Whitesboro Central School District

65 Oriskany Boulevard Suite #1
Whitesboro, New York 13492

Dental Handbook

WHITESBORO CENTRAL SCHOOL DISTRICT

Administrative Office - Suite 1
65 Oriskany Blvd
Whitesboro, NY 13492

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Introduction

This booklet explains your dental benefits under the Whitesboro Central School District Dental Benefits Plan ("Plan"). The Plan is funded by Whitesboro Central School District ("Plan Administrator"). Lifetime Benefit Solutions, Inc. is the ("Claim Administrator") and administers the claims for the dental benefits of the Plan on behalf of the Plan Administrator.

Section One
Important Terms and Phrases You Need to Know

To help make the information in this booklet easier to understand, general definitions of important words and phrases used throughout the document are described below. In addition, definitions of other terms and phrases appear in sections of this booklet where they are relevant.

1. **Allowable Amount**. The maximum amount that will be paid to the Provider for services or supplies covered under this Plan, before any applicable deductible, Copayment or Coinsurance amounts are subtracted. We determine our Allowable Amount as follows:

   A fee schedule amount is assigned to dental services or procedures based upon a review of factors such as Provider specialty, geographic location, and network adequacy, in addition to market forces such as price point. In the absence of a set fee schedule amount, the Allowable Amount will be determined by taking into consideration the type of Covered Service and the average fee schedule amount for similar Covered Services.

   a. If the Plan has a Preferred Provider Reimbursement Schedule, the Allowable Amount for a Covered Service received from a dentist who is a Preferred Provider will be the lower of:

      i. the Preferred Provider Reimbursement Schedule amount for the Covered Service, or
      ii the dentist's billed charge.

   b. If the Plan has a Maximum Amount Payable (MAP) Fee Schedule, the Allowable Amount for a Covered Service received from a dentist who is a Preferred Provider will be the lower of:

      i. the maximum amount payable under the MAP Fee Schedule for the Covered Service, or
      ii. the dentist's billed charge.

   c. The Allowable Amount for a Covered Service received from a non-Participating Provider will be the lower of:

i. a percentile of the Reasonable and Customary charge, as defined below, or
ii. the dentist's billed charge.

The Reasonable and Customary charge is a fee or charge the Plan determines based on provider charge data known as the Prevailing Healthcare Charges System (PHCS), which the Claim Administrator purchases from Fair Health, Inc., or provider charge data that the Claim Administrator purchases from a New York State-approved vendor of provider pricing data.

2. **Charge**. The charge is the amount the provider actually bills for a covered service. The date a charge is considered to have been incurred is determined in accordance with the following rules:

a. Dentures - the date the dentures or fixed bridges are completed.
b. Crowns - the date the crown is inserted/seated.
c. Root canal therapy - the date the work on the tooth begins.
d. Any other covered service – the date the service is completed.

3. **Covered service**. A covered service is any service, part or all of which may be paid by the Plan.

4. **Covered dependent**. A covered dependent refers to a participant's spouse and dependents covered under the Plan.

5. **Lifetime Benefit Solutions**. Lifetime Benefit Solutions refers to Lifetime Benefit Solutions, Inc., which provides administrative services for the Plan. You may contact Lifetime Benefit Solutions at:

Lifetime Benefit Solutions, Inc.
P.O. Box 21951
Eagan, MN 55121

6. **Dentally Necessary or Medical Necessary** means health care or dental services that a Dentist or Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical or dental practice;
b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Sickness, Injury or disease; and
c. Not primarily for the convenience of the patient, physician, or other health care Provider, and
d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's Sickness, Injury or disease.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally

recognized by the relevant medical community when available, Physician Specialty Society recommendations, the views of prudent Providers practicing in relevant clinical areas, and any other clinically relevant factors.

7. **Provider**. A provider is a professional health care provider licensed to provide covered services.

8. **Plan Administrator**. The Plan Administrator is Whitesboro Central School District. (Note that Lifetime Benefit Solutions is NOT the Plan Administrator.)

9. **Service**. A service is any treatment, technology, procedure, care, drug, appliance, equipment, device or supply provided by a provider.

Section Two
Deductible Amount – What A Participant Must Pay First

Deductible. After your coverage under this Plan begins, you must pay for the first $25 of covered expense for Class IV orthodontic services only.

Section Three
Coinsurance Amount – Sharing Expenses

The coinsurance amount is the percentage of a covered service not paid by the Plan (in addition to any deductible amount) for any Class III and IV covered services. The coinsurance amount applicable for a specific covered service is explained in the section of this booklet identifying that covered service.

Section Four
Plan Payments

The maximum amount that the Plan pays for a covered service is the Allowable Amount for that covered service, minus any deductible and coinsurance amount.

Section Five
Benefit Year Maximum Amount

The calendar year maximum amount is the maximum amount the Plan will pay for covered services, other than Class IV-Orthodontic Services, incurred for a participant or covered dependent in a benefit year (July 1 – June 30). The benefit year maximum amount is $1,000.00.

Section Six
Class I – Preventive Dental Services

The coinsurance amount for preventive dental services is 0% of the Allowable Amount. The participant is responsible for paying this coinsurance amount and any other amount not paid by the Plan.

The following preventive dental services are covered services.

1. **Oral evaluations**. Up to two (2) routine dental evaluations during any benefit year, but not more than once in a five (5) month period; plus additional oral evaluations when there is a confirmed disease or injury requiring a specific evaluation for treatment.

2. **Cleaning (prophylaxis)**. Up to two (2) cleanings of teeth during any benefit year, but not more than once in a five (5) month period.

3. **Fluoride application**. Up to two (2) topical applications of fluoride during any benefit year, but not more than once in a five (5) month period for a covered dependent under twenty-five (25) years of age.

4. **X-rays**. Up to one (1) full-mouth x-ray or panorex during any thirty-six (36) consecutive month period; up to two (2) sets of bitewing x-rays per benefit year, but not more than once in a five (5) month period; other dental x-rays required to diagnose a specific condition requiring treatment; and additional full-mouth x-rays required to diagnose or treat a specific disease or injury.

5. **Sealants**. Topical application of sealant per posterior tooth.

6. **Miscellaneous Services/Tests and Laboratory Examinations**. Diagnostic casts for complex restoration cases only, pulp vitality tests, and other miscellaneous laboratory tests in connection with examinations.

Section Seven
Class II – Basic Dental Services

The coinsurance amount for basic dental services is 0% of the Allowable Amount. The participant is responsible for paying this coinsurance amount and any other amounts not paid by the Plan.

The following basic dental services are covered services.

1. **Extractions**. Simple or surgical tooth extractions.

2. **Restorations (fillings)**. Restorations to cover single and multiple tooth surfaces and pin-retained teeth restorations, utilizing amalgam or composite material.

3. **Endodontics**. Treatment of diseases of dental pulp, including root canal therapy.

4. **Periodontal prophylaxis**. Up to two (2) routine scaling procedures per benefit year, but not more than once in a five (5) month period to prevent periodontal disease in borderline periodontitis situations.

5. **Periodontics**. Surgical and non-surgical treatment of diseases of the gums and tissues of the mouth, including gingivitis.

6. **Emergency treatment**. Emergency dental procedures performed to temporarily alleviate or relieve acute pain, discomfort, or distress, but that do not effect a definite cure.

7. **Oral surgery**. Alveoloplasty (surgical preparation of ridge for denture); tooth replantation; biopsy of oral tissue and stomaplasty (removal and restoration of gum tissue); and medically necessary general anesthesia administered in connection with these services.

8. **Space maintainers**. Space maintainers provided to replace missing primary teeth for a covered dependent age fourteen (14) and under; modification of a space maintainer required because of a related change in the condition of the mouth.

9. **Consultation**. Benefits are payable for dental consultation.

10. **Fixed and removable appliances**. Benefits payable for covered dependents age fourteen (14) and under for appliances for control of harmful habits, such as thumb sucking and occlusal guards for bruxism.

11. **Relines and rebases**. Services provided to existing dentures.

12. **Prescription medication**. Benefits are provided for drugs that require a dentist's written prescription, including medication given at the dentist's office.

13.....**Occlusal Adjustment**. Occlusal adjustment not associated with restorations.

Section Eight
Class III – Major Dental Services

The coinsurance amount for major dental services is 50% of the Allowable Amount. The participant is responsible for paying the coinsurance amounts, and any other amounts not paid by the Plan.

The following major dental services are covered services.

1. **Inlays, onlays, gold restorations and crowns**. Procedures to restore diseased or accidentally broken teeth by applying crowns, inlays (gold filling put into the tooth), and onlays (covering the top of the tooth), but only when the tooth cannot be restored by conventional restoration, such as amalgam, composites, etc.

2. **Prosthetic services, dentures and bridges**.

   a. Construction, placement, insertion and repair of natural teeth not missing before the participant or covered dependent's coverage under the Plan began by artificial devices, including bridges and dentures; installation of fixed bridge work (including inlays and crowns as abutments); and placement of full or partial dentures; and

   b. repair or re-cementing of bridgework or dentures.

   Replacement of an appliance, existing partial or full removable denture or fixed bridgework by a new denture or new bridgework is covered only if:

   a. the replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was placed;

   b. the existing denture or bridgework cannot be made serviceable; at least five (5) years have elapsed before its replacement; or

   c. the existing denture is an immediate temporary denture that cannot be made permanent; and replacement by a permanent denture takes place within twelve (12) months of the date of initial placement of the immediate temporary denture.

Section Nine
Class IV – Orthodontic Services

The coinsurance amount for orthodontic services is 50% of the Allowable Amount. The participant is responsible for paying the deductible, this coinsurance amount and any other amounts not paid by the Plan.

The following major orthodontic services are covered services for dependent children between six (6) and eighteen (18) years of age.

1. **Orthodontic services**. Orthodontic diagnostic procedures and treatment, including one (1) panorex x-ray during a thirty-six (36) consecutive month period; functional/myofunctional therapy, including related oral evaluations; surgery; extractions; appliances; and installation of appliances.

2. **Lifetime maximum payment**. The Plan's calendar year maximum limit does not apply to orthodontic services. However, the lifetime maximum amount payable by the Plan for orthodontic services provided to any covered participant or covered dependent is $1,200.00. When the Plan's payments for any orthodontic services provided to any individual reach this amount, Plan coverage for orthodontic services provided to that individual stops.

Section Ten
Exclusions

The following exclusions and limitations apply, in addition to all other exclusions and limitations described in other sections of this booklet. Remember that, even if there is an exception from an exclusion listed below for certain services, other sections of this booklet may still exclude the services from being covered services.

1. **No coverage**. The Plan does not cover any services incurred for a participant or covered dependent before his Plan coverage begins.

2. **VA/Government/Uniformed Service Hospitals**. The Plan does not cover any service received in an institution owned or operated by the Veterans Administration ("VA"), a federal, state, or local government, or the United States uniformed services, except as follows:

   a. **VA hospitals**. The Plan covers services for non-military services related conditions received in an institution owned or operated by the VA.

   b. **Government hospitals**. The Plan covers services received by an inpatient in a hospital that is state or municipally owned and operated, if the hospital usually charges for its services.

c. **Uniformed service hospitals**. The Plan covers services received by participants who are retired military personnel (or their covered dependents), and dependents of military personnel on active duty, as inpatients in a hospital operated by the United States uniformed services.

d. **Emergency care**. The Plan covers services in any of the above hospitals if:

i. the services are necessary because of a sudden and serious illness or injury;
ii. the services are provided immediately at the hospital because of its proximity;
iii. it is impossible for the participant or covered dependent to transfer to another institution; and
iv. the participant or covered dependent stays in that hospital only as long as such emergency care is necessary.

3. **Government programs**. The Plan does not pay amounts payable under Medicare, or any other federal, state or local government program, except when it is required to do so by state or federal law. When a participant or covered dependent is eligible for a government program, Plan payments are reduced by the amount the government program pays or would pay for the services, even if the participant or covered dependent fails to enroll in the government program, or does not pay the charges for the program, or receives services at a hospital that cannot bill the government program.

4. **Workers' compensation**. The Plan does not cover any service covered under a workers' compensation law or similar law, even if the participant or covered dependent does not receive benefits because he does not submit a claim for benefits under the Workers' Compensation Act or similar law, or does not appear for a hearing.

5. **No-fault automobile insurance**. The Plan does not cover any service covered under no-fault automobile insurance, even if no timely claim is made under the insurance or, if a claim is made and denied, no available appeal is filed or arbitration hearing is requested. This exclusion does not apply to the extent amounts are not payable under the insurance solely because of a deductible amount requirement.

6. **Free care**. The Plan does not cover any service furnished without charge, or which would not normally be billed by the provider, or which would have been furnished without charge if there were no coverage under the Plan.

7. **Employer services**. The Plan does not cover any service furnished to an employee or his dependents by a medical department or clinic provided by his employer.

8. **Cosmetic surgery**. The Plan does not cover any service related to cosmetic or beautifying surgery and intended only to improve appearance. However, this exclusion does not apply to services provided in connection with reconstructive surgery as a result of an infection, injury or disease and reconstructive surgery to

correct a functional birth defect of a covered dependent child (but only for the type of oral surgery otherwise covered under the Plan).

9. **Experimental and investigational services**. The Plan does not cover services determined to be experimental or investigational by the Plan Administrator. A service may be determined to be experimental or investigational even if it has received governmental approval or is ordered by a provider. "Experimental or investigational" means:

   a. the service is considered experimental or investigational by any appropriate technological assessment body established by a state or federal government;
   b. the service does not have appropriate governmental or regulatory approval when it is provided;
   c. reliable evidence (defined below) shows that the service is not customarily recognized as standard medical treatment for a condition; or
   d. reliable evidence (defined below) shows that the service is, or there is consensus among experts that it should be, the subject of further study or ongoing clinical trials to determine maximum tolerated dosage; toxicity; safety; effectiveness; or effectiveness as specifically compared with the standard means of treatment or diagnosis for a condition.

   "Reliable evidence" includes:

   a. the views and practices of medical or dental communities throughout the country;
   b. reports and articles published in authoritative medical, dental, and scientific literature;
   c. the opinion of professional consultants;
   d. written protocols used by health care providers studying the service or substantially the same service; and
   e. informed consent forms used by health care providers studying the service or substantially the same service.

10. **Unnecessary care**. The Plan does not cover any service determined by the Plan Administrator to be not medically necessary (see Section 1 for the definition of medically necessary).

11. **Criminal behavior**. The Plan does not cover any service related to the treatment of an illness, accident, or condition arising out of participation in a felony (as determined by the law of the state where the criminal behavior occurred).

12. **Prohibited referral**. The Plan does not cover any pharmacy services, clinical laboratory, x-ray, or imaging services provided pursuant to a referral prohibited by the New York State Public Health Law.

13. **Act of war**. The Plan does not cover an illness or injury incurred as a result of any war or act of war, whether declared or undeclared.

14. **Accidental injury**. The Plan does not cover services for the treatment of an accidental injury to sound natural teeth unless the service is not covered under another group health plan, policy or program or arrangement.

15. **Care by more than one provider**. If a participant or covered dependent transfers from one provider to another during a course of treatment, or if more than one provider renders a service or part of a service, the Plan will not cover more than it would have covered if there were only one provider.

16. **Sub-standard services**. The Plan does not cover any service that does not meet professionally recognized national standards of treatment, or is not provided by a professional health care provider licensed to provide the service.

17. **Miscellaneous**. The Plan does not cover

    a. oral hygiene, dietary or plaque control programs;
    b. replacement of lost, missing or stolen space maintainers and prosthetic devices;
    c. installation of fixed bridgework or placement of a participant's or covered dependent's dentures for teeth that were missing before the participant's or covered dependent's coverage under this Plan began;
    d. appliances or restorations necessary to increase vertical dimension or restore occlusion;
    e. except as otherwise noted in this booklet, replacement or repair of any appliance covered under the Plan; and
    f. charges for telephone consultations, missed appointments, or fees that may be added for completing a claim form.

18. **Not Dentally/Medically Necessary**. For charges that are not Dentally or Medically Necessary, as defined, except as specifically provided for in this Plan.

    The fact that a physician may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device, or drug does not, in and of itself, make it "Medically Necessary" or make the charge a Covered Service under the Plan, even if it has not been listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.

19. **Temporomandibular Joint Dysfunction (TMJ)**. The Plan does not cover charges for or in connection with Temporomandibular Joint Dysfunction (TMJ).

20. **Veneers.** Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth.

21. **Dental Implants**. The Plan does not cover charges related to dental implants.

22. **Medical Plan Benefits.** The Plan does not cover charges for dental services that are payable under a medical benefits plan sponsored by this Employer.

Section Eleven
Coordination of Benefits

If a participant, his spouse or dependent is covered under this Plan and also has other health coverage, this Plan follows a procedure called coordination of benefits ("COB") to determine how much of a covered service this Plan should pay when there is a claim. These COB rules are complicated and cover a wide variety of circumstances.

A participant, his spouse or dependent may be asked to identify and provide information regarding all of his Health Plan coverage so that the Plan can determine whether it is the "Primary Plan" (the Plan that pays the claim first) or "Secondary Plan." For purposes of the COB rules, "Health Plan" means any: individual, group, fraternal, blanket or franchise insurance policy; health maintenance organization (HMO) contract; other form of group or non group-type coverage (whether insured or uninsured); health care components of long-term care contracts, such as skilled nursing care; coverage under a group or individual automobile contract; Medicare; and any other governmental plan, program or coverage provided by federal or state statute. However, it does not include any coverage for which federal law prohibits coordination of benefits with this Plan.

When a person is covered under more than one Health Plan, the "Primary Plan" and the "Secondary Plan" are determined using the following rules applied in the order below (i.e., the first rule to apply will control).

1. If a Health Plan covers the person as other than a dependent (e.g., a Health Plan that covers the person as an employee, member, policy holder, subscriber or retiree) and another Health Plan covers the person as a dependent, the Health Plan covering the person as other than a dependent is the Primary Plan and the Health Plan covering the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Plan covering the person as a dependent and primary to the Health Plan covering the person as other than a dependent, then the Health Plan covering the person as other than a dependent is the Secondary Plan and the other Health Plan is the Primary Plan.

2. Unless a court decree states otherwise, if a dependent child is covered by the Health Plans of his parents and:

    a. the child's parents are married or are living together (whether or not they have ever been married), the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan.

    b. the child's parents are divorced, separated or not living together (whether or not they have ever been married) and:

        i. a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage, the Health Plan of that

parent is the Primary Plan for the child. This rule applies to Plan Years commencing after the Health Plan is given notice of such court decree;

ii. a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan for the child or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan for the child;

iii. a court decree states that the parents have joint custody without specifying which parent has responsibility for the health care expenses or health care coverage of the child, the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan for the child or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan for the child; or

iv there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the Primary Plan for the child will be:

- the Health Plan covering the custodial parent or, if no Health Plan covers the custodial parent,
- the Health Plan covering the spouse of the custodial parent or, if no Health Plan covers the spouse of the custodial parent,
- the Health Plan covering the non-custodial parent or, if no Health Plan covers the non-custodial parent,
- the Health Plan covering the spouse of the non-custodial parent.

The custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

3. If the child is covered under more than one Health Plan of individuals who are not both parents of the child, the rules above apply as if those individuals were the parents of the child.

4. If a person is covered by a Health Plan as an active employee, e.g., an employee who is neither laid off nor retired (or as a dependent of an active employee) and is covered by another Health Plan as an inactive employee (or as a dependent of an inactive employee), the Health Plan covering the person as an active employee (or as a dependent of an active employee) is the Primary Plan, and the Health Plan covering the person as an inactive employee (or as a dependent of an inactive employee) is the Secondary Plan.

5. If a person is covered by a Health Plan pursuant to COBRA or similar state law and is covered by another Health Plan as a member, policy holder, subscriber, active employee or retiree, the Health Plan covering the person as a member, policy

holder, subscriber, active employee or retiree is the Primary Plan and the other Health Plan is the Secondary Plan.

6. If a person is covered by the Health Plans as a member, policy holder, subscriber, active employee or retiree, the Health Plan covering the person as a member, policy holder, subscriber, active employee or retiree for the longer period of time is the Primary Plan and the Health Plan covering the person as a member, policy holder, subscriber, active employee or retiree for the shorter period of time is the Secondary Plan.

7. If the rules above do not determine the order of benefits, the Allowable Expenses (as defined below) are shared equally between the Health Plans; provided, however, that this Health Plan will not pay more than it would have paid had it been the Primary Plan.

The Primary Plan pays benefits before, and without regard to, those of any Secondary Plan. A Secondary Plan determines its benefits after those of the Primary Plan, and may reduce the benefits it pays so that all Health Plan benefits do not exceed 100% of total Allowable Expenses. Generally, an Allowable Expense is a health care expense, including deductibles, coinsurance and co-payments, covered at least in part by a Health Plan. If a Health Plan provides benefits in the form of services, the reasonable cash value of each service is considered an Allowable Expense. Any expense that a provider is prohibited, by law or in accordance with a contract, from charging a covered person is not an Allowable Expense.

A Secondary Plan may reduce its benefits so that the total benefits paid or provided by all Health Plans during a Plan Year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other Health Plans and apply that calculated amount to any Allowable Expense that is unpaid by the Primary Plan. However, the Secondary Plan may reduce this amount so that its payment, when combined with the amount paid by the Primary Plan, does not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan will credit against its deductible amounts any amounts it would have credited against its deductible in the absence of other Health Plan coverage.

Payment made under another Health Plan may include an amount that should be paid under this Health Plan. In that event, this Health Plan will pay that amount directly to the Health Plan that made the payment. That amount will then be treated as though it were a benefit paid under this Health Plan, and this Health Plan will not have to pay that amount again. If benefits are provided in the form of services, "payment made" means the reasonable cash value of the benefits provided in the form of services.

If the amount of the payments made by this Plan (including the reasonable cash value of any benefits provided in the form of services) is more than it should have paid, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

Section Twelve
Excess Payments and Subrogation

1. **Excess Payments**. If payments are made by the Plan that exceed any of the Plan's benefit limits, or any other Plan provision or rule, the Plan Administrator has the right to recover the excess from the person who received the payments, the person for whom the payments were made, or from any insurance company or other party that owes payment for the expense for which the excess payment was made. The Plan Administrator also reserves the right to decrease future benefits otherwise payable under the Plan to the participant who benefited from the excess payment.

2. **Subrogation**. Whenever the Plan pays a covered service, it is subrogated to any right that the participant or covered dependent (or his legal representative, heirs or beneficiaries) may have against any third party that caused the injury or sickness for which the covered expense was incurred. The participant or covered dependent (and his legal representative, heirs and beneficiaries) may not act to prejudice this right of subrogation, and must execute and deliver documents and do whatever else is necessary to secure the Plan's right of subrogation (including the right to sue the third party). The Plan Administrator may require the participant or covered dependent (or his legal representative, heirs or beneficiaries) to sign an agreement acknowledging these Plan rights as a condition to receiving payment from the Plan. However, even if the Plan does not require such an agreement, this will not affect the Plan's subrogation rights.

Section Thirteen
Claim Forms

When a participant or covered dependent has an appointment with a participating or non-participating provider, the participant should proceed as follows.

1. He should obtain a claim form from the Human Resources Department at Whitesboro Central School District, complete and sign the top portion of the claim form indicating the name of the patient who is to be treated by the provider and the participant's name, and fill in other information requested on the form. The participant must sign the section authorizing use of claim information. If he signs the section of the form authorizing Plan payment to the provider, any Plan payment will be made to the provider. If he does not sign this section, any payment will be made directly to him.

2. He should give the claim form to the provider. The provider must fill out the form upon completion of services and send the form to the Claim Administrator at the address printed on the top of the form. If for any reason the participant is unable to obtain a claim form in advance of treatment (for example, if an emergency service is required, or service is required while on vacation), the participant should attach a copy of the provider's bill to a claim form obtained as soon as possible afterwards.

THE CLAIM FORM MUST BE SUBMITTED TO THE CLAIM ADMINISTRATOR WITHIN 180 DAYS FOLLOWING THE LAST DATE OF TREATMENT ON THE FORM.

3. When another appointment is scheduled with a provider, he should obtain another claim form and follow the procedure above again.

Section Fourteen
Adverse Determination

ADVERSE DETERMINATION

The Covered Family Member will receive a written explanation of any Adverse Determination (a claim is wholly or partially denied) within 30 days after filing a Claim. The Covered Family Member or an Authorized Representative may file an appeal of an Adverse Determination involving a Claim within 180 days of receiving written notification.

The Covered Family Member will be notified in the event that additional time or information is needed to review a claim. The notice will explain why benefits were denied, and will include the following information:

(1) Specific reasons for the denial, and
(2) Specific references to pertinent Plan provisions on which the denial is based, and
(3) A description of any additional material or information necessary to complete the claim, and an explanation of why such material is necessary, and
(4) An explanation of further appeals procedures, and
(5) A statement that a failure to submit a written request for review within 180 days after the receipt of the denial will render the Adverse Determination final.
(6) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Family Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Determination on review, and
(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, either such information; or a statement that such information was relied upon in making the Adverse Determination will be provided free of charge to the Covered Family Member upon request, and
(8) If the Adverse Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Family Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

CLAIM APPEALS

When an Adverse Determination of claim is made (the claim was denied, in whole or in part) the Covered Family Member can take the following steps to appeal the Adverse Determination:

(1) Write to the Claim Administrator within 180 calendar days of receiving the Adverse Determination and request an appeal. You may submit written comments, documents, records, and any other pertinent information relating to the claim. Copies of all information relevant to the claim for benefits will be available upon request. This information will be available without regard to whether or not the information was considered or relied upon in making the Adverse Determination. The review the Claim Administrator completes:

(A) Will take into account all submitted information, without regard to whether or not the information was submitted or considered in the initial Benefit Determination, and
(B) Will not provide deference to the initial determination, and
(C) Will not be decided by the individual who made the initial Adverse Determination or that individual's subordinate, and
(D) Will include a consultation with an independent health care professional with appropriate training and experience in the field of medicine if the review is being done to determine Medical Necessity.

<u>This action must be taken within 180 calendar days of receiving an Adverse Determination of a claim, or the Claim Administrator's decision shall be the final decision of the Plan.</u>

(2) Within 30 calendar days of receiving an appeal, the Medical Services Team will review the claim and provide a written determination on the appeal. The written decision will specify the reasons for the decision and will give specific references to the Plan provisions on which it is based:

(A) Specific reasons for the denial, and
(B) Specific references to pertinent Plan provisions on which the denial is based, and
(C) A description of any additional material or information necessary to complete the claim, and an explanation of why such material is necessary, and
(D) An explanation of further appeals procedures, and
(E) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Covered Family Member's right to bring a civil action under New York State law following an Adverse Determination on review, and
(F) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, either such information; or a statement that such information was relied upon in

making the Adverse Determination will be provided free of charge to the Covered Family Member upon request. Copies of all information relevant to the appeal will be made available to the Covered Family Member upon request, and

(G) If the Adverse Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Family Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the advice of a medical, dental or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Plan.

(3) If the Medical Services Team maintains the original denial and the Covered Family Member still does not agree, the Covered Family Member has 30 calendar days to appeal to the Plan Administrator. When resubmitting the claim to the Plan Administrator, include correspondence received from the Claim Administrator and any other information that may be appropriate.

(4) Within 30 calendar days of filing the appeal with the Plan Administrator, the Covered Family Member will receive a written decision. The Plan Administrator will either authorize the Claim Administrator to pay the claim or maintain the denial. The written explanation of the Plan Administrator's decision will cite the specific Plan provisions upon which the decision is based. The decision of the Plan Administrator is final.

(5) No action at law or in equity will be brought to recover on the Plan until after proof of loss for a Claim has been filed with the Claim Administrator and the appeal process described above has been completed. No action will be brought at all unless brought within 24 months of the time within which proof of loss is required.

Physical Examinations: The Claim Administrator and the Plan Administrator have the right and opportunity to have any individual whose Sickness or Injury is the basis of a claim examined when and as often as it may reasonably require when such claim is pending. <u>The findings of such examinations will not affect an Employee's or Dependents' Eligibility for continued enrollment under the Plan.</u>