll an eligible dependent within 30 days from the date such dependents were acquired, the new dependent will be considered a late entrant. The effective date of coverage will generally be the first day of the month after the date the District Benefits Office accepts your late enrollment application. The District Benefits Office can give you details concerning their established late enrollment rules.

b. Cancellation of Another Health Plan. Eligible persons who did not enroll themselves and/or their dependents at the time of initial eligibility because of coverage under another employer's plan may elect coverage in this Plan to be effective on the date the other coverage canceled if the following conditions are met:

- a. Person had health coverage at the time coverage was previously offered; and
- b. Person stated in writing at the time he or she declined enrollment in this Plan that the reason for declining was due to the other coverage; and
- c. The other coverage was involuntarily terminated due to loss of eligibility; or exhaustion of the prior plan continuation of coverage; or cessation of employer contributions to the other plan; or cancellation of coverage by the employer, insurer, or other issuing entity.
- d. Person requests enrollment within 30 days after the date the other plan was canceled.

You must pay any applicable contribution for individual or family coverage to be eligible for benefits from the date the other plan coverage ended. Generally, persons who fail to enroll within 30 days after involuntary cancellation of the other plan will be covered under this Plan no sooner than the first of the month following the date the District Benefits Office accepts the late enrollment application. The District Benefits Office can provide details concerning their effective date for enrollments after 30 days. This rule applies to persons who voluntarily cancel other plan coverage then seek late enrollment in this Plan. Voluntary cancellation includes, but is not limited to, cancellation or withdrawal from the other coverage by the enrollee; removal of eligible dependents from family coverage by the enrollee; or cancellation of coverage due to enrollee fraud or nonpayment of required participation payments.

D. PLAN PARTICIPATION CONTRIBUTIONS

The District Benefits Office can provide details on your costs, if any, for Plan participation. If required, you must make your designated participation payments to maintain Plan eligibility. If you fail to authorize any payroll deductions, you could be refused Plan coverage. If you fail to make direct payment of required participation payments during a leave of absence or other continuation of coverage, coverage could end for you and your dependents.

E. END OF COVERAGE

Plan coverage for you and your eligible dependents will end when you no longer meet the eligibility requirements of the Plan. However, you or your dependents could be eligible for *Continuation of Coverage under COBRA* shown later in this section. Coverage ends for a dependent when she or he no longer meets the dependent eligibility requirements. However, the dependent could be eligible to continue coverage under COBRA. Eligibility and coverage ends for the following unless enrollment under COBRA is elected:

1. You no longer meet employment eligibility due to reasons such as termination of employment, lay off, reduction in scheduled work hours, death, retirement, or change in job class. Coverage ends for you and

your eligible dependents at the end of the month following the date you are no longer considered a full-time active employee.

2. For failure to pay required Plan participation contributions, coverage ends for you and your dependents at 12:01 a.m. on the first day following the coverage period for which the a participation payment was made.
3. Divorce of spouse. Coverage ends for your ex-spouse at 12:01 A. M. on the date the divorce or dissolution of marriage becomes final.
4. Dependent Child coverage ends at 12:01 a. m. due to reasons such as:
 - a. The date your child marries.
 - b. The date your child, other than your biological or adopted child, is no longer living in your home and/or is no longer dependent on you for most of his or her support or maintenance.
 - c. The date the child reaches age 19 and is not a full-time student or is not eligible as a disabled/handicapped child dependent on the employee for support.
 - d. The date a disabled child age 19 or older is no longer disabled and/or dependent on the employee for support.
 - e. The date the child between ages 19 and 25 is no longer eligible as a full-time student.
 - f. The date the full-time student reaches age 25; or
 - g. The date a pre-adoptive child is removed from placement for adoption or the employee is no longer legally responsible for most of the pre-adoptive child's support.

Coverage may be stopped immediately if you or your dependents knowingly submits a claim, or allows a claim to be submitted with false information, or conceals any facts, that could affect the outcome of a claim determination. In this case, you or your dependents cannot continue coverage under COBRA.

F. CONTINUING COVERAGE UNDER USERRA

The District Benefits Office must be notified, in writing (in advance when practical), should your eligible employment stop due to active United States Military Service. The District Benefits Office can provide full details concerning Employee rights under USERRA and the costs to continue coverage while on active military duty. The following information is a brief summary. This Plan excludes health expenses resulting from injuries or sickness incurred in or aggravated while on military duty. This Plan excludes any illness or injury caused by or resulting from military service.

The District must comply with the terms of the Uniformed Services Employment and Reemployment Rights Act (USERRA), a federal law. This law gives employees certain rights concerning employment and health continuation should they meet the USERRA requirements. In general, eligible employees whose coverage would stop due to active United States Military Service have the right to continue Plan coverage for up to 18 months or for the period of military service (whichever is shorter). To maintain coverage, the employee may be required to pay a monthly participation payment up to 102% of the full premium equivalent for individual or family coverage. However, if the active service is less than 30 days, he or she will not be required to pay more than the normal participation contribution, if any. In addition, eligible employees are entitled to immediate eligibility for Plan enrollment and coverage when he or she meets the requirements of USERRA. Should you return to work when military service ends, the District Benefits Office can provide full details concerning your eligibility for immediate enrollment and Plan coverage according to USERRA regulations.

G. CONTINUING COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1996, a federal law otherwise known as COBRA, provides that most employers who sponsor group health plans must offer employees and their dependents the opportunity to temporarily continue their group health coverage at group rates in specific instances where this

coverage would otherwise end. This notice summarizes this law and its current rules concerning your rights and obligations under COBRA continuation. For questions concerning your specific circumstances and rights under this Plan, contact the District Benefits Office. ***You, your Spouse, and your Dependents should take the time to read this provision carefully.***

POMCO has been selected by the District to administer its COBRA continuation program where written inquiries may be sent. Phone inquiries concerning COBRA continuation can be made by phoning the POMCO toll - free number.

You or your Dependents who cease to meet the Plan eligibility requirements must notify the District Benefits Office of a divorce, legal separation, child losing eligibility status or other qualifying event. This Notice must be in writing sent to the District Benefits Office within 60 days after the event. If notice not given in 60 days, Coverage cannot be continued. POMCO will send COBRA election forms to qualified beneficiaries, usually within 14 days of after notification to the District Benefits Office. Details concerning election options, participation payments and time restrictions for COBRA enrollment will be sent with the election forms. At the time of COBRA election, Employees and/or Dependents will be offered coverage identical to that available to similarly situated Plan participants who are not receiving COBRA coverage under the Plan. (Generally, the same coverage they are enrolled in at the time of the qualifying event). All notices of changes in benefits and/or premiums occurring during the COBRA continuation will be sent directly to the participating qualified beneficiaries. Qualified beneficiaries are also allowed to change from their current level of benefits during any open enrollment period in the same manner as other Plan participants who are not receiving COBRA coverage under the Plan.

1. Qualifying Events

- a. **As a Employee Covered** under the Bedford Central School District Group Dental Benefits Plan, you and/or your Dependents may qualify for temporary extension of existing Plan coverage when Coverage is lost due to the following COBRA qualifying events:
 - 1) A reduction of your work hours which makes you ineligible for group health Coverage;
 - 2) Termination of your eligible employment with the District. (For reasons other than gross misconduct); or
 - 3) Resignation of your employment with the District.

- b. **If you are the Spouse of a Covered Employee**, you could qualify for continuation of Plan coverage under COBRA when you lose eligibility under the Plan due to any of the following reasons:
 - 1) Death of your spouse;
 - 2) Termination of your spouse's employment with the District. (For reasons other than gross misconduct);
 - 3) Spouse's resignation from employment with the District;
 - 4) Reduction of a spouse's work hours. (So that he or she is no longer eligible for group health Coverage);
 - 5) Divorce or legal separation from your Spouse; or
 - 6) Your Spouse becomes eligible for Medicare.

- c. **Dependent children of Covered Employees** may continue their Plan coverage when Plan eligibility is lost due to any of the following reasons:
 - 1) Death of a parent who was a covered employee;

- 2) Termination of a parent's employment with the District. (For reasons other than gross misconduct);
- 3) Parent's resignation from employment with the District;
- 4) Reduction in parent's work hours. (So that he or she is no longer eligible for group health coverage);
- 5) Parent becomes eligible for Medicare;
- 6) Loss of the child's Dependent status (i.e., marriage, limiting age, no longer full-time student); or
- 7) Parents' divorce or legal separation.

Qualified beneficiaries also include an Employee's child(ren) born, adopted, or placed for adoption (who are under age 18 acquired during a period of COBRA continuation elected by that Employee. To be covered under COBRA continuation, the Employee must enroll the child under family coverage within 30 days after the date of birth, adoption or placement for adoption.

Rights similar to those described may apply to retirees, their Spouses, and Dependents if the District commences a bankruptcy proceeding that causes a loss of coverage. Should this happen the District Benefits Office will advise you of your rights.

2. **Notification of Qualifying Events.** You, as an Employee of the District, or your Dependents are responsible for notifying the District Benefits Office in writing within 60 days following the date of a divorce, legal separation, Social Security disability, child losing eligibility status, or other qualifying event that would otherwise cause Plan coverage for you or your Dependent(s) to end. POMCO will send written notice of your COBRA rights, your costs, and election forms for COBRA enrollment within 14 days after your notification to the District Benefits Office.

In case of resignation or termination of employment (other than for gross misconduct), reduction of work hours, or the death of an Employee, POMCO will notify the qualified beneficiaries of their option to continue their current coverage within 14 days.

Please Note

If written notice of a qualifying event is not received by the District Benefits Office within 60 days after such event, COBRA continuation will not be available and Plan coverage will stop on the date eligibility ended. POMCO administers COBRA enrollment and billing procedures.

3. **COBRA Continuation Periods.** The following chart outlines the qualifying event and the maximum length of COBRA continuation available for each event:

In no event, will COBRA continuation exceed more than 36 months for any beneficiary		
<i>When continued coverage may be elected? ("Qualifying Events")</i>	<i>Who may elect continued coverage? ("Qualified Beneficiaries")</i>	<i>For how long may coverage be continued?</i>
Termination of employment or loss of hours for covered Employee (other than for gross misconduct), or reduction in hours of covered Employee	Employee, Spouse and Dependent children	18 months
Termination of employment or reduction of hours of covered Employee (other than for gross misconduct) when Employee eligible for Social Security Disability	Employee, Spouse and Dependent children	29 months (Includes the additional 11 months due to Social Security disability)
Termination of employment or reduction of hours (other than gross misconduct) when Dependent eligible for social security disability	That Dependent Spouse or Child	29 months (Includes the additional 11 months due to Social Security disability)
Death of covered Employee	Spouse and Dependent children	36 months
Divorce or legal separation	Spouse and Dependent children	36 months
Covered Employee becomes entitled for Medicare	Spouse and Dependent children	36 months
Dependent child becomes ineligible pursuant to Plan	Dependent child	36 months

Qualified Beneficiaries who receive Social Security disability benefits could be eligible for an additional 11 months extending the 18-month continuation period to 29 months. To be eligible for this extension, the beneficiary must have been disabled at the time coverage ended or become disabled within 60 days after the start of his or her COBRA continuation period. A copy of the Social Security determination showing the date of disability must be sent to POMCO or the District Benefits Office within 60 days following the date Social Security approved the disability and within the first 18 months of COBRA continuation. This extension applies to each disabled beneficiary (Employee, Spouse or child).

In cases where a second qualifying event occurs after COBRA continuation starts, the law states "...a qualified beneficiary may have more than one qualifying event, but the length of coverage cannot exceed 36 months." For example, if an Employee's eligibility ends due to reduction in work hours and he or she elects to continue family coverage, and then dies while COBRA coverage is in effect, his or her death is a second qualifying event. Because the death of an Employee is a qualifying event for a 36-month continuation period, his or her Dependent beneficiaries may elect to continue COBRA coverage up to 36 months from the date of the first qualifying event, the date the Employee lost eligibility due to reduction in hours. In no event will COBRA continuations exceed 36 months for any beneficiaries.

- 4. COBRA Election.** Qualified beneficiaries will have at least 60 days to elect COBRA continuation. The election period is measured from the later of the date that coverage was lost or the date that the COBRA

election notice is provided. COBRA coverage is retroactive if elected and paid for. If a qualified beneficiary waives COBRA continuation during the election period, the waiver may be revoked before the end of the election period. The Plan need only provide COBRA continuation from the date the waiver was revoked.

- 5. COBRA Participation Payments.** To temporarily continue coverage, COBRA qualified beneficiaries may be required to pay the entire costs of coverage for individual or family coverage plus administrative costs. By law, the payment cannot exceed 102% (or 150% for the 11-month Social Security disability extension) of the premium equivalent costs for the selected Plan Coverage.

The beneficiary must pay his or her initial COBRA participation payment within 45 days after COBRA election is made. If this initial payment is received after the 45-day period, COBRA continuation will not be available. Payment will not be made for any expenses incurred after Plan coverage ended. Subsequent premium payments may generally be made on a monthly or quarterly basis. If the amount of the payment is made in error, but is not significantly less than the amount due, the qualified beneficiary will be notified of the deficiency and granted 30 days to pay the difference.

If premium payments are not received 30 days from the date due, your continued coverage will cease as of the last day of the month for which a prior timely payment was received. Benefits will not be available for covered expenses unless timely COBRA participation payments have been made for the periods such expenses were incurred.

- 6. When Continued Coverage Ends.** Once COBRA continuation is ended, an individual cannot be reinstated for COBRA continuation even if they have not exhausted the maximum period of COBRA continuation. Continued coverage ends for qualified beneficiaries on the earliest of any of the following:

- a. The last day at the end of the applicable maximum continuation period;
- b. The date the District longer sponsors group health insurance for any of its Employees;
- c. The date the District no longer provides health plan coverage for any of its Employees;
- d. The due date when the COBRA participation payment is not paid or is not paid on a timely basis;
- e. The date that coverage becomes effective under another group plan (or if the beneficiary becomes entitled to Medicare Parts A or B or Medicare Part C) after COBRA was elected. This does not apply if pre-existing provisions of the other plan affects coverage for a beneficiary. The coverage would then end on the date the other plan covers the pre-existing condition;
- f. The date a beneficiary is no longer disabled during the 11-month Social Security disability extension;
- g. The date the Employee is reinstated for Coverage under this Plan; or
- h. Coverage may be stopped immediately if you or your Dependent knowingly submits a claim or allows a claim for benefits to be submitted with false information, or conceals any facts, that could affect the outcome of a claim determination.

COBRA Beneficiaries are required to notify the District Benefits Office when Medicare entitlement or another group health coverage become effective or when eligibility for Social Security disability ends during a period of COBRA continuation.

Please Note

Any individual who elects to continue Coverage under COBRA will be eligible for the same Coverage in effect at the time that person first lost Plan eligibility status. Subsequent Plan Amendments apply to COBRA continuation in the same manner as for individuals who maintained Plan Coverage eligibility requirements. Benefits will not be payable for covered expenses incurred during a period of COBRA continuation until the applicable Contribution payment has been made for that period of continuation.

*This continuation Coverage could be secondary payer after other group plans or Medicare. See **Section IV - Coordination of Benefits.***

H. PLAN CANCELLATION

If the Plan cancels, coverage will end for all persons enrolled in the Plan.

SECTION III - COVERED SERVICES

Benefits are available for a wide range of dental services when found dentally necessary for the treatment of dental disease, defect, accidental injury or preventive according to Plan provisions. Coverage also includes limited preventive dental services. Please refer to **Section I - Summary of Benefits** and **Section V - Plan Exclusions** for further details on your coverage.

A. VOLUNTARY PRETREATMENT ESTIMATE

Voluntary Pretreatment Estimate. A pretreatment estimate permits the review of the proposed treatment in advance and allows for resolution of any questions before, rather than after, the work is done. Additionally, you and the dentist will know in advance what services are allowed under the Plan and what the estimated benefits are, assuming you or your dependent(s) remain eligible under the Plan.

If the proposed cost of extensive dental work is more than \$100.00 for you or your eligible dependent(s), you are advised to have your dentist or physician submit a treatment plan to the Claims Administrator. This Treatment Plan is the dentist's report that (a) itemizes his or her recommended services, (b) shows the charge for each service, and (c) is accompanied by supporting X-rays or other diagnostic records where required or requested by the Claims Administrator. The Claims Administrator will review the information supplied by the dentist and will send a written response to the dentist or physician advising which services are covered and the estimated benefit for each service.

Please Note

The pretreatment estimate is not a guarantee of benefits. Plan benefits will be payable at the time of claim submission based on Plan limitations and exclusions in effect at the time services were incurred.

B. ALTERNATE BENEFITS/STANDARD PROCEDURES

Coverage will be based on the most appropriate standard procedures needed to adequately correct or treat the dental condition. If the dentist and/or the patient selects personalized restoration, prosthetics, orthodontics or to employ special techniques as opposed to standard procedures, the benefits provided will be limited to the allowance for the standard procedure as decided by the Claims Administrator. There may be occasions when differences of opinion regarding the dental care arise. In these situations, the District will rely on the findings of the Claims Administrator and/or their dental consultant.

C. INCURRED DATE

Benefits will be payable for covered services as Allowable Fees are incurred. Charges will be deemed incurred as of the date the service is rendered or the supply is furnished, except that the charges will be deemed incurred:

1. With respect to, crowns, inlays, onlays or gold restorations, on the date of the first preparation of the tooth or teeth involved;
2. With respect to bridgework or dentures, on the date the final impression was taken; or,
3. With respect to root canal therapy, on the later of the dates that the pulp chamber was opened or canals are explored to the apex.

4. With respect to periodontal surgery, on the date that the surgery was actually performed.

D. ALLOWABLE FEES

Benefit determination will be based on the Usual, Customary and Reasonable (UCR) fee as decided by the Claims Administrator for a covered service. When the Claims Administrator has approved an alternate dental procedure, benefits will be based on the UCR allowance for the alternate procedure. If the dentist does a more expensive procedure instead of the approved alternate procedure, allowance will be limited to the UCR fee for the alternate procedure. You are responsible for the payment of any fees more than the UCR allowance. Please refer to **Section VIII - Definitions** under *Usual, Customary and Reasonable Fee*.

E. DENTAL SERVICES

Benefits will be paid for Allowable Fees for covered dental services incurred while the Covered Person is eligible for Plan coverage. Such services must be found dentally necessary according to Plan provisions. Coverage also includes limited preventive care. Services done for orthodontic reasons are considered orthodontic expenses subject to orthodontic benefit limits. Services must be billed and provided by licensed physician or dentist or his or her professional employee licensed to render such service or by other duly licensed technician rendering a covered service ordered by the attending dentist or physician. Please refer to **Section I - Summary of Benefits** for benefit limits.

Sometimes a service could be considered an integral part of another service or case fee procedure. Temporary services including but not limited to temporary crowns, bridges or dentures are not covered. In such cases, benefits will be limited to the allowance for the major service or procedure. Separate benefits will not be available if billed separately from the major procedure. Local anesthetic is always considered part of a dental procedure. Separate charges for local anesthetic are not covered when done in conjunction with a dental procedure.

F. TYPE 1 - DENTAL EXPENSES - DIAGNOSTIC AND PREVENTIVE

1. **Diagnostic Services.** Separate payment will not be made for diagnostic services considered part of a major procedure or case fee procedure. Except as shown otherwise, diagnostic services must be related to a dental illness or injury.
 - a. Clinical Oral Examinations. Initial and periodic oral examination by the dentist including treatment plan, if necessary. Coverage is limited to twice per calendar year for each Covered Person.
 - b. Dental X-rays
 - 1) Full series x-rays, complete series including bitewings or panoramic. Coverage is limited to once in 36 consecutive months for each Covered Person.
 - 2) Intraoral periapical x-rays done separately from complete series are covered as needed for dental disease or injury.
 - 3) Bitewing x-rays done separately from full-series. Coverage is limited to twice per calendar year for each Covered Person.
 - 4) Panoramic x-rays. Coverage is limited to once in 36 consecutive months whether done separately or as part of complete series.
 - 5) Other dental x-rays will be considered on a by report basis when found dentally necessary for covered dental treatment.
2. **Preventive Services.** Clinical oral examinations shown previously are covered whether related to treatment or routine preventive care. Bitewing x-rays shown previously are covered when related to routine

exams. In addition, the following routine preventive services are covered. No other routine or preventive care is covered by the Plan.

- a. Prophylaxis, including cleaning, scaling and polishing. Coverage is limited to twice per calendar year for each Covered Person.
- b. Topical Fluoride application for Covered Person under age 19. Benefits are not available for Covered Persons age 19 or older. Coverage is limited to one application once per calendar year for each Covered Person. Fluoride must be applied separately from prophylaxis paste.
- c. Sealant application for pits and fissures of posterior tooth for dependent children age three and under age 15. Coverage is limited to one treatment per tooth in three consecutive years. Only sealants to posterior teeth are covered.
- d. Space Maintainer passive appliances, fixed or removable, used in place of prematurely lost teeth limited to one appliance every three consecutive years. Coverage includes recement of fixed space maintainer. Coverage is limited to non-orthodontic treatment.

Benefits are not payable for separate charges billed for nutritional counseling, oral hygiene instructions or similar services.

G. TYPE 2 DENTAL EXPENSES – THERAPEUTIC

1. **Emergency Exams or Palliative Care.** Benefits are available for emergency exams or palliative (pain) care as needed. Separate charges for examinations done at the same time as palliative treatment are not covered. Exams or palliative treatment considered part of a major dental procedure will be included in the allowance for the major procedure. X-rays are covered separately.
2. **Tests and Laboratory Examinations.** Benefits are provided for the following tests and laboratory examinations related to covered dental treatment. Routine or preventive tests are not covered. Sometimes, a service could be considered an integral part of another service or case fee procedure. In such cases, benefits will be limited to the allowance for the major service or procedure. Separate benefits will not be available if billed separately from the major procedure.
 - a. Bacteriologic studies for determination of pathologic agents
 - b. Caries susceptibility tests
 - c. Pulp vitality tests
 - d. Diagnostic casts
 - e. Diagnostic photographs
 - f. Histopathologic examinations
 - g. Other oral pathology procedures will be covered on a by report basis when found dentally necessary for covered treatment according to Plan provisions
3. **Basic Restorative Services.** The following services are covered for restoration of tooth damage due to dental decay or injury only. Services must be considered appropriate and usual for the dental conditions. Services primarily for cosmetic or aesthetic reasons are not covered. Allowance for restoration procedures includes preparation, supplies, local anesthetic and normal follow-up care. Separate charges for these inclusive services are not covered. Multiple surfaces restored on the same tooth are considered one filling. The Plan allowance will be based on the number of surfaces for each filling per each tooth.
 - a. Fillings consisting of resin (silver amalgam, silicate and plastic or a composite of these materials).
 - b. Sedative filling when not considered part of another procedure. Example: root canal therapy, palliative

care.

- c. Core Buildup, including any pins, pin retention, cast post and core in addition to crown.
- d. Pin Retention in addition to restoration.
- e. Temporary Crown for fractured tooth.

4. Endodontics. Coverage includes treatment for diseases of pulp cavities inside the root of a tooth and surrounding tissues. Allowance for endodontic procedures includes preparation, supplies, local anesthetic and usual after care. Separate charges for these inclusive services are not covered.

- a. Pulp capping exclusive of final restoration.
- b. Therapeutic pulpotomy exclusive of final restoration. Not covered separately if done during root canal therapy.
- c. Root canal therapy including treatment plan, intraoperative X-rays, clinical procedures and follow up care.
- d. Periapical services including apicoectomy, retrograde filling per root, root amputation per root and reimplantation of tooth including necessary splinting.
- e. Hemisection (including any root removal), not including root canal therapy.

Bleaching of a discolored tooth is not covered whatever the reason.

5. Periodontics. Coverage includes treatment of periodontal and other diseases to or around the root portion of a tooth except periodontal prophylaxis. Allowance for periodontic procedures includes preparation, supplies, local anesthetic and usual after care. Separate charges for these inclusive procedures are not covered.

- a. Surgical periodontic preoperative examination.
- b. Gingivectomy or gingivoplasty when not part of tooth extraction. (Generally needed in moderate, advanced or refractory progressive periodontitis.) Benefit determination will be based on dental necessity as documented by the attending dentist report and evaluation by the Claims Administrator.
- c. Gingival curettage when not part of tooth extraction. (Generally needed for localized sites of recalcitrant periodontitis, juvenile periodontitis, treatment of gingivitis, slight periodontitis or aesthetic purposes.) Benefits are not payable for services rendered primarily for aesthetic purposes.
- d. Gingival flap procedure, including root planing.
- e. Mucogingival surgery.
- f. Osseous surgery including flap entry and closure.
- g. Management of acute infection and oral lesions.

6. Oral Surgery. Allowance for oral surgery includes supplies, local anesthesia and normal follow-up care. Separate charges for these inclusive services are not covered. Surgery must be due to oral or dental disease or injury. Services done for aesthetic or cosmetic purposes are not covered. Services done for orthodontic reasons are covered as orthodontic expense subject to the orthodontic benefit limitations.

- a. Simple extractions.
- b. Root removal of exposed roots when not related to extraction of teeth.
- c. Surgical extractions of erupted teeth.
- d. Surgical extraction of bony or tissue impacted teeth (partially or completely impacted).
- e. Surgical removal of residual tooth roots (cutting procedure) when not related to tooth extraction.
- f. Biopsy of oral tissue done by incisional cutting procedure. Biopsy not covered if done with another cutting procedure.
- g. Surgical treatment of tumor, cysts and soft tissue abscess when not related to another oral procedure.

- h. Treatment of fractures including reduction with or without tooth immobilization and surgical approaches of the mandible, maxilla, malar and/or zygomatic arch, alveolus, (stabilization of teeth, open reduction splinting) and facial bones (complicated reduction with fixation and multiple surgical approaches).
 - i. Injection of antibiotics by the dentist or physician.
7. **Repairs Crowns and Dentures.** Repairs, relining, recement or adjustments of crowns, inlays, dentures and bridgework are covered. Benefits will be based on the type of dental service needed to make the prosthetic serviceable. Separate charges for repairs, relining, recement and adjustments done within six months of placement are not covered.
8. **General Anesthesia.** The administration of general anesthetic is covered only when dentally or medically necessary in conjunction with covered oral or dental surgery or for other covered dental procedures. The anesthetic agent must produce a state of unconsciousness with absence of pain sensation over the whole body. Benefits will not be paid for general anesthesia that does not meet the preceding requirement, whatever the reason.
9. **Prescription Drugs** when ordered by a physician in connection with covered dental procedures. Drugs must be considered medically or dentally necessary and require a physician's prescription.

H. TYPE 3 DENTAL EXPENSES - MAJOR RESTORATIONS OR SERVICES

1. **Major Fillings and Crowns.** The following services are covered for restoration of tooth damage due to illness or injury only:
- a. Gold or other high noble metallic fillings.
 - b. Inlay or onlays restorations consisting of metallic, porcelain/ceramic or composite/resin when not part of a bridge.
 - c. Crown restorations consisting of resin, porcelain/ceramic or with noble metal and full cast or partially cast metal when not part of a bridge.
 - d. Stainless steel crown restorations.
 - e. Core Buildup, including any pins, pin retention, cast post and core, in addition to crown.

Services must be considered appropriate and usual for the dental conditions. Services primarily for cosmetic or aesthetic purposes are not covered. Any series of treatment that involves crowns on any of the four front upper or lower teeth will automatically be considered cosmetic, unless a pretreatment review shows that a deterioration of each tooth makes other restoration methods inapplicable. Allowance for restoration procedures includes preparation, supplies, local anesthetic and normal follow-up care. Additional benefits will not be payable for any charges billed for the inclusive services.

Please Note

The charge for a crown, inlay or for a gold or other high noble metallic filling will be limited to the charge for a silver, porcelain, resin or composite filling unless the tooth cannot be adequately restored by such fillings. Replacement of a crown or gold filling is covered only if the crown or filling is over five years old.

2. **Prosthodontics (prosthetics, dentures and bridgework).** Allowance for prosthetic procedures includes preparation, materials or supplies. Allowance also includes rebase, reline, recement or adjustments within six months after the date of placement and other usual follow-up care. Separate charges for inclusive services will not be paid.
- a. **Initial or First Placement.** Coverage is available for the initial placement of a denture or bridge when needed to replace one or more diseased or injured natural teeth that were extracted or lost while covered

under the Plan. The denture or the bridgework must replace the missing tooth or teeth and be installed within 12 months after the date the tooth or teeth were lost or extracted. An initial placement denture or bridgework is considered an initial prosthetic when it does not replace an existing denture or bridgework. If fixed bridge is used, the abutments (crowns) will be covered only to the extent that they are needed to support the pontics that replace the missing natural tooth.

b. Replacement or Addition of Teeth for Existing Dentures or Bridgework. Allowance for prosthetic procedures includes preparation and supplies. Allowance also includes rebase, relin, recement, adjustments within six months after placement and other usual follow-up care. Separate charges for inclusive services will not be paid. Replacement of dentures or bridgework or tooth additions to existing prosthetics are covered for:

- 1) Additional loss or extraction of diseased or injured natural teeth while covered under this Plan; or
- 2) The existing denture or bridgework has been in use at least five years and cannot be made serviceable and the person has been covered under the Plan for two or more years; or
- 3) The existing denture is an immediate temporary denture installed within the past twelve months and must now be replaced by a permanent denture; or
- 4) The existing denture is no longer serviceable due to an accidental injury requiring oral surgery or oral surgery which involves changing the position of muscle attachments, removing a tumor, cyst, torus or excess tissue.

Replacements for any other reasons are not covered. Under no circumstances will the Plan pay replacement of dentures or bridgework that can be made serviceable.

c. Temporary or Interim Prosthodontics. Temporary or interim bridgework is considered part of the total service for dentures or bridgework. Separate benefits will not be payable for this service.

3. Temporomandibular Joint Dysfunction (TMJ). Coverage is available for treatment of TMJ. However, this benefit excludes expenses related to TMJ surgery.

I. ORTHODONTIC EXPENSES CORRECTION OF ABNORMALLY POSITIONED OR ALIGNED TEETH

1. Coverage Limitations. Coverage is limited to orthodontic services for treatment of handicapping malocclusion (usually four or more degree arch discrepancy). Benefits will not be payable for any orthodontic service which is primarily cosmetic or aesthetic. Coverage includes orthodontic services consisting of the initial and subsequent, if any, installation of orthodontic appliances and all orthodontic treatments rendered by a qualified dentist (orthodontist).

Covered services must be incurred while the individual was enrolled in the Plan. For example, if the appliance was inserted before the effective date of coverage, benefits would not be payable for the appliance. However, coverage would be available for orthodontic adjustments incurred while eligible under the Plan.

2. Benefit Payments/Course of Orthodontic Treatment. Benefits will be payable on a report basis. The dentist must complete a dental form with full details of the treatment plan. The completed form must be mailed to the Claims Administrator for benefit approval. Plan Payment will be prorated based on the available benefits for the course of treatment. Please refer to **Section I-Summary of Benefits** for details. Two or more course of treatments will be considered one course of orthodontic treatment unless separated by at least two years from the date of last orthodontic treatment.

If orthodontic services are ended for any reason before the completion of the treatment course, benefits will cease at the time care ended. If the patient becomes ineligible for coverage under the Plan, benefits will not be paid for any period after the date coverage ends. If the patient is on a quarterly payment schedule, payment will only be based on that portion of the quarterly period that the patient actually received services and was eligible for Plan benefits. Charges for the replacement and/or repair of any appliance furnished under the treatment plan are not covered. Separate benefits will not be payable.

J. EXTENDED COVERAGE

If coverage for you or your dependent ends, benefits cease. However, dental expenses (except orthodontic expenses) incurred after coverage ends will be considered for Plan benefits when all of the following conditions apply:

1. The Covered Person's coverage did not end because the Plan Administrator discontinued or changed the Health Plan to end this Dental Plan for all participants; and
2. The dental expense is due to one or more of the following:
 - a. Root Canal Therapy when the pulp chamber was opened prior to the date coverage ended; or
 - b. A covered crown, bridge or restoration for which the tooth was prepared prior to the date coverage ended; or
 - c. A covered appliance, if the impression was take prior to the date coverage ended; and
3. The covered treatment is given within 30 days after the date the Covered Person lost eligibility for Plan coverage; and
4. Must be before the date coverage becomes available under another group plan.

Please Note

All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions. You must comply with requests for additional dental or medical documentation as deemed necessary by the Claims Administrator to evaluate a claim for benefits. Failure to submit requested documentation or information could result in denial of benefits. The Claims Administrator confidentially maintains all dental or medical documents. Treatment decisions are independent from payment decisions. The patient's dentist or physician is responsible for determining whether treatment should be rendered despite whether the charges are totally or partially included in, or excluded from, coverage under the Plan.

SECTION IV - COORDINATION OF BENEFITS (COB)

Information necessary to administer the COB provision will be required when claims are submitted. If you or your dependents are covered by more than one plan, *all claims should be filed with each plan*. You should file claims first with the primary plan, then to the secondary plan(s) with copies of the primary plan explanation of benefits or denial.

Special rules apply when you or your family members are covered by more than one dental or dental/health benefit program. This can happen if you, your spouse, and/or children are covered under This Plan and another plan (with your spouse's employer, for example). Coordination of Benefits (COB) means that the Dental Expense Benefits payable under This Plan, shown in the preceding pages, are coordinated with the dental benefits payable under another group plan. The purpose of COB is to avoid duplicate payments that could exceed 100% of the total allowable expenses.

One of the two or more plan(s) involved is the primary plan and the other plan(s) is the secondary plan(s). The order of benefit determination shown later in this section, determine which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another Plan may cover some expenses. The secondary plan pays after the primary plan and may reduce its benefits so that payments from all involved plans do not exceed 100% of Allowable Fees.

A. COB TERMS AND DEFINITIONS

The following definitions show the meaning of terms used in the administration of this COB provision.

1. **This Plan.** Whenever the term "This Plan" is used in this section, it means the Bedford Central School District Group Dental Benefits Plan.
2. **Plan.** The term "plan" includes any of the following:
 - a. A group insurance or group type dental or dental/health coverage, whether insured or uninsured, including, but not limited to, coverages such as prepayment; indemnity; hospital or medical or dental service organizations; group practice or individual practice; health or dental maintenance organizations or similar type organizations; group auto plan or individual auto health coverage on an automobile leased or owned by an employer; student coverage sponsored by, or provided through, a school or other educational facility except school accident type coverage.
 - b. Coverage under a governmental program for dental benefits offered, required, or provided by federal, state, or local laws. This includes, but is not limited to mandatory no-fault automobile coverage or similar plans, when not prohibited by law. This does not include government coverage, such as Medicaid, that by its terms, prohibits coordination for the allowable expenses.

Each contract, policy or other arrangement for coverage under "a." or "b." is a separate plan. Also, if an arrangement has two parts and the COB rules apply only to one, each of the parts is a separate plan.

3. **Primary Plan/Secondary Plan.** The order of benefit rules determine whether This Plan is a primary or secondary plan to another plan covering the person. When This Plan is primary, its dental benefits are determined before those of the other plan and without regard to the other plan benefits. When This Plan is the secondary plan, its benefits are determined after those of the other plan and may be reduced because of the primary plan dental benefits. If a person is covered by more than one secondary plan, the order of benefit

rules determine the order in which secondary plans are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the order of benefit rules, has its benefits determined before those of that secondary plan.

4. **Claim Determination Period.** The claim determination for coordination of benefits is based on the calendar year and includes Allowable Fees incurred during that period. However, it does not include any Allowable Fees incurred during any part of a calendar year during which a person has no coverage under This Plan.
5. **Allowable Expense.** The term “allowable expense” means dental care expenses, including deductibles and copayments, covered at least in part by any of the plans covering the person. When a Plan provides benefits as dental services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or services that is not covered by any of the plans will not be considered an allowable COB expense. The following are examples of expenses not considered allowable expenses or otherwise limited under this COB provision:
 - a. If a person is covered by two or more plans that determine dental benefit payments based on usual and customary (UCR) charges, any amount more than the highest of the UCR charges for the specific dental benefit is not an allowable expense.
 - b. If a person is covered by two or more plans that provide dental benefits or services based on negotiated fees, any amount more than the highest of the negotiated fees for the specific dental benefit is not an allowable expense.
 - c. If a person is covered by one plan that determines its dental benefits based on usual, customary and reasonable fees and another provides benefits or services based on negotiated fees, the primary plan’s payment arrangements shall be the allowable expense for all plans.
 - d. As secondary payer, This Plan will consider only expenses for dental care when coordinating dental benefits with primary plans. Unless covered by This Plan, allowable expenses do not include expenses for services and supplies covered under hospital, surgical-medical, vision care, prescription drug, hearing aid coverages or similar non-dental coverages.
 - e. As secondary payer, This Plan will not consider any dental benefits paid due to mandatory no-fault laws as allowable expense for COB. However, charges for dental expenses applied to no-fault plan deductibles, copayments or more than the cumulative benefit maximum per accident will be considered as allowable expense, if otherwise covered by This Plan.
 - f. If Medicare is primary, charges more than the allowable expenses permitted under Medicare regulations will not be considered allowable expenses for COB.

B. ORDER OF BENEFIT DETERMINATION

If a Covered Person is eligible for Medicare, the order of benefit determination can be affected by Medicare Secondary Payer (MSP) rules. Current MSP rules and any future changes in MSP rules will automatically apply. ***Rule # 4 shown below applies if you or your dependents are continuing Coverage under COBRA.***

The rules shown below determine which plan pays first. The primary plan pays first without regard to the possibility that another plan could pay some or all of the expenses. A secondary plan pays after the primary plan

and reduces its available benefits so that payments from all involved plans do not exceed 100% of the total allowable expenses.

This Plan is always secondary payer to any dental or dental/health plans that pay without regard to coverage by other plans. This Plan is always secondary to government plans or coverages provided by federal, local, or state laws unless otherwise prohibited by law. For example: This Plan pays before Medicaid. To determine the order plans should pay dental expenses covered by two or more plans with a COB feature, an order of benefit determination has been established as follows:

- 1. Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, enrollee, or retiree is primary. The plan that covers the person as a dependent is secondary. However, this changes if the person is eligible for Medicare primary benefits. For example, the Medicare rules for beneficiaries without employment status could apply making the dependent's active plan primary over the plan of an employee without employment status.
- 2. Child Covered under More than One Plan.** The following order of benefit determination is used when a child is covered by more than one Plan.
 - a. The primary plan is the plan of the parent whose birthday is earlier in the year if the parents are married, not separated (whether or not they have ever been married), or a court decree awards joint custody without specifying that one party has the responsibility to provide dental or health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - b. If the specific terms of a court decree state that one parent is responsible for the child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of a court decree.
 - c. If the parents are not married, or are separated (whether or not they have ever been married) or are divorced, the order of benefits is the plan of the custodial parent, then the plan of the spouse of the custodial parent, then the plan of the non-custodial parent and then the plan of the spouse of the non-custodial parent. The custodial parent is the parent awarded custody by a court decree. Without a court decree, it is the parent with whom the child resides more than half the calendar year without regard to temporary visitations.
- 3. Active/Inactive Employee.** The Plan that covers a person as an employee who is neither laid off nor retired are determined before the Plan that covers that person as a laid off or retired employee. The same would hold true for dependents of that person.
- 4. Continuation Coverage.** If a person is covered under continuation of coverage pursuant to federal or state laws, such as COBRA, and is also covered under another plan, the order of benefit rules change. The plan that provides dental or dental/health coverage for the individual as an employee, member, subscriber, enrollee, or retiree is primary for that person and/or that person's eligible dependents. The plan providing continuation coverage is secondary.

If the preceding order of benefit rules fail to establish the primary plan(s), then the plan that has covered the patient for the longer time will consider its plan benefits first. If according to the above rules, This Plan is secondary and another plan's rules conflict making This Plan primary, This Plan will use the National Association of Insurance Commissioners (NAIC) Model Regulation and any court cases to determine the validity of the conflicting rules.

C. COB EFFECT ON PLAN BENEFITS

When this Plan is secondary, the benefits of This Plan will be reduced so that the total benefits paid or provided by all plans are not more than 100% of the allowable expenses incurred during a claim determination period. When the benefits of This Plan are so reduced, each benefit is reduced in proportion and applied against any applicable benefit limit of this Plan. It is then charged against any applicable benefit limit of This Plan.

If a Covered Person fails to file a claim with the primary payer or fails to obtain services through a primary plan according to its rules, then benefits for the primary plan will be estimated. If a person is eligible for Medicare primary coverage according to Medicare secondary payer rules and is not enrolled in Medicare Part A and/or Part B or in Part C, then Medicare benefits will be estimated. The estimated Medicare payments will be used to determine the benefit reduction under this COB provision.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts it needs. It may get needed facts from, or give them to, any other organization or person. The Claims Administrator need not tell or get the consent of any person to do this. Each person claiming benefits under the Plan must give the Claims Administrator any facts required to pay the claim.

E. FACILITY OF PAYMENT

Payments made under another plan may include an amount that should have been paid under the Plan. If it does, the Claims Administrator may pay the amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under the Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits as services in which case "payment made" means reasonable cash value of the benefits provided as services.

F. RIGHT OF RECOVERY

If the amount paid by the Claims Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

1. The person it has paid or for whom it has paid; or
2. Insurance companies; or
3. Self-Funded Claims Administrator; or
4. Other organizations.

SECTION V - PLAN EXCLUSIONS

Plan Exclusions are shown in this section under *Dental Procedures Not Covered* and under *General Plan Exclusions*. The following dental expenses are not reimbursable unless specifically shown otherwise under the Plan. Also refer to **Section VII - Definitions** for further explanation.

A. DENTAL PROCEDURES NOT COVERED

Covered services do not include, and no payment will be made for, services or supplies related to the following dental procedures:

1. Dental services related to procedures that do not meet common dental standards or are related to investigative or experimental procedures or to methods not approved by the appropriate dental specialty society.
2. Dental services done primarily for elective, cosmetic or esthetic purposes including but not limited to extraction and/or replacement of sound natural teeth to improve appearance, personalization or characterization of dentures. Any series of treatment that includes crowns on any of the four front upper or lower teeth will automatically be considered cosmetic, unless a pretreatment review shows that a deterioration of each tooth makes other restoration methods inapplicable.
3. Dental services that are not dentally or medically necessary for the treatment of dental illness or injury. Services not prescribed as necessary by a dentist or physician.
4. Preventive care except as otherwise specifically included in the Plan. (See **Section III -Covered Services** under *F. Type 1-Dental Expenses-Diagnostic and Preventive.*)
5. Replacement or duplication of a bridge, crown or denture for one or more of the following:
 - a. Made useless due to patient abuse, misuse or neglect.
 - b. Lost or stolen appliance.
 - c. Within five years of an initial installation or a prior replacement except as otherwise specifically included in the Plan. (See **Section III - Covered Services** under *I. Type 3 Dental Services - Major Restorations; 2. Prosthodontics.*)
 - d. Which is or can be made functional or serviceable according to common dental standards.
6. Implant, transplant or reimplantation of any type including any prosthetic device attached to it. Any procedure or service associated with the placement or prosthodontic restoration of a dental implant. This exclusion includes reimplantation of natural tooth or teeth that has been dislodged or removed.
7. Bite registrations, precision or semi-precision attachments or splinting.
8. Porcelain veneers on crowns or pontics that are on or replacing the upper and lower first, second and third molars to the extent the charges would be more than the charge for acrylic veneered crowns. Facings on crowns or pontics for teeth posterior to the second bicuspid.
9. Procedures, appliances or restorations (except full dentures) whose main purpose is to change vertical dimensions or to diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ) or to stabilize periodontal involved teeth or to restore occlusion.
10. Educational services including dietary planning, oral hygiene, plaque control and related materials.
11. Athletic appliances, mouth guards and other protective appliances.
12. Sedation or separate charges for local anesthetic. General anesthesia except as otherwise specifically included in the Plan.
13. Drugs and Medicines obtainable without a prescription or not connected with a covered dental procedure.
14. Services or supplies not included as covered services under the Plan.

B. GENERAL PLAN EXCLUSIONS

Benefits are not payable for the following:

1. Services or supplies incurred while an individual is not eligible and enrolled in the Plan or while the Plan is not in force.
2. Services or supplies that done by someone other than a licensed dentist, physician or duly licensed technician employed by the physician or by a duly licensed technician providing covered services ordered by the attending dentist or physician. Services or supplies provided outside the scope of a qualified provider's license or outside the geographical area of license.
3. Charges more than the usual, customary, and reasonable allowance for covered services or supplies. Charges more than the allowable fee for a standard procedure or for alternate treatment covered instead of non-standard or specialized dental care.
4. Services or supplies received from a dental or medical department sponsored or maintained by, an employer, labor union or other similar person or group.
5. Services or supplies received from a hospital.
6. Services rendered by an immediate relative or household member.
7. Services or supplies to the extent that the care or payment of the care is unlawful where the patient resides or where the care was received at the time rendered.
8. Services or supplies covered under a medical plan sponsored by the District. The coordination of benefits provision does not apply in this case.
9. Services or supplies for which benefits are or can be provided because of related illness or injury arising from the past or present service of any person in the armed forces of a government.
10. Services or supplies related to an occupational injury or occupational sickness that entitles the Covered Person to benefits under a worker's compensation law or occupational disease law or similar legislation. Payment will not be made even if you do not claim the entitled benefit.
11. Services or supplies that could be provided by or paid for by any governmental program (other than Medicaid) under which you could be covered. Exception: services or supplies covered by Medicare. See **Section IV - Coordination of Benefits**.
12. Services or supplies received for which no charge would have been made without coverage under the Plan or for which there is no obligation to pay.
13. Services or supplies received because of an injury or sickness due to an act of war, whether declared or undeclared, or a warlike action in time of peace.
14. Service rendered for medical/dental summaries and invoice preparations or fees for completion of claim forms or fees for missed appointments, telephone consultations and fees for services not actually provided.
15. Services or supplies that are not included as covered services under the Plan or that are not rendered and billed by a qualified provider.

SECTION VI – CLAIM SUBMISSION AND REVIEW PROCEDURES

A. HOW TO SUBMIT A CLAIM

If another health/dental plan is the primary plan, claims should be submitted to that plan, then to POMCO with copies of their explanation of benefits or denial. If due to illness or injury for occupational cause, no-fault accident or incident, or for which benefits could be payable by a third party plan not owned by you or your dependent, claims should be submitted to the appropriate insurance company or plan administrator. Be sure to advise the provider of these situations to avoid overpayment by this Plan.

1. **Claim Submission Procedures.** If billed for covered services, you must take the following steps to submit a claim for benefits:
 - a. A dental claim form should be obtained from the District Benefits Office. Be sure to read the instructions printed on the claim form. **Note:** You must attach a completed claim form each time you send in dental bills and a separate claim form is needed for each family member.
 - b. Once you have completed your portion of the claim form, the dentist can complete his or her portion.
 - c. For services rendered by other than a doctor, the bill should also include the provider's signature and tax identification number.
 - d. If services are due to a non-occupational or other accidental injury, you must provide complete details on how, where, the date, and the time such injury was sustained.
 - e. Attach other plan explanation of benefits or denial, if appropriate. All completed forms and itemized bills should be submitted to:

**POMCO
P.O. BOX 6329
SYRACUSE, NY 13217**

The Claims Administrator will accept other valid claim forms that provide the necessary information to decide coverage. If you fail to provide necessary information, your claim could be returned with a request for missing information or additional details. This could delay the determination of Plan benefits. POMCO will advise you of the approval or rejection of your claim by mail.

B. TIME LIMIT ON CLAIM SUBMISSION

Claims should be submitted as incurred. Claims may not be submitted later than March 31 of the calendar year following the end of the calendar year in which the covered expenses were incurred.

C. PAYMENT OF BENEFITS/AUTHORIZATION TO PAY PROVIDER

Although direct payment may be authorized as shown below, under no circumstances may you assign your right to benefits under this Plan to any person, corporation or other organization. You may not assign your right to take legal action under this Plan to any provider of service. Any assignment of your right to benefits or your right to legal action under this Plan will be void.

Plan benefits are usually paid to you unless you sign the authorization on the claim form to have payment made directly to the provider. A separate claim form is necessary for each provider. The Plan may, at its option, accept such authorization of payment to a dentist or other qualified provider. The Plan may, at its option, elect to pay benefits directly to the provider or other entity, if appropriate. Without provider tax identification information, the Plan may, at its option, reimburse benefits to you rather than the provider, even if you authorized benefit payment to that provider. If this Plan is considered a secondary payer, the Plan may, at its option, pay you, the provider, or pay the primary plan for its overpaid benefits. If you die, the Plan may elect to pay benefits to any

unpaid provider, your estate, your spouse, your parents, your children or your brothers and sisters as deemed appropriate.

D. DENTAL CLAIM INQUIRIES

When you have any questions concerning your coverage, you may call the District Benefits Office or the following phone number at POMCO: **1 800-234-9862**.

E. CLAIM APPEALS PROCEDURE

If a claim for benefits is denied in whole or in part, you may appeal the claim determination to the Claims Administrator. Your appeal must be in writing and mailed to the Claims Administrator within 60 days after the date of the explanation of benefit or denial. The Plan Administrator reserves the right to maintain denial of benefits without further review for any appeals received more than 60 days after the initial notice of claim payment or denial. POMCO will advise you of the results of their appeal review. Your written appeal should be mailed to:

**POMCO
Dental Appeals Unit
PO Box 6329
Syracuse, NY 13217-6329**

F. LEGAL PROCEEDINGS

No action at law or equity shall be brought to recover under the Plan before the expiration of the later of 60 days after proof of claim has been furnished to the Claims Administrator or 30 days after the exhaustion of all appeal rights under this Section. No action shall be brought at all unless commenced within two years from the date the covered service or supply was incurred. However, in the event the District is canceling this self-funded Plan and the Covered Person is notified of the end, no action to recover under this Plan shall be brought unless commenced before the later of 30 days after the date of that notification, or 90 days from the date of the Plan cancellation. The agent for service of legal process is the Bedford Central School District.

SECTION VII - OTHER PROCEDURES AND PROVISIONS

A. NOT A CONTRACT

All rights accruing to any person under the Plan shall be subject to the terms and conditions of the Plan. The Plan does not constitute a contract between the District and any covered enrollee or participant, nor is it considered an inducement for the initial or continued employment of any employee. Likewise, maintenance of the Plan shall not be construed to give any employee the right to be retained as an employee by the District or to any benefits not specifically provided by the Plan.

B. VERIFICATION OF CLAIM INFORMATION

The District and the Claims Administrator have the right to request any dental or medical records or information from you or your dependents' dentists as needed for the proper handling of claims. When you become covered under the Plan, you automatically give permission to the Plan Administrator and the Claims Administrator to obtain and use those records and that information. Failure to release the records or information on a timely basis, or failure by the enrollee, patient, parent or guardian to authorize the release of appropriate information could result in denial of benefits. The Claims Administrator confidentially maintains all dental or medical records.

C. RIGHT OF EXAMINATION

The District or the Claims Administrator shall have the right, to require an independent dental examination for you or your dependent when and so often as it may reasonably require such examination during the determination of a claim.

D. INDEMNITY BENEFITS

Benefits under the Plan are only payable for services rendered. Except as otherwise specified, benefits cannot be pre-approved. Benefit determination will be based on Plan limitations (eligibility, benefits, etc.) and exclusions in effect at the time services are received.

E. MISREPRESENTATION/FRAUD

If it is found that a claim for benefits, or any materials provided for evaluating a claim for benefits under the Plan, contains false information, or that you or your dependent or a provider conceals, for the purpose of misleading, information concerning any fact material to a claim for benefits thereto, the claim may be denied in total and the Plan Administrator and/or the Claims Administrator may recover any benefits paid to you and/or a provider. This paragraph does not affect the right of the Plan Administrator to pursue any criminal or civil remedies that may exist under applicable state or federal law.

F. REFUND DUE TO OVERPAYMENT OF BENEFITS

If payment has been made for covered services or supplies that are more than the benefits that should have been paid, or for services or supplies that are not covered, according to Plan provisions, the Plan Administrator or Claims Administrator has the right to demand full refund and/or may cause the reduction of present or future benefits until overpayment refunded; or recover the amounts by any other appropriate method that the District shall determine. Each Covered Person hereby authorizes the deduction of excess payments from present and future Plan benefits or other present or future compensation payment. Payments made in error for services or supplies not covered by this Plan shall not be considered certification of coverage and will not limit the enforcement of any provision of this Plan for any and all claims submitted under the Plan.

G. NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The named fiduciary and Plan Administrator is Bedford Central School District who will have the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to appoint or remove plan supervisors, plan managers or claim administrators, fix their compensation, if any, and exercise general administrative authority over them. The Plan administrator has the sole authority and responsibility to review and decide Plan determinations and claims for benefits.

H. AMENDMENTS OR CANCELLATION OF THE PLAN/RIGHT TO DEVELOP GUIDELINES

The Plan Administrator, to the fullest extent allowed by law, will have the discretion to determine all matters relating to eligibility, coverage or benefits under the Plan, and will have the discretion to determine all matters relating to the interpretation and operation of the Plan. The Plan Administrator reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures for which expenses for services or supplies may be approved within the limitations and exclusions of this dental Plan. For any dental expenses for which there is not definition, the Plan Administrator's interpretation will apply. Any such determination, construction, or judgment adopted by the Plan Administrator in good faith will be final and binding on all parties hereto and any Covered Persons under the Plan. No decision of the Plan Administrator will be reversed or overturned unless determined to be arbitrary and capricious.

I. SEVERABILITY

If any provision of the Plan is found by a court of competent jurisdiction to be void, invalid, or unenforceable, the same shall either be reformed to comply with applicable law or stricken, if not so conformable, so as not to affect the validity or enforceability of the remainder of the Plan.

J. WAIVER AND ESTOPPEL

No term, condition, or provision of this Plan will be deemed waived, and there will be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel.

No such written waiver will be deemed a continuing waiver unless explicitly made so, and will operate only regarding the specific term or condition waived, and will not be deemed to waive such term or conditions in the future, or as to any act other than specifically waived. No enrollee, participant or beneficiary other than as named, or described by class, in the waiver will be entitled to rely on the waiver for any purpose.

K. HEADINGS

All article and section headings in this Plan have been inserted for convenience only and will not determine the meaning of the content thereof.

SECTION VIII – DEFINITIONS

Certain words and phrases applicable to or used in this SPD are listed below with the definition or explanation of the manner in which the term is used for the purpose of the Plan. Masculine pronouns, if used in this SPD, will include masculine or feminine gender, unless the context shows otherwise.

ACTIVE EMPLOYEE - Any full time teacher or administrative employee who is on the regular payroll of the Bedford Central School District and does, for the District, all the substantial and material duties of the job and regularly works the minimum hours per day or week established by the District for regular employment.

ALLOWABLE FEES - The Usual, Customary and Reasonable Charges, according to Plan provisions, for covered dental treatment given and billed by a qualified provider. The Plan will not pay charges more than the Allowable Fees for any covered services or supplies.

AMENDMENT - A change, revision, deletion, or addition to the Plan Document and/or Summary Plan Description duly made, and signed by an authorized representative of the Plan Administrator.

APPROVED CARE OR PLAN OF CARE - Any service or course of dental treatment approved for benefits under the terms and limitations of the Plan.

CALENDAR YEAR - A period of twelve months, commencing with January 1 and ending December 31 of the same year.

CLOSE RELATIVE - See Immediate Relative.

COBRA - The continuation of Plan coverage according to Federal regulations under the Consolidated Omnibus Budget Reconciliation Act of 1986 and subsequent Federal COBRA regulations affecting this type of Plan.

COPAYMENT - That figure shown as a percentage used to compute Plan payment based on Allowable Fees. The Covered Person is responsible for payment of the copayment reduction amounts.

COURSE OF ORTHODONTIC TREATMENT - The period of orthodontic care that begins with the first orthodontic appliance (diagnostic procedures and installation) and ends when the last appliance is taken off. Two or more treatment courses will be considered as one course of orthodontic treatment unless separated by at least two years from the date of last orthodontic treatment.

COVERAGE OR COVERED - Dental treatment shown in the Plan as eligible for Plan payment when incurred by Covered Persons.

COVERED EXPENSES - See Allowable Fees.

COVERED FAMILY - The enrollee and his or her eligible dependents enrolled in the enrollee's family coverage.

COVERED PERSON - Any person eligible and enrolled for benefits or coverage under this Plan.

COVERED PROVIDER - See Provider.

COVERED SERVICES OR SUPPLIES - Dentally necessary services or supplies, or other care, specifically shown as covered expenses according to Plan provisions and not otherwise specifically excluded under the Plan.

DEDUCTIBLE - The amount of allowable expenses that must be paid by the enrollee before certain benefits can be determined under Plan provisions.

DENTAL EXPENSE BENEFITS - Plan payment for covered dental services, supplies or devices related to treatment of dental illness or injuries or for specified preventive services.

DENTALLY NECESSARY OR DENTAL NECESSITY for purposes of benefit determination means services, drugs, supplies or devices received by a patient for the treatment of a dental illness or injury, only when it the most appropriate treatment of the dental sickness according to generally accepted standards of good dental and/or medical practice in the USA. It is not done for primarily cosmetic or aesthetic purposes. The fact that a dentist or physician prescribes, recommends, orders or approves a dental service or supply, by itself, does not decide dental and/or medical necessity or make such service or supply eligible for benefits, even if not expressly excluded under the Plan.

DENTIST - A person legally licensed as a physician to practice dentistry or to perform dental surgery (D.D.S., D.M.D. or M.D.)

DEPENDENT - An enrollee's legal spouse or child who meets the conditions as shown in Section II - Eligibility

and Enrollment.

EFFECTIVE DATE - The date coverage became effective with respect to the Plan or with respect to eligible and enrolled individuals after designated waiting periods.

ELIGIBLE DEPENDENTS - See Dependents.

EMPLOYEE - Any person who is considered an eligible employee or retiree according to criteria established by the Plan as set forth in Section II - Eligibility and Enrollment. It does not mean persons without employment or retiree status such as former employees that have been terminated or laid off unless continuing coverage during an authorized leave of absence or COBRA period.

ENROLLEE - An eligible employee or COBRA participant under whose social security number enrollment is made.

EXPERIMENTAL - See Investigative.

FAMILY MEMBER - The employee or enrollee and eligible dependents enrolled in the employee or enrollee's family coverage.

HANDICAPPING MALOCCLUSION - Improper alignment of biting or chewing surfaces of upper or lower permanent teeth usually with arch discrepancy of four or more degrees.

HOUSEHOLD MEMBER - Any person sharing a common abode as part of a single family unit, including domestic employees and others, who live together as part of a family unit, but not including a mere roomer or boarder.

IMMEDIATE RELATIVE - Any of the following relatives of the patient or enrollee:

1. Spouse of the patient or enrollee;
2. Natural or adoptive parent, child or sibling;
3. Stepparent, stepchild, stepbrother or stepsister;
4. Father-in-law, mother-in-law, brother-in-law, or sister-in-law;
5. Grandparent or grandchild; or
6. Spouse of grandparent or grandchild.

INCURRED or INCURRED DATE - The date the covered services or supplies were actually given to, or received by, a Covered Person.

INJURY - Non-occupational injury to natural teeth, the jaw or surrounding structures caused by an event that is sudden and not foreseen, and is exact as to time and place. Injury must be unexpected and unavoidable. The breakdown or fracture of natural teeth or other dental condition caused by chewing will not be considered accidental injury.

INVESTIGATIVE or EXPERIMENTAL - Any care that is not widely accepted professionally in the United States as effective, appropriate and essential treatment of a reported dental condition or injury based on recognized standards of dental care in effect at the time services or supplies were incurred.

LATE ENTRANT - An eligible employee or eligible dependent who is enrolled for Plan coverage after his or her initial enrollment eligibility period, usually more than 31 days after initial eligibility.

LEAVE OF ABSENCE - An eligible employee who does not meet the actively-at-work requirement, whether or not receiving wages or remuneration, is eligible to continue under the Plan with specific advance written approval of the District.

LEGAL SPOUSE - A person who is the legal husband or wife of an eligible employee according to the laws of the state or other jurisdiction in which such person resides.

NON-OCCUPATIONAL - A condition or injury that does not arise and is not caused or contributed to, by or because of, any disease or injury that arises out of or during any employment or occupation for compensation or profit.

PARTICIPATION CONTRIBUTION - The Plan participation costs that the District collects from its Plan participants or enrollees.

PERCENTAGE COPAYMENT - See Copayment.

PHYSICIAN - A doctor of medicine (M.D.) doctor of dentistry (D.D.S. or D.M.D.) legally licensed and operating within the scope of the license to provide covered dental treatment.

PLAN ADMINISTRATOR - The Bedford Central School District

PLAN OF CARE - See Approved Care.

PLAN SPONSOR - The Bedford Central School District.

PROVIDER - Any legally licensed physician (D.D.S. or M.D.) To be covered, a provider must meet Plan definitions and limitations, render a covered service within Plan limitations, be operating within the scope of their license, and operating according to the laws of the jurisdiction where services or supplies are given or delivered.

QUALIFIED PROVIDER - See Provider.

RETIREE - A person who was actively employed by Bedford Central School District when retired and who was eligible for Plan continuation under the written retirement program established by the District; and who elects to continue Plan coverage at the time of eligible retirement and pays the required participation contributions.

SERVICES - Dentally necessary professional dental care services, supplies or other care shown as covered expenses according to Plan provisions and not otherwise excluded under the Plan.

SPOUSE - See Legal Spouse.

SUPPLIES - Any drugs, medicines, devices, appliances, prosthetics, materials, or other items used for dental care.

UCR - See Usual, Customary and Reasonable Charges

USUAL, CUSTOMARY AND REASONABLE CHARGES (UCR) - The lowest of the following:

- a. The actual charge for the service or supply;
- b. The usual charge by the dentist or physician or other provider for the same or similar service or supply; or
- c. The usual charge of other dentists or physicians or other providers in the same or similar geographic area for

the same or similar service or supply (prevailing fees) based on established criteria using percentiles of current fee data profiles.

In the determination of benefits for a claim, the usual level of charges may be modified by a relative value study, where appropriate, to model actual claims experience in a given area across a range of percentiles. The term "area" as it would apply to any particular service, medicine, or supply mean a zip code, county or such greater area as is necessary to obtain a representative cross section of level charges. The part of the cost that exceeds that of any other services that would have been sufficient to safely and adequately diagnose or treat an individual's physical or mental condition will not be deemed as usual, customary or reasonable charges. The Claims Administrator, based on the above rules, makes the determination of the Usual, Customary and Reasonable Charges for a service or supply.

WAITING PERIOD - The designated period between the employee's date of eligible employment and the date the employee becomes covered for Plan benefits. The designated period between Plan enrollment and the effective date of coverage for Late Entrants.

YOU OR YOUR - An eligible and enrolled employee of the District. It also means a COBRA participant enrolled for individual coverage, or a COBRA participant whose social security number is used for family coverage enrollment.