

Glens Falls City School District

Dental Insurance Plan

July 1, 1998

Sponsored by:

Preferred Group Plans, Inc.
P.O. Box 15136
Albany, NY 12212-5136
(866) 989-8997 Fax (518) 641-0325
www.thepreferredgroup.com

Enrollment Information

Eligible Employees

You are eligible to enroll in the dental insurance plan if you are an active employee of the Glens Falls City School District and:

- You have been designated as a member of a negotiating unit for which the plan has been bargained: and
- You meet all requirements as defined in your contract. If you have eligibility questions, please contact the school business office.

Eligible Dependents

Your spouse and your unmarried children under nineteen years of age are eligible to be enrolled in the plan. Unmarried, dependent students between the ages of 19 and 25 may continue to be covered under their parents' contracts if they are full-time students enrolled in an accredited institution of learning, whose principal, legal residence while not attending classes is the same as yours. This child must be claimed as a dependent on your federal income tax return.

Additionally, any unmarried child, 19 years of age or older, who is unable to support themselves due to any of the following reasons shall be eligible:

- Mental illness as defined by the New York State Office of Mental Hygiene
- Mental retardation as defined by the NY State Mental Hygiene Law
- Developmental disability as defined by NYS Mental Hygiene Law, or
- A physical handicap

For coverage to be extended under these particular conditions, the condition must have occurred prior to the age at which dependent coverage would have terminated. Such disabilities must be certified by a physician. Should the condition terminate, coverage for the dependent shall be terminated. Preferred Group Plans, Inc. reserves the right to check on the status of any dependent covered under this clause.

Enrollment

If eligible, you will be issued an enrollment application. You should complete the form and return it to your business office as soon as possible to avoid a possible delay in starting coverage.

If you do not elect to enroll in the dental program, as a new hire, you may join the program during the open enrollment period. The only exception to this eligibility criteria would be the loss of coverage under a spouse's plan. Should your spouse lose dental coverage, and you/your family need to enroll in the school district's plan, proof of loss must be provided to the business office.

You may select either Individual or Family coverage. You may not be covered as both an enrollee and a dependent: if coverage under another dental insurance plan is provided to you as an employee or a dependent, you are not eligible for coverage under this plan.

Effective Dates of Coverage

Your coverage under the plan will become effective according to the established employee eligibility requirements for the Glens Falls City School District.

Evidence of Insurance

A dental insurance identification card indicating your Certificate, Group and category numbers will be issued by Preferred Group Plans directly to you. This booklet will serve as your Certificate of Insurance under the contract.

Change in Family Status

If you enroll for Individual coverage but subsequently wish to change to Family coverage to include eligible dependents under the plan, you may do so by filing a new enrollment application with your business office. Your dependents' coverage will become effective according to the established eligibility requirements for the Glens Falls City School District.

If you are enrolled for Family coverage but cease to have any eligible dependents, you must submit an enrollment application requesting Individual coverage. The individual coverage will become effective on the first day of the calendar month following the month in which your last dependent loses eligibility.

Expiration of Coverage

Your eligibility to participate in the plan will cease in the event that you are removed from payroll.

Cost

Cost of coverage is negotiated between the Glens Falls City School District and its employees. Program expenses will remain within the parameters negotiated and stipulated in any official contracts between the employer and employee groups. The current contract provides for an 80%-20% co-payment for participants. This ratio provides for 80% of a fee schedule to be paid by the insurer, while the eligible employee must contribute 20% for covered services along with any amount over the fee schedule.

Dental Insurance Benefits

General

The self-funded dental plan under which you are now enrolled is one designed to offer you a comprehensive and flexible choice in seeking dental coverage. While the plan will not pay all of the bills you may incur for dental care for yourself or your dependent, it will provide financial assistance when you are faced with large dental expenses.

Dental Insurance Benefits

Your dental insurance coverage will provide payments in accordance with the OUTLINE OF BENEFITS for most types of dental service to the extent that they are necessary for dental health and are performed by the attending licensed dentist. There are no waiting periods for any benefits after you become eligible, though pre-authorization for procedures in excess of \$300 is required.

Participating Dentist and Participating Specialist

A Participating Dentist or Participating Specialist is a dentist who has agreed to charge no more than the Preferred Group Plans Permitted Charge for covered services, provided you advise the dentist of your coverage prior to service. A listing of participating dentists and specialists will be distributed during the open enrollment period. If your dentist is not a participating provider, please let us know and we will be happy to contact them to try and add them to the list of participating dentists.

Basic Services Contract

The basis for the self-funded dental plan is to provide for cost-effective services that allow for optimum dental health. Dental procedures are categorized by two areas:

Diagnostic/Preventative

- Oral examinations including a course of action should further care be required
- Prophylaxis-cleaning, scaling and polishing teeth
- Periapical x-rays and bitewing x-rays as required
- Topical fluoride for those under 19 years of age

Restorative Services

- Palliative emergency treatment for dental emergencies
- Simple tooth extractions
- Fillings, limited to silver amalgam and synthetic materials approximating natural tooth color
- Endodontics including pulpotomy, pulp capping and root canal treatment
- Denture repair as provided for in the covered expenses schedule

Additional Coverage

- Crowns and Inlays which are not part of a bridge
- Space maintainers
- Apicoectomy
- Oral Surgery including extraction and treatment of cysts, impactions and abscesses

Pre-authorization of Benefits

Please remember that all services in excess of \$300 require that you receive pre-authorization prior to services being rendered in order to qualify for benefit coverage. As many of the services offered under the Additional Coverage portion of your dental plan fall into the pre-authorization price range, please ask your dentist to contact our office prior to treatment. This procedure will ensure that you are eligible for treatment and will avoid instances where benefits might be denied, resulting in additional costs to you.

Exclusions and Limitations of Coverage

The following exclusions and limitations apply to your dental plan:

- Orthodontia is not covered
- Services rendered by other than a duly licensed dentist or for services rendered beyond the scope of licensure
- Services and appliances not required by accepted standards of dental practice
- Dental surgery or treatment performed solely for the purpose of improving the patient's appearance (cosmetic dentistry)
- Treatment available without cost under laws enacted by any State Legislature or the Congress of the United States (such as Worker's Compensation, Veterans Administration, etc.) with the sole exception of Medicaid
- Service from a dental or medical department of an employer, mutual benefit association, labor union, trustee or other similar person or group
- Gold foil restorations
- Any loss for which mandatory automobile no-fault benefits are covered or recoverable

Coordination of Benefits

Coordination of Benefits is the method by which subscribers who are covered by more than one insurance company cannot collect more than the amount of expenses they actually incurred. Briefly, this is accomplished by determining what are known as the "primary" and "secondary" insurance companies. The plan covering the patient as a subscriber (primary) pays before the plan covering the patient as a dependent (secondary). The primary plan calculates benefits as though duplicate coverage did not exist. The secondary plan then reimburses the subscriber for the difference between what the primary plan has paid and 100% of the actual expenses: provided this amount does not exceed the benefits that the plan would have paid in the absence of duplicate coverage.

Primary or Secondary

If this plan is considered primary, any other plan covering the employee is secondary. If the patient is covered by two plans (i.e. has two jobs and two plans, etc), both with or both without COB then the plan with the earlier date of issue is primary. If only one plan has Coordination of Benefits then the one without COB is primary.

Children

If children are covered by both parents' plans, the plan of the parent with the birth date earlier in the year will be primary. If parents are divorced or separated, then the plan of the parent with custody of the child is primary unless a court approved divorce or separation agreement supercedes this rule and the insurance carrier has been notified.

Claims Submission Procedures

A claim for services rendered shall be made by either the participant, or the dentist, through an assignment of benefits. Simply request a dental claim form from the personnel or administrative offices of your employer, and bring the form to your dental appointment. Present your claim form with your identification card. Ask your dentist to fill out his/her portion of the form. The dentist may ask you to assign your dental benefits to his/her office. Simply, this means that your dentist will ask you for your co-pay amount, and will then forward all of the necessary claim forms and paperwork to preferred Group Plans, Inc. Dental benefits for the services provided on that occasion will be paid directly to your dentist's office, thus alleviating you of the responsibility of forwarding the claim form and paperwork to Preferred Group Plans. Should you choose not to assign your dental benefits to your dentist, he or she may request that you pay the full amount of your bill. You should then forward a copy of your claim form and your receipt directly to Preferred Group Plans for processing. A check will be issued in your name to the address listed on the claim form within 7 to 10 business days.

If your dentist is a non-participating provider, you may submit a claim form yourself or you may assign your benefits to the dentist. You should ensure that the schedule of benefits that your plan offers is acceptable to your dentist or you may find that your co-pay for services is far greater than you originally anticipated. Should your dentist find the schedule of benefits acceptable, you may assign your benefits to the dentist, thus alleviating the need to send a claim form to PGP. In the event that your dentist will not accept the schedule of benefits, you may still utilize that dentist, but you will be responsible for paying the difference between the plan's allowable expense and the dentist's fees in addition to your regular co-pay. In this situation, it is always advisable to consult with both your dentist and Preferred Group Plans, to determine the amount of services that will be covered under the plan and the amount for which you will be responsible for paying, prior to any course of treatment. Once again, pre-authorization of

treatment is always required for procedures in excess of \$300, whether or not your dentist is a participating provider under this plan.

Submit all claims to:

Preferred Group Plans, Inc.
Dental Insurance Department
P.O. Box 15136
Albany, NY 12212-5136

(866) 989-8997 fax: (518) 641-0325

You, or your dentist (if you have assigned your benefits to him/her), should receive a check within 7 to 10 business days.

If you have any questions concerning your dental benefits under this plan, please feel free to contact Preferred Group Plans at (866) 989-8997.

Claims Review Procedures

Occasionally Preferred Group Plans, Inc. denies coverage for certain requested procedures. When this occurs, an appeal is made to the dental plan Board of Trustees for a final determination of benefits. A written statement detailing the circumstances along with all paperwork from both your dentist and the claims denial should be forwarded to the designated trustee(s). You will be notified of any decision within 60 days.