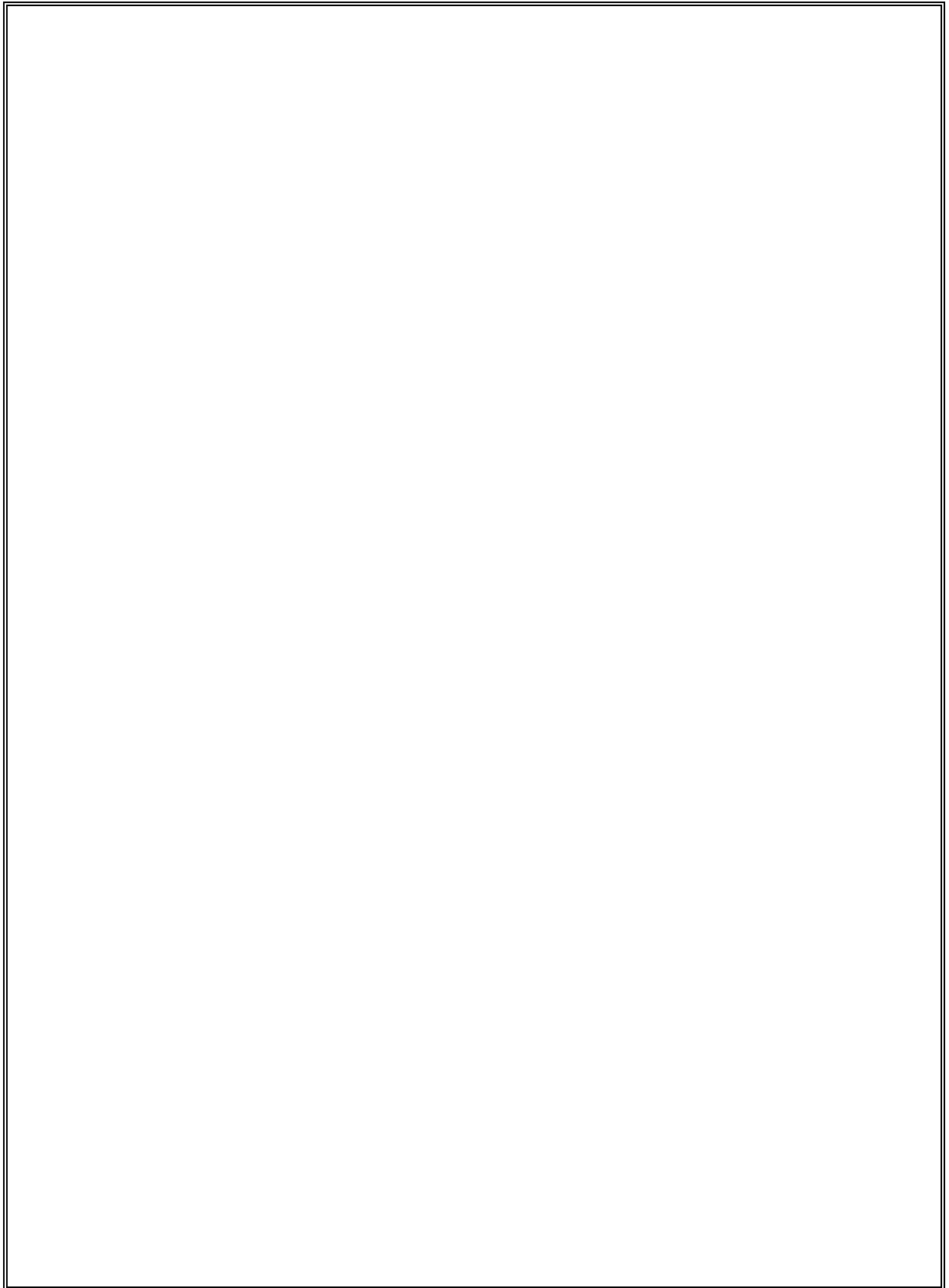
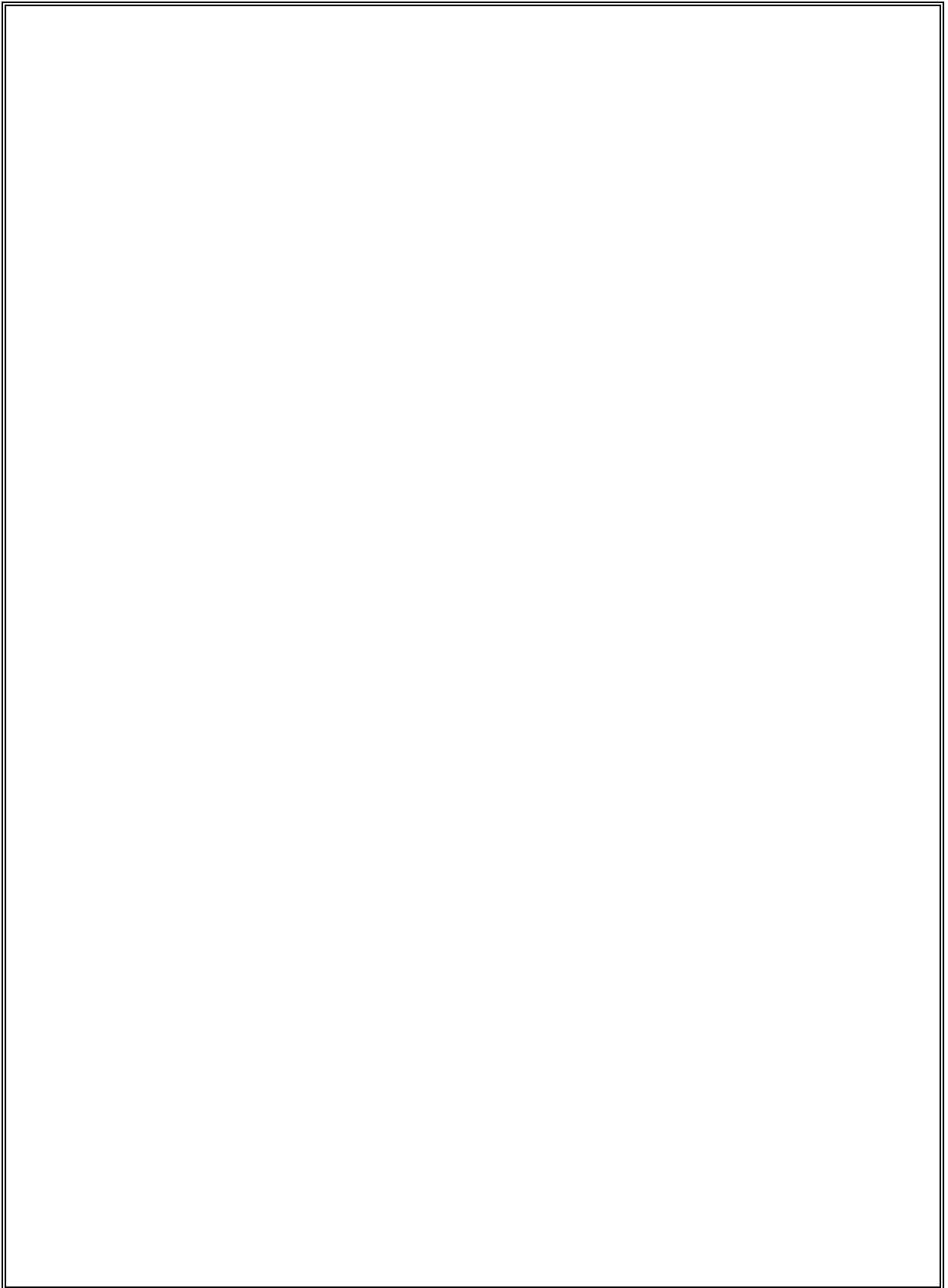


**SUMMARY PLAN DESCRIPTION  
FOR  
SSMC Employee Dental Benefit Plan**

**RESTATEMENT EFFECTIVE JANUARY 1, 2003**

4/30/03





## IMPORTANT REMINDERS

### Enrollment

Failure to report enrollment changes could result in overpayment or denial of benefits. You will be required to reimburse the full amount of any benefit overpayment. Refer to **Section II - Eligibility and Enrollment** for details.

You must keep your enrollment information updated. It is important that you notify the SSMC Human Resources Department immediately for the following:

- Change in marital status
- Birth of a child or addition of a child
- Address change
- Student status of child age 19 or older
- Enrolled disabled child approaching age 19
- Marriage of your Dependent child
- Any family member death
- Other group health plan information, including effective dates of coverage and name and address of the other group health plan(s)
- If you or your Dependent become eligible for Medicare due to disability, age or End Stage Renal Disease

### COBRA Continuation of Coverage

Written notice of most qualifying events must be sent to the SSMC Human Resources Department within 60 days following the event. If written notice is not given within 60 days, continuation of coverage under COBRA will not be available. Refer to **Section II - Eligibility and Enrollment** under ***Continuing Coverage under COBRA*** for details.

#### **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/medical documentation as deemed necessary by the Claims Administrator to evaluate a claim for benefits. Failure to submit requested documentation or information or failure to provide a signed release for dental records could result in denial of benefits. The Claims Administrator confidentially maintains all dental/medical documents. Treatment decisions are independent from payment decisions. The patient's 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.*

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## INTRODUCTION

Sound Shore Medical Center of Westchester (also shown herein as SSMC) is pleased to give you a copy of the Summary Plan Description for the SSMC Employee Dental Benefit Plan (also shown herein as Plan). This Plan provides health expense benefits for eligible and enrolled Employees and their eligible enrolled Dependents. You should read this Summary Plan Description (also shown herein as SPD) carefully to acquaint yourself with its provisions for eligibility, coverage, filing a claim and other important information.

### Plan Identification

<b>Plan Name:</b>	SSMC Employee Dental Benefit Plan
<b>Plan Administrator:</b>	Sound Shore Medical Center of Westchester, 16 Guion Place, New Rochelle, NY 10802, Tel.: (914) 632-5000
<b>Plan Sponsor:</b>	Sound Shore Medical Center of Westchester, 16 Guion Place, New Rochelle, NY 10802, Tel.: (914) 632-5000
<b>Administrative Manager:</b>	The Human Resources Manager of Sound Shore Medical Center of Westchester, 16 Guion Place, New Rochelle, NY 10802, Tel.: (914) 632-5000
<b>Service of Legal Process:</b>	Agent for Service of legal process is the Administrative Manager or any officer of Sound Shore Medical Center of Westchester, 16 Guion Place, New Rochelle, NY 10802, Tel.: (914) 632-5000
<b>Named Fiduciary:</b>	Sound Shore Medical Center of Westchester
<b>Plan Number:</b>	501
<b>Tax ID Number:</b>	13-1740117
<b>Plan Effective Date:</b>	April 1, 1993
<b>Plan Restatement Date:</b>	January 1, 2003
<b>Plan Year:</b>	Twelve consecutive months beginning January 1 and ending December 31
<b>Type of Plan:</b>	This is a self-funded Plan providing dental benefits for covered dental expenses. The funding for Plan payment is provided from the general assets of the Plan Sponsor, SSMC.
<b>Claims Administrator:</b>	POMCO, 2425 James Street, P.O. Box 6329, Syracuse, New York 3217-6329; Tel.: toll-free <b>1-800-501-9536</b>

### **Please Note**

*The pronoun you or your means an eligible and enrolled Employee of SSMC. It also means a COBRA participant whose social security number is used for Plan enrollment. Terms throughout this SPD have been capitalized and are defined in **Section VII -Definitions** to help you understand your Plan coverage and benefits. This SPD updates and replaces previous publications showing coverage for the self-funded Plan formerly known as New Rochelle Hospital Medical Center Dental Health Benefit Plan. It is a restatement of Plan benefits showing provisions and benefits as of January 1, 2003.*

This SPD is written in the English language to show your rights and coverage under this Plan. If you have any difficulty understanding any part of this SPD, contact the SSMC Human Resources Department for assistance and interpretation. You may phone the SSMC Human Resources Department at their local phone number (914) 632-5000 on normal business days between 9:00 A.M. and 5:00 P.M. (ET) You may also contact the Claim Administrator (POMCO) for assistance by phoning their local number toll-free number 1-800-501-9536 Monday through Friday, during normal work hours from 8:30 A.M. to 4:30 P.M. (ET).

The Master Plan Document of the SSMC Employee Dental Benefit Plan consisting of the SPD, the terms of the Plan and any Amendments to the Plan are maintained and on file with the Plan Administrator. The provisions of this Plan may only be determined accurately by reading the Master Plan Document. To the extent, the SPD or other Plan information is inconsistent with the provisions of the Master Plan Document; the terms of the Master Plan Document will govern.

This SPD and the benefits shown are subject to change by the Plan Administrator, SSMC anytime and at its sole discretion. The Plan Administrator and the Plan Sponsors intend to continue this Plan, but reserve the right to cancel it anytime without the consent of Covered Persons. Any changes or cancellations will not be retroactive. You will be notified of any reduction in benefits within 60 days of such changes. In addition, it is understood that all professional services are the sole responsibility of the Dentist and that SSMC acting as Plan Administrator or as Plan Sponsor and the Claims Administrator have no responsibility or liability whatsoever to persons who are Enrollees or participants in this Plan with respect to the provision of any professional services.

#### **A. Plan Funding**

SSMC has hired POMCO the Claims Administrator for the Plan. The Claims Administrator does not act as an insurer, but merely as a Claims processor. Claims for benefits are sent to the Claims Administrators. They process the claims, then request and receive funds from SSMC to pay the claims, and makes payment on the claims to the Providers and Plan Participants, as appropriate. SSMC is ultimately responsible for providing Plan benefits, not the Claims Administrators. Benefits are paid directly out of the general assets of SSMC. There is no special fund or trust or insurance from which benefits are paid.

#### **B. Claims Administrator**

POMCO has been engaged by SSMC to administer the dental claim benefits for covered dental expenses. Claims should be mailed directly to POMCO for benefit determination. If you have any questions or concerns about your coverage, you can phone POMCO or your Human Resources Department. Claim forms can be obtained from the SSMC Human Resources Department or from POMCO. Refer to **Section V - Claim Submission/Plan Determination/Appeals** for details on submitting your claims and appeal procedures.

**POMCO Dental Claims  
P.O. Box 6329  
Syracuse, NY 13217  
Phone: Toll-free # 1-800-501-9536**

## SECTION I – COVERED SERVICES / BENEFIT SCHEDULE

The Plan provides payment, according to the *Benefit Schedule*, for a broad range of dental services when rendered and billed by licensed Dentists. The *Benefit Schedule* described later in this section lists the maximum payment amount for each dental service. Benefit payment for a covered service will be based on the lesser of Dentist's usual charge or the scheduled maximum for that service. You will be responsible for the payment of charges that are more than the Plan scheduled allowance for covered procedures. Refer to **Section IV - Plan Exclusions** for further details on your dental coverage.

### **A. Services by More than One Provider**

You or your Eligible Dependent may seek covered services from your choice of any licensed Dentist. However, the covered services and supplies will be used to decide the Plan benefits not the number of Providers rendering such services or supplies. If dental care is transferred from one Dentist to another Dentist during treatment, the total Plan payment will not exceed the Plan allowance that would have been paid had one Dentist rendered the covered dental services.

### **B. By Report/Pretreatment Estimate**

If you or your Dentist anticipates that your dental expenses will exceed \$100.00, you may ask your Dentist to submit a pretreatment estimate to POMCO before dental care begins. POMCO will complete the pretreatment estimate showing which services are covered by the Plan and the available allowance for each. The completed pretreatment estimate will be returned to your Dentist. Pretreatment estimates will help you or your Eligible Dependent to make decisions concerning dental care costs and the availability of Plan benefits. You can obtain forms for this purpose from the SSMC Human Resources Department or from POMCO.

#### **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 are Incurred.*

### **C. Coverage Limitations**

1. **General.** 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 chooses a personalized restoration, prosthetic or orthodontic devices, or to employ special techniques as opposed to standard procedures, the benefits provided will be limited to the allowance for the standard procedures as decided by the Claims Administrator.
2. **Bridgework and Dentures** (Prosthodontics).
  - a. Initial replacement of natural teeth that were missing before a Covered Person was eligible and enrolled under the Plan will be payable at **50%** of the scheduled amount. This *does not apply* to persons enrolled in the Plan for 24 continuous months or persons who were enrolled in the prior plan (replaced by this Plan) and this Plan for a combination of 24 continuous months. Full scheduled benefits apply if initial replacement is for natural teeth extracted or lost while the Covered Person is eligible and enrolled under this Plan.
  - b. Replacement of an existing bridge or denture will only be covered when the:
    - 1) Existing bridgework or denture is five years or older and cannot be made serviceable according to commonly held dental standards.

- 2) Replacement was made necessary due to extraction of additional natural teeth.
- 3) Replacement was made necessary due to an original opposing full denture.
- 4) Replacement of existing prosthetic made necessary due to damage beyond repair caused by an Accidental Injury while the prosthetic was in the Covered Person's mouth. The replacement and related accident must occur while covered under the Plan.

Under no circumstances will the Plan cover replacement if the existing bridge or denture can be made serviceable or functional according to common dental standards.

3. **Incurred Services.** Benefits are available for covered dental services Incurred by a Covered Person while the Plan is in force. Benefits will not be paid for any services Incurred when the person was not eligible and enrolled in the Plan. Exception: The Plan will provide benefits for covered dental procedures that were actually started while the person was covered under the Plan and completed or placed within 90 days after the person's coverage ended. This extension of benefits does not apply to orthodontic care. Plan benefits will not be paid for any services or supplies related to orthodontic care Incurred after coverage ends.
4. **Orthodontics - (correction of abnormally positioned or aligned teeth).** Orthodontic benefits are only available for Eligible Dependent children under age 19. Coverage is not available if orthodontic appliance was installed before the Dependent was covered under the Plan.

The treatment plan requires coverage approval before orthodontic care starts. The Dentist must mail a pretreatment estimate with a detailed care plan to the Claims Administrator. Coverage will be limited to the services pre-approved for coverage by the Claims Administrator, according to Plan limitations. If the Plan does not cover the orthodontic treatment, payment will not be made for related orthodontic services and supplies.

Coverage is limited to orthodontic care related to disabling malocclusion, or for orthodontic care needed due to reconstructive cosmetic surgery resulting from Injury, infection or disease or from reconstructive surgery because of a birth defect of a covered Dependent child; but only for the type of oral surgery covered under the Plan. Covered orthodontic services include orthodontic diagnostic surveys, orthodontic appliances, installation and adjustment of appliances, functional/myofunctional therapy, and related exams. Payments for orthodontic expenses count toward the Covered Person's orthodontic Lifetime benefit maximum. Please refer to the **Benefit Schedule** under **Orthodontics** for benefit allowances and special limits that apply to covered orthodontic expenses.

Benefits are not payable for orthodontic expenses Incurred during any time the person receiving services was not eligible and enrolled in the Plan. Coverage does not include services and supplies related to orthodontic care that is interceptive or retention treatment or that is primarily cosmetic or esthetic; or to increase vertical dimensions; or to restore the vertical occlusion; or that are related to treatment of temporomandibular joint syndrome (TMJ) or similar disorder. Benefits are not payable for the replacement and/or repair of any appliance furnished under the treatment plan.

If orthodontic services end for any reason before the completion of the treatment course, benefits will cease at the time care ended. If the patient loses eligibility for Plan coverage, Plan payment will not be made for any period on or after the date coverage ends. If the patient is on a quarterly payment schedule, payment will be based on that portion of the quarterly period that the patient actually received services and was eligible for Plan benefits. In no event, will the Plan exceed its benefit limits for active care.

#### **Please Note**

*When differences of opinion regarding dental care and Plan benefits arise, the Plan Administrator will rely on the findings of the Claim Administrator's dental consultant. The dental Plan excludes services covered under a SSMC sponsored health benefits plan. Claims for these services should be submitted to the health benefits Claims Administrator. Examples of claims that the health plan should consider are excision of tumors, removal of cysts and neoplasm, excision of bone tissue and Accidental Injury to natural teeth. If the health benefit plan denies benefits, submit the claim to the Dental Plan Claims Administrator with a copy of that denial.*

**D. Benefit Maximums**

<b>Orthodontic Expenses Lifetime Maximum</b>	<b>\$1250.00</b> per each Covered Persons Lifetime Plan payments are limited to the scheduled allowance with a maximum Lifetime payment of \$1250.00 per Covered Person. Once the Plan has paid \$1250.00 for orthodontic care, benefits for orthodontic expenses stop for the remainder of that Covered Person's Lifetime
<b>All other Covered Expenses</b>	Payment for all other covered dental expenses is limited to the scheduled allowance as shown under the Schedule of Allowances.

**E. Benefit Schedule**

The following is a list of covered dental procedures and the maximum allowance payable for each. The allowance for unlisted procedures for covered dental services will be determined by the claims administrator and shall be consistent with the other items listed in this benefit schedule. The Plan Administrator may, at its option, change the Schedule of Allowances from time to time. Please refer to **Section IV-Plan Exclusions** for additional Plan limitations and exclusions.

**Please Note**

*You are responsible for payments of charges more than the applicable UCR allowance or scheduled amount.*

**1. Preventive Services**

<i>Plan pays 100% of the Usual Customary and Reasonable (UCR) allowance for covered preventive expenses. Preventive care is limited to the following procedures services.</i>		
<b>Covered Preventive Procedures</b>	<b>Allowance</b>	<b>Special Limits</b>
<b>Prophylaxis</b> (scaling/cleaning with or without inflamed gums) and related routine oral examinations.	UCR	Coverage is limited to twice per Calendar Year.
<b>Fluoride Topical Application</b> (limited to children under age 14)	UCR	Maximum once per Calendar Year for any combination of treatment. They must apply topical fluoride separately from the paste or substance used for prophylaxis. Coverage ends on child's 14th birthday. Separate Plan payment will be made for Prophylaxis done at the same time.
<b>Sealants</b>	UCR	Limited to molars and once per tooth in any 36 consecutive months. Not a benefit for Covered Persons age 16 or older.
<b>Space Maintainer</b> Fixed or Removable, unilateral or bilateral	UCR	

**2. Diagnostic Services**

<i>Diagnostic Services are limited to those shown below. Unlisted procedures are not covered. Occasionally, diagnostic services will be considered part of a major procedure allowance or part of a case fee allowance. In these instances, the Plan will not make a separate Plan payment. The Plan pays 100% of the UCR allowance for the listed procedures.</i>
--

Covered Diagnostic Procedures	Allowance	Special Limits
<b>Clinical Oral Exams</b> Periodic exams	UCR	Limited to twice per Calendar Year
Emergency Exams Palliative treatment (emergency pain relief)	UCR	Must not be at the same time as another service except x-rays. X-rays are allowed separately. Benefits are not payable for emergency exams done on the same day as palliative treatment. Palliative treatment includes sedative fillings. If the service is the start of treatment for root canal therapy or other procedure, separate charges will not be covered.
Office visit for Injury to teeth	UCR	For treatment and observation of Injuries to teeth and supporting structure, other than for routine operative procedures.
<b>X-rays</b> Intraoral complete series with or without bitewings; Panoramic maxillary or mandibular, single film.	UCR	Coverage limited to once for either complete series or panoramic x-rays, not both in any 36-consecutive months.
Bitewings One film Two films same day Three to four films same day	UCR	Coverage limited to twice per Calendar Year.
Other X-rays, including but not limited to periapical and occlusal	UCR	When needed to diagnose a covered dental condition. Cephalometric x-rays are not covered.
<b>Tests and Laboratory</b> Diagnostic Casts for Comprehensive Cases	UCR	When needed for comprehensive diagnosis of covered dental condition.

### 3. Composite Restorations (Also, see *Other Restorations*)

<i>The Plan pays 100% of the UCR allowance for the listed procedure.</i>		
<b>Resin Based Composite</b>	UCR	

### 4. Endodontic (Also see *Other Endodontics*)

<i>The Plan pays 100% of UCR allowance for the listed procedure.</i>		
Covered Endodontic Therapy	Allowance	Special Limits
<b>Vital Pulpotomy</b>	UCR	Deciduous teeth only
<b>Root Canals</b>	UCR	Allowance includes related services such as treatment plan, pulp tests, pulpotomy, x-rays, clinical procedures, and follow up care (separate charges for these procedures will not be covered). Apicoectomy and final restoration expenses are covered separately.

## 5. Other Restorations

*The Plan covers the following services for restoration of tooth damage due to illness or Injury only. Services must be considered appropriate and usual for the dental conditions. Benefits are not payable for services considered cosmetic or esthetic. Allowance includes local anesthetic and usual care before and after restorative procedure. Multiple surfaces restored on one tooth during the same visit are considered one restoration. Each surface filled on the same tooth during one treatment is not considered a separate tooth.*

Covered Other Restoration Procedures	Maximum Allowance	Special Limits
<b>Amalgam Restorations</b> Primary Teeth One surface Two surfaces Three or more surfaces Four or more surfaces Permanent Teeth One surface Two surfaces Three or more surfaces Four or more surfaces	\$ 8.00 12.00 16.00 18.00 9.00 13.00 16.00 20.00	Allowance based on the total number of surfaces filled per tooth.
<b>Sedative Filling</b>	10.00	
<b>Pin retention</b>	3.00	Allowance is per pin. Maximum two pins per tooth. Amalgam restoration considered separate service.
<b>Inlay</b> Metallic/porcelain peramic/resin One Surface Two surfaces Three or more surfaces Recement	53.00 67.00 74.00 10.00	Allowance based on total number of surfaces restored per tooth.
<b>Onlay</b> Metallic/porcelain ceramic/resin	\$ 10.00	Allowance per tooth in addition to inlay.

## 6. Crown Restorations

Crown Restoration Procedures	Maximum Allowance	Special Limits
Plastic (acrylic)	\$ 30.00	Allowance is per tooth. Crowns must be considered dentally necessary for restoration. Benefits are not payable if considered cosmetic or aesthetic. Benefits are not payable for porcelain crowns on second and/or third molars. If porcelain crown used, benefits will be limited to the alternate covered crown considered adequate for the restoration. Replacement of crown following additional treatment of natural teeth is covered. Otherwise, crown replacement is only covered if previous crown placement is 5 years old and unserviceable. Temporary crown is not covered.
Prefabricated	16.00	
Plastic with gold	93.00	
Plastic with non-precious metal	83.00	
Porcelain	95.00	
Porcelain with gold	97.00	
Porcelain with non-precious metal	88.00	
Gold (full cast)	91.00	
Non-precious metal (full cast)	82.00	
Semi-precious	82.00	
Gold (3/4 cast)	86.00	
Stainless steel	17.00	
Cast post & core in addition to crown	24.00	
Prefabricated post & core in addition to crown	31.00	

<b>Crown Restoration Procedures</b>	<b>Maximum Allowance</b>	<b>Special Limits</b>
<b>Recement Crown</b>	10.00	
<b>Crown Repair</b>	\$ 12.32	

## 7. Other Endodontics

*Treatment for diseases of pulp cavities inside the root of a tooth and surrounding tissues. The Plan covers services and supplies for the following procedures when not considered part of another procedure. Local anesthetic such as novocaine is considered part of a dental procedure. Separate benefits are not available for local anesthetic. Allowances include usual initial and follow up care.*

<b>Covered Other Endodontic Procedures</b>	<b>Allowance</b>	<b>Special Limits</b>
<b>Apicoectomy</b> Without root canal therapy	\$ 54.00	Not in conjunction with root canal. Allowance is per tooth. No benefit if considered part of any other procedure.
<b>Hemisection</b>	\$ 41.00	

## 8. Periodontics

*Treatment of the gums and tissues of the mouth, including gingivitis. The Plan covers services and supplies for the following procedures when **not considered** part of another procedure. Allowances include local anesthetic and usual follow up care. All periodontic care is subject to the Claim Administrator's dental consultant review for approval of Plan Benefits.*

<b>Covered Periodontic Procedures</b>	<b>Maximum Allowance</b>	<b>Special Limits</b>
<b>Gingivectomy/gingivoplasty</b> Per Quadrant Per Tooth	\$ 67.00 22.00	If more than one periodontal service done, allowance will be limited to the most inclusive covered procedure.
<b>Gingival Flap</b> Per quadrant	67.00	
<b>Mucogingival Surgery</b> Per Quadrant Per Tooth	86.00 29.00	
<b>Crown Lengthening</b>	41.56	
<b>Gingival Curettage and Root Planing</b> Per Quadrant	21.00	
<b>Osseous surgery</b> , with or without graft (includes flap entry and closure). Per Quadrant Per Tooth	126.00 32.00	
<b>Debridement</b>	35.00	
<b>Scaling and Root Planing</b> Per Quadrant	30.00	Limited to one service, up to four quads per Calendar Year.
<b>Grafting</b> Surgical graft Soft tissue graft	65.00	

Covered Periodontic Procedures	Maximum Allowance	Special Limits
Pedicle soft tissue graft	70.00 63.00	
<b>Tissue Regeneration - Guided</b> General	32.00 32.30	
<b>Occlusal Adjustments –Complete</b> Limited	43.00 \$ 11.00	

## 9. Prosthodontics (Dentures and Bridges)

*The Plan covers services and supplies for the following dentures and bridges. Allowances include related services such as diagnostic procedures, impressions, denture materials, adjustments, clasps, rests, false teeth, crowns, and usual post-delivery care. Coverage for prosthodontic replacement is limited to circumstances shown previously in this section under Coverage Limitations, Bridgework and Dentures.*

Covered Prosthodontic Procedures	Maximum Allowance	Special Limits
<b>Complete Dentures</b> Complete upper or lower Immediate upper or lower	\$144.00 144.00	
<b>Partial Dentures</b> Maxillary or mandibular partial denture- Resin base (including any conventional clasps, rests and teeth)  Maxillary or mandibular partial denture- Cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	169.00  169.00	
<b>Removable Unilateral one piece cast metal</b>	169.00	Not covered if considered temporary
<b>Denture Repairs</b> Repair broken full or partial denture No teeth damaged (plastic repair) <i>With replacement of damaged denture teeth:</i> First broken tooth Each additional tooth Repair Clasp <b>Adding Tooth To Partial Denture</b> To replace extracted tooth, each tooth Not involving clasp Involving clasp	15.00  15.00 7.00 7.00  19.00 25.00	
<b>Adjustments to Dentures</b> Complete maxillary or mandibular denture Partial Maxillary or mandibular denture	8.00 8.00	Not covered if done within six months after denture placement
<b>Rebase</b> Complete or partial denture <b>Reline</b> Complete denture, office Partial denture, office	54.00  33.00 30.00	Not covered if done within six months after denture placement

Covered Prosthodontic Procedures	Maximum Allowance	Special Limits
<b>Tissue Reconditioning</b>	17.00	
<b>Fixed Bridge-Pontics</b> Cast gold Cast non-precious Porcelain fused to gold Porcelain fused to non-precious metal Plastic processed to gold Plastic processed to non-precious metal	92.00 83.00 110.00 99.00 97.00 87.00	Allowances are per pontic. Plan payment will be limited to <b>50%</b> of allowance if related to replacement of natural teeth all of which were missing before the person became covered under the Plan. Exception: Person covered or eligible for 24 consecutive months shown previously in this section under <i>Coverage Limitations, Bridgework and Dentures</i> .
<b>Retainers-Gold Inlays-per tooth</b> Two surfaces Three or more surfaces Onlaying cusps, in addition to inlay <b>Retainer Cast</b>	67.00 74.00 10.00 34.00	
<b>Fixed Bridge Abutments (crowns)</b> Plastic processed to gold Plastic processed to non-precious metal Porcelain fused to gold Porcelain fused to semi-precious Porcelain fused to non-precious metal Porcelain ¾ noble metal Gold (full-cast) Semi-precious-(full-cast) Non-precious metal (full cast) noble metal	93.00 83.00 97.00 88.00 88.00 86.00 91.00 82.00 82.00	Allowances are per abutment. Porcelain crowns or abutments on second and third molars are not covered. If used, allowance will be limited to the maximum for a full cast gold crown.
<b>Fixed Bridge Repairs</b> Repair or replace broken pontic	23.00	
<b>Recement Bridge</b>	12.00	Not covered if done within six months after date of placement.
<b>Stress Breaker</b>	20.00	
<b>Occlusal Orthotic Device</b>	\$ 55.25	

## 10. Oral Surgery

*Allowances include local anesthesia and routine follow up care. Separate payment is available for general anesthesia rendered for covered oral surgery.*

Covered Oral Surgery Procedures	Maximum Allowance	Special Limits
<b>Extractions, Simple, per tooth</b>	\$ 10.00	
<b>Surgical Extractions, per tooth</b> Erupted tooth Soft tissue impacted tooth Partial bony impacted Complete bony impacted Root Recovery - <b>Surgical removal residual root</b>	19.00 24.00 39.00 52.00 \$ 19.00	Allowances are per tooth. Surgical extractions include tissue flap and bone removal.

Covered Oral Surgery Procedures	Maximum Allowance	Special Limits
<b>Surgical Ridge Preparation for Bridgework - Alveoplasty</b> With extractions Without extractions	22.00 32.00	Allowance is based on <i>per quadrant</i> . Plan makes separate payment for covered extractions.
<b>Other Surgical Procedures</b> Tooth replantation Oroantral fistula closure Surgical exposure /ortho related Surgical exposure to aid eruption Biopsy – hard Biopsy – soft tissue Frenulectomy (frenectomy or frenotomy) – separate procedure Excision of hyperplastic tissue – per arch Excision of pericoronal gingiva	40.00 94.00 49.00 33.00 29.00 23.00 41.00 31.00 9.77	
<b>Surgical Incision</b> Incision and drainage of abscess Intraoral soft tissue Extraoral soft tissue  Removal of foreign body, skin, or subcutaneous alveolar tissue  Removal of exostosis – per site	17.00 19.00  20.00  58.00	
<b>Removal of Tumors, Cysts, and Neoplasms</b> Excision Benign Tumor lesion diameter up to 1.25 cm lesion diameter greater than 1.25 cm  Removal of odontogenic cyst or tumor lesion diameter up to 1.25 cm lesion greater than 1.25 cm  Removal of nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm lesion diameter greater than 1.25 cm  Destruction of lesion(s) by physical or chemical method, by report	40.00 60.00  42.00 85.00  48.00 68.00  \$ 15.00	

## 11. Orthodontics

*Coverage is limited to the active course of treatment for Dependent child to age 19. Interceptive or retention orthodontia is not covered. Orthodontic Lifetime benefit maximum is \$1250 payable per Covered Person for any combination of Orthodontic Expenses.*

Covered Orthodontic Procedures	Maximum Allowance	Special Limits
<b>Diagnostic Preliminary Study</b>	\$ 38.00	Allowance includes all services related to diagnostic orthodontic survey including, but not limited to, initial consultation or exam, and diagnostic procedures and treatment plan.

Covered Orthodontic Procedures	Maximum Allowance	Special Limits
<b>Active Treatment, First Month</b>	183.00	Allowance includes first month of active treatment and includes all active and retention appliances.
<b>Active Treatment per month after the first month.</b>	\$ 24.00	<i>After 1st month</i> , allowance is per month up to the <b>\$1250.00</b> Lifetime benefit maximum for all orthodontic expenses. Benefits begin the month following the placement of appliances. Monthly allowance includes all services related to active treatment including but not limited to appliance adjustments, therapy, related exams and tests.

### 9. Other Covered Procedures

Other Covered Procedures	Maximum Allowance	Special Limits
General Anesthesia	\$ 20.00	Must be for a covered oral/dental surgical procedure.
<b>Other Anesthetics</b>		
Local anesthesia not in conjunction with operative or surgical procedures	2.97	Must be for covered oral/dental surgical procedure
Regional or trigeminal division block anesthesia	1.27	
Local anesthesia	1.53	
Analgesia, anxiolysis, inhalation nitrous oxide	1.27	
<b>Professional Consultation</b>		
Consultation	12.00	
Hospital call	22.00	
Office visit for observation	7.00	
Office visit – after regularly scheduled hours	15.00	
<b>Drugs</b>		
Therapeutic drug injection, by report	6.00	
Other drugs and/or medicaments, by report	4.00	
<b>Miscellaneous Services</b>		
Application of desensitizing medicament	5.00	
Occlusal guard, by report	\$ 34.00	

### **F. Potential Causes for Benefit Reduction**

In addition to Plan exclusions and limitations, benefits could be reduced or denied if you or your Eligible Dependents are covered by more than one dental or health plan. Refer to **Section III - 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/medical documentation as deemed necessary by the Claims Administrator to evaluate a claim for benefits. Failure to submit requested documentation or information or failure to provide a signed release for dental records could result in denial of benefits. The Claims Administrator confidentially maintains all dental/medical documents. Treatment decisions are independent from payment decisions. The patient's 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, enrollment, Effective Dates, and cancellation provisions of the Plan. The content in this section is not intended to constitute, or be validated as, the origin or basis for Plan eligibility requirements. The SSMC Human Resources Department can provide full details concerning your eligibility for Plan coverage. Enrollment forms can be obtained from the SSMC Human Resources Department.

### A. Eligibility for Plan Enrollment

- 1. Employment Classifications.** The following Employees are eligible for Plan enrollment when meeting the minimum eligibility requirements.
  - a. Physicians, Professional technical and clerical Employees of SSMC; or
  - b. SSMC Employees represented by Teamsters Local 338 or NYS Nursing Association; and
  - c. Who are not covered under a collective bargaining agreement that already provides dental benefits under another plan sponsored by SSMC.
  
- 2. Minimum Employment Requirements.** Includes individual or family coverage for Eligible Employees. See *Dependent Eligibility* shown later in this section for description of Dependents.
  - a. Full-Time Employees.** Eligible Employees who are hired to work a regular full time schedule of not less than 37.50 hours per week and who have been so employed for a period of three full months.
  
  - b. Part time Employees.** Eligible Employees who are hired to work a regular part-time schedule of 30 but less than 37.50 hours per week and who have been so employed for a period of six full months.
  
  - c. Persons not Eligible.** Persons in the following categories are not eligible for Plan enrollment or coverage:
    - 1) Any terminated, retired or laid-off employee.
    - 2) Per diem/casual employees, persons hired on a seasonal or temporary basis or student interns or students employed during school holidays.
    - 3) Regular Part-time employees or employees hired to work less than 30 hours per week.
    - 4) Any non-enrolled employee who submits an initial application while temporarily removed (i.e., leave of absence, disability, military service) from the payroll.
    - 5) Any employee covered under a collective bargaining Agreement that already provides similar dental benefits under another plan sponsored by SSMC.
    - 6) Any employee on active duty in the military service of any country.
  
- 2. Dependent Eligibility.** Dependents are only covered for eligible Employees who are eligible and enrolled in the Plan. Proof of Dependent status may be required. Criteria of support will be considered met if the Employee shows at least 50 percent of the financial support for the Dependent child and that child qualifies as an exemption under federal income tax rules. The term Dependent means your Spouse and eligible children. To be eligible for enrollment in your family coverage, your Dependents must meet the following requirements:
  - a. Legal Spouse.** (A legally separated Spouse may be enrolled in the Plan, but a divorced spouse is not eligible.) You may enroll your legal Spouse if she or he is a residence in the same country in which you reside.

**Please Note**

*The Spouse or survivor Spouse of an eligible retiree maintains eligibility under this Plan until age 65. At age 65, dental coverage ends for the retiree Spouse/Survivor Spouse. The SSMC Human Resources can provide full details concerning eligibility, enrollment and costs for this coverage.*

- b. Unmarried Children of Employees.** Your unmarried children who have never been married and are residents of the same country in which you reside may be considered Dependents. To be eligible, for enrollment in your family coverage the children must meet the following child definition and age requirements:

**1) Child Definition.** A child (children) means:

- a) The Employee's own unmarried child or legally adopted unmarried child who is dependent on the Employee for support and qualifies as Dependent under federal income tax rules;
- b) Any unmarried stepchild of the Employee who permanently resides in the Employee's home and qualifies as a Dependent under federal income tax rules;
- c) Any other unmarried child related to the Employee or who is under legal guardianship before the child is age 19 and who is permanently living in the Employee's home; supported by the Employee and qualifies as a dependent under federal income tax rules;
- d) 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 a 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 SSMC to establish eligibility. Once the child is legally adopted, he/she retains eligibility as a legally adopted child shown above; or

**Please Note**

*The residence and support rules are waived if you are required to provide health coverage due to a court order or divorce decree or qualified medical support order for a child who is under age 19 and not living in your home and/or not dependent for more than 50% of his or her support.*

*To obtain Plan coverage for children you may be required by the SSMC Human Resources Department to document appropriate certification of guardianship, pre-adoptive status and/or that the child resides in your home and is dependent on you for support and maintenance. After initial enrollment, the SSMC Human Resources Department may require periodic proof to verify that Plan eligibility requirements continue to be met. Failure to provide the required information, when requested, will result in that child being removed from enrollment and eligibility until proof is provided which supports Plan enrollment. This could cause a lapse in coverage and/or loss of benefits.*

- 2) Age Requirements.** Eligibility is limited to your Dependent children who meet the above child definition and who are:

- a) Under 19 years of age. Your Newborn child is eligible as a Dependent from the moment of birth. Dependent child remains eligible until the end of the Calendar Year in which he or she turns age 19;
- b) Over 19 years of age, but under 23, who receive more than half their support from you or your Spouse, and are full-time students (12 or more credit hours) at an accredited secondary school, College, or University. The full-time student remains eligible until the end of the Calendar Year in which he/she graduates but no later than the end of the Calendar Year in which he/she turns age 23.

In the event a Dependent child, between ages 19 and 23 who is a full-time student, is disabled and is granted a medical leave by the school, he or she is attending, eligibility will continue for a maximum of 12 calendar months following the month in which the child withdraws from school, but no later than the end of the Calendar Year in which he/she turns age 23. If the end of the 12 calendar months occurs during a vacation period, benefits will be extended to the beginning of the next regular semester.

Your unmarried child, between the ages of 19 and 23, 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; or.

**Please Note**

*To obtain Plan coverage for each semester, you may be required, to document appropriate certification of full-time student status to the SSMC Human Resources Department. 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. This could cause a lapse in coverage and/or loss of benefits.*

- c) 19 years of age, or older, who is 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, eligibility for continued benefits should be established at the time of his/her 19th birthday. You must request disabled child continuation within 31 days after the 19th birthday. Failure to do so could result in loss of eligibility and benefits.

**Please Note**

*After eligibility for the disabled or handicapped child has been established, proof that the child remains physically or mentally unable to earn his or her own living and continues to be dependent on you for most of his or her support and maintenance may be requested periodically from the SSMC Human Resources Department. After two years, this proof will usually not be requested more than once each year. Failure to provide requested documentation or proof of eligibility as a disabled child could result in loss of coverage for that child. SSMC, at its expense, may have a Physician of their choice examine the child to clarify the extent of the child's disability. Such examinations will not be required more than once each year. Failure to participate in a required Physician examination will result in loss of coverage for that child. The SSMC Human Resources Department will advise you, based on their review of the proof submitted or the results of an independent Physician's examination, whether the child meets the eligibility requirements for disabled or handicapped child eligibility.*

- 3. Persons Not Eligible as Dependents.** The following persons are not considered eligible for Plan enrollment as Dependents:
  - a. Married children or children who have been married. Eligibility ends on the date of marriage.
  - b. Any child, other than natural or adopted child, who is not Dependent on the Employee for the majority of his or her support.
  - c. Any non-enrolled Dependent on active duty in the military service or armed forces of any government or country.
  - d. Any person who does not meet the Plan definition or eligibility requirements as a Spouse or child of the eligible Employee.
  - e. Retiree Spouse/Survivor Spouse, age 65 or older.
- 4. Qualified Medical Child Support Orders.** Federal Law requires SSMC, under certain circumstances, to provide Plan coverage for your children when you or your Spouse divorce or separate. The law also provides for children born out of wedlock. SSMC must comply with qualified

medical child support orders (QMCSO) that relate to Plan benefits. QMCSO means orders, judgment, 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 an employer to provide available dental plan 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 the existing 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 for the child of an eligible active Employee, it will provide immediate Plan enrollment. This means the child identified will be included under the Employee's Plan coverage, as required according to the QMCSO requirements. You will be required to pay any new or added monthly participation costs for the child's enrollment. Upon request, the SSMC Human Resources Department can provide a copy of their QMCSO procedures, free of charge.

**5. Leave of Absence.** You could have Plan eligibility for individual or family coverage extended during your authorized leave of absence. The following are general rules for these eligibility extensions. The SSMC Human Resources Department can give you full details concerning extension of Plan eligibility and the costs for continued Plan participation.

**a. Authorized Leave of Absence.** You may retain your individual coverage or family coverage under the Plan for an approved leave of absence due to Total Disability or other leave when authorized by SSMC, according to its established rules or according to Federal and State laws including the Family and Medical Leave Act shown below. If any part of the leave is without pay, you must submit your designated Participation Payment, if any, on a timely basis to maintain coverage.

If you continue to be absent from work beyond the approval period, your Plan coverage will end at midnight on the last day of your approved absences. However, you and your Dependents may be eligible for *Continuing Coverage under COBRA* shown later in this section. If you fail to pay a scheduled Participation Payment, if any, within 31 days of the due date, coverage will end for you and your Dependents at the end of the month for which your last Participation Payment was made. If Plan coverage ends while you are absent from work, you cannot be reinstated until you return to work and enroll in the Plan. You will be considered a new Employee if more than 6 months have passed since your last day of approved absence.

**b. Family and Medical Leave Act.** 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 any 12 consecutive months for certain family and medical reasons. If you are on an FMLA leave of absence, you may continue Plan coverage by paying the designated Participation Payment, if any, for Individual or Family coverage. Plan continuation will be according to the FMLA law, as amended. The SSMC Human Resources Department can provide the details of your rights under the FMLA and your costs to continue coverage while on the FMLA. An FMLA absence could run concurrent with other SSMC authorized leave of absence.

## **B. Enrollment**

Persons cannot enroll in more than one SSMC sponsored dental Plan as an Employee/Retiree nor be enrolled both as an Employee/Retiree and a Dependent nor as a Dependent of more than one Employee/Retiree. Enrollment in the Plan is not automatic. You are required to enroll yourself and your Dependents. The SSMC Human Resources Department can provide forms and explanations needed for any enrollment updates or changes. **Failure to report enrollment changes could result in Plan overpayment. Should this happen, you may be required to reimburse the full amount of any overpayment.**

You must be in eligible employment to enroll in the Plan. Your enrollment options are as follows:

- 1. Individual or Personal Coverage.** Employee or a COBRA participant is enrolled. Plan covers only that eligible and enrolled person even if other members of the family meet eligibility requirements.
- 2. Family Coverage.** Employee and one or more Eligible Dependents are enrolled. It also includes a surviving Spouse, ex-Spouse and one or more of his/her Dependents under COBRA continuation of coverage. Coverage provides benefits only for the eligible and enrolled persons, even if other family members meet eligibility requirements.
- 3. Enrollment Changes.** It is your responsibility to apply for any enrollment changes including, but not limited to:
  - 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 any time you no longer have Eligible Dependents or when you no longer wish to provide coverage for 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;
  - g. Changing or adding new Dependents, or removing existing Dependents, from family coverage; or
  - h. Reporting other group plan(s) and Medicare coverage information and changes.

### **C. Effective Dates of Benefits**

The SSMC Human Resources Department can provide full details concerning the Effective Date of benefits for you or your Dependents. The following are general rules for Effective Dates of benefits:

- 1. Eligible Employment.** To be eligible for Plan benefits, you must be in eligible employment (on SSMC payroll as an eligible Employee) on the Effective Date of your Plan coverage or the date your Dependent's coverage becomes effective. You must be in eligible employment to be eligible for Plan changes unless on unpaid FMLA or Continuing Coverage under USERRA or COBRA. If you return to eligible employment at a later date, you may need to establish another Waiting Period and make a new enrollment. Plan benefits will not be paid for any expenses that are Incurred by any person before their Effective Date of Plan coverage.
- 2. Waiting Periods.** If you enroll in the Plan before the applicable Waiting Periods have elapsed, coverage will automatically become effective when the Waiting Periods have been met, if you are an eligible Employee at that time. Benefits will not be payable for any expenses Incurred during a Waiting Period. Coverage begins no sooner than the first day of month following the applicable Waiting Periods of three full months for eligible Full-time Employees or six full months for eligible part-time Employees.

#### **Please Note**

*You will receive credit for previous accumulated Waiting Periods if you, the Employee, lost eligible employment status with SSMC (laid-off, shorter hours etc.), and return to eligible employment within six months. If you return to eligible employment status six months or more after you lost eligible employment status, you must again accumulate the full employment Waiting Periods. Exception: You will receive credit for previously accumulated Waiting Periods if you return to eligible employment during a period of COBRA continuation. If you return to work at the end of U. S. military service, you could be eligible for immediate Plan enrollment when you meet the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA), a Federal law. The SSMC Human Resources can provide full details concerning USERRA reinstatement.*

### 3. Employee Effective Date

- a. On Effective Date of the Plan.** Each Employee in an eligible class whose employment commenced on or before the Effective Date of the Plan will be Covered on the Effective Date of the Plan if:
- 1) He or she was continuously employed by SSMC as an eligible Full-time Employee for at least three full months (six-full months for part time Employee) at the time this Plan became effective; or
  - 2) He or she was enrolled as an eligible Employee in the previous Plan when this Plan went into effect; and
  - 3) He or she is in eligible employment and enrolls in this Plan at the time this Plan became effective.
- b. Employment after Effective Date of Plan.** If your employment in an eligible class starts after the Plan Effective Date, your eligibility date for Plan enrollment is 12:01 on the first day of the month after three full months of continuous eligible employment (six full months, including sick days, for eligible part-time Employees). If you enroll before the end of the Waiting Period or within 31 days after the Waiting Period, coverage will begin on your eligibility date. If you do not enroll within 31 days after the Waiting Period, coverage begins no sooner than the Effective Dates shown later in this section under *Special Enrollment Effective Dates*.

- 4. Dependent General Rules .** Coverage for your Dependents becomes effective on the same date as your Effective Date if they are enrolled at the time of your initial enrollment. If you did not enroll existing Dependents at the time of your initial enrollment, coverage for Dependents begins no sooner than the Effective Dates shown later in this section under *Special Enrollment Effective Dates*.

### 5. Special Enrollment Effective Dates.

**a. Adding New Dependents .**

- 1) After your initial enrollment, when you acquire new Dependents and enroll the new Dependents in family coverage within 31 days after the date acquired, Plan coverage for the new Dependents will begin on the date you acquired the Dependents, but no sooner than your Effective Date of your own coverage. You will be required to pay the family coverage Participation Payments, if any.
- 2) If you are an eligible Employee and 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 (but no sooner than the first day of the month following your applicable Waiting Period), you must enroll yourself and new Dependents within 31 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 fail to enroll yourself or Dependents within 31 days from the date the Dependents were acquired, *Cancellation of Another Dental Plan* or *Late Entrant Enrollment* rules shown below apply.

- b. Cancellation of Another Dental Plan.** Eligible persons who were not enrolled in this Plan under active Employee coverage, due to other dental plan coverage, may elect coverage under this Plan. To be effective from the date the other coverage ended, but no sooner than your applicable Waiting Period, the following conditions must be met:

- 1) Person had dental coverage at the time this coverage was previously offered;

- 2) 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;
- 3) 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; and
- 4) Person requests enrollment within 31 days after the date the other plan was canceled.

If you fail to enroll yourself or Dependents within 31 days after involuntary cancellation of the other plan, coverage begins no sooner than the **Late Entrant Enrollment** Effective Date shown below. This Late Entrant rule also applies to persons who voluntarily cancel the other plan 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 Dependents from family coverage by the Enrollee; or cancellation of coverage due to Enrollee fraud or Enrollee nonpayment of required participation premiums or Contributions.

- c. Late Entrant Enrollment.** If you fail to enroll yourself or your Dependents when first eligible, or under the **Adding New Dependents** and **Cancellation of Another Dental Plan** rules shown above, coverage begins 12:01 A. M. on the first day of the month after the date SSMC Human Resources accepts your Employee or Dependent enrollment application, but no sooner than the first day of the month following three full months of eligible employment (six full months for eligible part-time Employees).

#### **D. Monthly Participation Payment**

Currently, SSMC provides Plan individual and family coverage to eligible Employees at no costs. However, SSMC has the authority to Amend the Plan, at its discretion, to require Participation Payments by Enrollees.

##### **Please Note**

*The Plan does require Participation Payments for **Continuing Coverage under USERRA** or **Continuing Coverage under COBRA** shown later in this section.*

#### **E. End of Coverage**

Plan coverage for you or your Dependents will end when you or your Dependents no longer meet the eligibility requirements of the Plan. Expenses Incurred after Plan ends will not be considered for Plan benefits. However, you or your Dependents may be eligible and elect to continue coverage under COBRA. Refer to **Continuing Coverage Under COBRA**, shown later in this section. Eligibility and coverage ends for the following unless enrollment under COBRA is made:

1. For any and all Plan Participants when the Plan is terminated.
2. For Employee and all his or her enrolled Dependents when no longer eligible due to termination of employment, reduction in hours or retirement. Coverage ends on the date eligible employment status is terminated.
3. For Employee and all his or her Dependents, coverage ends on the date after 30 days of full time active duty in the military service or armed forces of any country. However, the Employee may elect **Continuing Coverage under USERRA** shown later in this section.
4. For Employee and all his or her Dependents for Nonpayment of Plan Participation Payment, if any. For Dependents, non-payment of Plan Participation Payment for family coverage, if any.
5. Divorce, annulment or other dissolution of your marriage. Coverage ends for your ex-Spouse on the date dissolution of your marriage becomes final.
6. If Employee dies, coverage ends for the Employee and all his enrolled Dependents unless Dependents eligible as Survivors.
7. For a Dependent, coverage ends for that Dependent on the date after 30 days of full time active duty by that Dependent in the military service or armed forces of any country.
8. Dependent Child coverage also ends on:

- a. The date the child marries.
- b. The date the child no longer qualifies as a Dependent according to eligibility rules shown in this section. For example:
  - 1) 12:01 A. M. on the date no longer dependent on the Employee for support or no longer resides in the Employee's home.
  - 2) 12:01 A. M. on January 1 following the Calendar Year in which the eligible child turns age 19 and is not a full-time student or is no longer eligible as a disabled/handicapped child dependent on the Employee for support.
  - 3) 12:01 A. M. on January 1 following the Calendar Year in which the eligible full-time student between the ages 19 and 23 is no longer eligible as a full-time student or graduates.
  - 4) 12:01 A. M. on January 1 following the Calendar Year in which the full-time student turns age 23.
  - 5) 12:01 A. M. on the date a pre-adoptive child is removed from placement for adoption or the Employee is no longer legally responsible for total or partial support of the pre-adoptive child.
  - 6) 12:01 A. M. on the date a child previously eligible as a handicapped or disabled child marries, is able to earn his or her own living, fails to provide proof of disability, or to participate in a required Physician exam or the date SSMC establishes that the child no longer meets criteria as a disabled or handicapped child based on submitted proof of disability and examination results.

Coverage may be stopped immediately if you or your Dependent 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. Cancellation of your coverage due to these actions on the part of yourself or your Dependents is not considered a qualifying event under COBRA. In this case, you or your Dependents cannot elect *Continuing Coverage under COBRA*.

#### **F. Continuing Coverage Under USERRA**

The SSMC Human Resources Office must be notified, in writing (in advance when practical), should your eligible employment stop due to active United States Military Service. The SSMC Human Resources Department 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 while on military duty. This Plan excludes any Illness or Injury caused by or resulting from military service.

SSMC 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 Payment, 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 SSMC Human Resources Department can provide full details concerning your eligibility for immediate enrollment and Plan coverage according to USERRA regulations.

## **H. 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 SSMC Human Resources Department. ***You, your Spouse, and your Dependents should take the time to read this provision carefully.***

Participants must send written notification to the SSMC Human Resources Department within 60 days after the qualifying event. SSMC will send COBRA election forms to qualified beneficiaries within 14 days of after notification such. 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 an Employee Covered** under the SSMC Employee Health 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 that make you ineligible for group health coverage;
  - 2) Termination of eligible employment with SSMC. (For reasons other than gross misconduct);  
or
  - 3) Resignation of your employment with SSMC.
  
- 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 (eligible Employee of SSMC);
  - 2) Termination of your spouse's employment with SSMC. (For reasons other than gross misconduct);
  - 3) Spouse's resignation from employment with SSMC.
  - 4) Reduction of a spouse's work hours. (So that he/she is no longer eligible for Plan coverage)
  - 5) Divorce or legal separation from your Spouse; or
  - 6) 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 SSMC (For reasons other than gross misconduct);
  - 3) Parent's resignation from employment with SSMC;
  - 4) Reduction in parent's work hours. (So that parent is no longer eligible for Plan 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.

- 2. Notification of Qualifying Events.** You, as an Employee of SSMC, or your Dependents are responsible for notifying the SSMC Human Resources Department 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. The SSMC Human Resources Department will send written notice of your COBRA rights, your costs, and election forms for COBRA enrollment within 14 days after your notification to the SSMC Human Resources Department.

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

**Please Note**

*If the SSMC Human Resources Department does not receive written notice of a qualifying event within 60 days after such event, COBRA continuation will not be available and Plan coverage will stop on the date eligibility ended. SSMC 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:

<b>In no event, will COBRA continuation exceed more than 36 months for any beneficiary</b>		
<i>When continued coverage maybe 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 Employee (other than for gross misconduct), or reduction in hours of Employee	Employee, Spouse and Dependent children	18 months
Termination of employment or reduction of hours of Employee. (other than for gross misconduct) when Employee or Dependent is eligible for Social Security Disability	Employee, Spouse and Dependent children	29 months  (Includes the additional 11 months due to Social Security disability)
Death of Employee	Spouse and Dependent children	36 months
Divorce or legal separation	Spouse and Dependent children	36 months
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 the SSMC Human Resources Department within 60 days following the date Social Security approved the disability and within the first 18 months of COBRA continuation. This extension applies to the disabled beneficiary (Employee, Spouse or child) and family members enrolled in family coverage, if applicable.

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 SSMC no longer sponsors or provides group health coverage for any of its Employees;
  - c. The due date when the COBRA Participation Payment is not paid or is not paid on a timely basis;
  - d. 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;

- e. The date a beneficiary is no longer disabled during the 11-month Social Security disability extension;
- f. The date the Employee is reinstated for coverage under this Plan; or.
- g. 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 SSMC Human Resources Department when Medicare entitlement or another group health coverage become effective or when eligibility for Social Security disability ends during a period of COBRA continuation.

- 7. COBRA Coverage and Pre-existing Conditions.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, makes it easier for an employee to change jobs and become covered by a new employer's plan even if the employee or his or her Dependents have a pre-existing medical condition. COBRA beneficiaries must notify the SSMC Human Resources Department when they become covered under another employer or other group plan.

HIPAA requires that the time, in which you and your Dependents had continuous health coverage (including COBRA) before changing jobs, will reduce, day by day, the new plan's preexisting condition exclusions. In this situation, COBRA coverage ends for a beneficiary when that beneficiary becomes covered under the new employer's group health plan and pre-existing limitations do not apply to that beneficiary. In general, if a beneficiary or participant had health coverage for the previous 12 months, he or she will be covered by a new employer's plan without regard to any pre-existing conditions. Contact your new employer to verify your coverage and any applicable pre-existing exclusion. If you or your Dependents become eligible under a new plan, you should contact the SSMC Human Resources Department to send you a coverage certification under this Plan.

#### **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 COBRA Participation Payment has been made for that period of continuation.*

*This continuation coverage could be secondary payer after other group plans or Medicare. See **Section III - Coordination of Benefits**. If a person becomes eligible for Medicare or another health plan after COBRA continuation takes effect, continuation coverage under this Plan will end on the effective date of the other Plan Medicare coverage.*

#### **H. Plan Cancellation**

It is the intent of SSMC to continue the Plan for an indefinite period. However, SSMC reserves the right to cancel the Plan or make changes in the Plan at any time with respect to Plan provisions and claims administration and Participation Payment rates. Some possible reasons why this Plan could end would be installation of a revised successor plan; merger, transfer, or consolidation with another health plan; or changes in economic conditions, laws, or corporate structure that would make the Plan unfeasible as it currently exists. If Plan ends or coverage changes, Covered Expenses Incurred while Plan coverage was in effect will continue to be processed according to the Plan rules in effect at the time the expenses were Incurred. If this Plan cancels or terminates, Plan payment for expenses Incurred on or after the date of cancellation or termination will not be provided for any Plan Participant. If the Plan cancels, coverage will end for all persons enrolled in the Plan.

## SECTION III - 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 benefits payable under This Plan, as shown in the preceding pages, are coordinated with the dental benefits payable under another 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 determines 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 SSMC Employee Dental Benefit 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, coverage such as prepayment; indemnity; hospital or medical service organizations; group practice or individual practice; health 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. Under government programs such as Medicare or Tricare/Champus, this Plan will abide by the secondary rules of the government program that are directed at this type of Plan. This does not include government coverage, such as Medicaid, that by its terms prohibits coordination for the allowable expenses and is always secondary to any other dental coverage.

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 of the two, 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, that are covered at least in part by any of the plans covering the person. When a Plan provides benefits in the form of dental services, (for example an HMO) 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 medical 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 medical 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. The amount dental benefits are reduced by the primary plan because a Covered Person does not comply with the plan provisions is not an allowable expense. Examples of these provisions include, but are not limited to, mandatory requirements of a dental predetermination program or preferred Provider arrangements.
  - e. As secondary payer, This Plan will consider only expenses for dental care when coordinating dental benefits with primary plans. Unless specifically covered by This Plan, allowable expenses do not include expenses for services and supplies covered under hospital, surgical-medical, major medical, vision care, prescription drug, hearing aid coverage or similar non-dental coverage.
  - g. 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 the no-fault plan deductibles, copayments or maximum that are more than the cumulative benefit maximum per accident will be considered as allowable expense, if otherwise covered by This Plan.
  - h. 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 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. The Medicare rules for with and without employment status could apply making the dependent plan primary over the employee without employment status plan.
- 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 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 health care expenses or health 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 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 one half of 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 providing 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 rules for order of benefits 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 health 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 such conflicting rules.

#### **D. 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 This Plan benefits 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.

#### **E. Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Claims Administrator may get the facts it needs from, or give them to, any other organization or person for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person for whom claim is made. The Claims Administrator need not tell, nor get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts required to pay the claim.

#### **F. Facility of Payment**

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, This Plan 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 This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services in which case "payment made" means reasonable cash value of the benefits provided as services.

#### **G. Right of Recovery**

If the amount of the payments made by This Plan 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 Enrollee or dependent for whom it has paid the Provider to whom benefits were paid;
2. Insurance companies;
3. Self-Funded claims administrators; plan administrators, plan sponsors; or
4. Other organizations or entities.

## SECTION IV - PLAN EXCLUSIONS

### **Please Note**

*All benefit determinations are based on Plan limitations and exclusions in effect at the time expenses are incurred. 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/medical documentation as deemed necessary by the Claims Administrator to evaluate a claim for benefits. Failure to submit requested documentation or information or failure to provide a signed release for dental records could result in denial of benefits. The Claims Administrator confidentially maintains all dental/medical documents. Treatment decisions are independent from payment decisions. The patient's 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.*

In addition to the limitations shown previously in this Plan description, charges for the following dental expenses are not reimbursable by the Plan, unless otherwise specifically included for coverage. 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 related to Experimental or Investigational procedures or methods not approved by the appropriate dental specialty society.
2. Dental services done primarily for elective, cosmetic or aesthetic purposes including but not limited to 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. Preventive care unless specifically included in the Plan.
4. Dental services that are not dentally or medically necessary for the treatment of Dental Illness or Injury.
5. An appliance, or modification of one, where an impression was made before the patient was eligible and enrolled in the Plan. A crown, prosthetic or gold restoration for which the tooth was prepared before the patient was eligible and enrolled in the Plan. Root canal therapy if the pulp chamber was opened before the patient was enrolled in the Plan.
6. An initial placement of a denture or bridge (including crowns and inlays forming abutments) when replacing teeth that were missing or extracted before the person became covered under the Plan unless Covered Person was enrolled for 24 continuous months as specifically included in the Plan.
7. The replacement or duplication of an previously placed 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 unless specifically included in the Plan.

- d. Which is or can be made functional or serviceable according to common dental standards.
8. 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.
9. Bite registrations, precision or semi-precision attachments or splinting.
10. Porcelain or acrylic veneers or facings on crowns or pontics.
11. Procedures, appliances or restorations (except full dentures) whose main purpose is to change dimension; for myofunctional therapy; to restore occlusion or occlusal adjustments; to stabilize periodontal involved teeth or for periodontal splinting; to diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ), other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to the joint.
12. Orthodontic procedures, appliances or supplies for Dependent child age 19 or older, Employee or Spouse; non-active or maintenance orthodontic procedures, appliances or supplies for any Covered Person.
13. Study models; Cephalometric x-rays.
14. Educational services including dietary planning, oral hygiene, plaque control and related materials.
15. Athletic appliances, mouth guards and other protective appliances; or appliances for correction of harmful habits including, but not limited to, grinding of teeth, thumb sucking.
16. Prescription drugs; oral or intravenous sedation; separate charges for local anesthetic; anesthesia except as specifically included in the Plan for oral-dental surgery.
17. Examinations for consultation purposes.
18. Services or supplies not shown as covered services under the Plan.

### **B. General Plan Exclusions**

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

1. Services or supplies incurred while an individual is not eligible and enrolled in the Plan; after the date coverage ends or while the Plan is not in force.
2. Services or supplies 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. Services or supplies provided outside the scope of a covered Provider's license or outside the geographical area of license.
3. Charges more than the scheduled allowance or the usual, customary, and reasonable allowance for covered services or supplies. Charges more than the allowable fee for a standard procedure or an 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 such 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 SSMC. The coordination of benefits provision does not apply in this case.
9. Services or supplies received at a Health Maintenance Organization (HMO) or similar organization when the person is a participant in the HMO or similar organization.
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 for which payment is received or are reimbursable because of claim settlement or legal action (third party claim or action), other than from an insurance carrier under an individual policy issued to you or your household family member. Failure to comply with the conditions of the Plan's Right to Subrogation could result in denial of benefits. See **Section VI - Other Provisions and Procedures** under *Right of Subrogation*.
12. 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 Covered Person in the armed forces of a government.
13. Services or supplies received because of an Injury or sickness due to an act of war, whether declared or undeclared.
14. 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 **III - Coordination of Benefits**.
15. 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.
16. Fees for completion of medical/dental summaries and invoice preparations or fees for completion of claim form; Mailing and/or shipping and handling charges; fees for missed appointments or telephone consultations and fees for services not actually provided.
17. Any treatments not shown as covered services under the Plan or charges that are billed by a non-covered Provider.

## **SECTION V - CLAIM SUBMISSION / PLAN DETERMINATION / APPEALS**

### **A. How to Submit a Claim**

If another plan is the primary coverage, claims should first be submitted to that plan and then to POMCO with copies of their explanation of benefits or denial.

Claims for services or supplies needed for a dental condition due to an illness or Injury resulting from an occupational cause or for which benefits could be payable by any plan or insurance policy that is not owned or issued to you or your Dependent should be submitted to the appropriate insurance company or other payer. This type of claim is not payable under the Plan. Be sure to advise the Dentist of these situations to avoid overpayment of Plan benefits.

If you are billed for covered services, you must take the following steps to submit a claim for benefits:

1. Obtain a claim form from the SSMC Human Resources Department or from POMCO. 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.
2. Once you have completed your portion of the claim form, the Dentist can complete his portion, if needed, or you may attach itemized bills. If an itemized bill is attached, it must clearly state the patient's name, diagnosis, full description of dental services rendered and an itemized list of charges with dates of service. The itemized bill must also show the Provider's name, address, phone number, degree and Provider's federal tax identification
3. 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.
4. 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 to you and/or additional details may be requested causing a delay in 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 must be submitted within twelve months from the date the covered expense was incurred. Plan benefits will not be paid for any claims received by the Claims Administrator more than twelve months after the date expenses were incurred.

### **C. Authorization to Pay Provider/Alternate Payee**

Benefits are usually paid directly to you unless you sign the authorization on the appropriate section of the claim form to have payment made directly to the Provider. The Plan may, at its option, accept such authorization of payment or may itself authorize payment to the Dentist. If conditions exist under which a

valid release or assignment cannot be obtained, the Plan may make payment to any individual organization that has assumed the care or principal support for you and is equitably entitled to payment. Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you. *A separate claim form should be used for each Provider to whom you want direct payment to be made.*

Although direct payment may be authorized as stated above, under no circumstances may you assign your right to benefits to any person, corporation or other organization. *Any assignment of your right to benefits under the Plan will be void.*

#### **D. Dental Claim Inquiries**

When you have questions concerning your coverage, you may call the SSMC Human Resources Department or phone POMCO at their toll-free number: 1 800-501-9536.

#### **E. Plan Determination Notices and Claimant Appeals** **(Effective for Claim submitted on or after January 1, 2003)**

##### **1. Definitions Used in This Provision.**

**ADVERSE BENEFIT DETERMINATION.** Any of the following:

- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan;
- A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or
- A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

**CLAIM FOR BENEFITS/CLAIM.** A written communication (written or oral for an Urgent Claim) received by the person or persons responsible for handling benefit matters that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested either on a pre-service or post service basis and is submitted in accordance with the Plan's procedures for filing claims.

**CLAIMANT.** When term is used in this provision, it means the Covered Person (Plan Participant, beneficiary, Enrollee or by whatever name called) who files a Claim for Benefits. It also means the authorized representative acting on behalf of the Claimant.

**NOTICE OR NOTIFICATION.** The delivery or furnishing of information to an individual in a manner that satisfies the standards of federal regulations under 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

**POST-SERVICE CLAIM.** Any Claim for Benefits under the Plan that is not a Pre-Service Claim within the meaning of "Pre-Service Claim" described below.

**PRE-SERVICE CLAIM.** Any Claim for Benefits under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

**RELEVANT.** A document, record, or other information shall be considered "Relevant" to a Claimant's Claim for Benefits if such document, record, or other information:

- Was relied upon in making the benefit determination;

- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination.
- Demonstrates compliance with the administrative processes and safeguards required under federal law.
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

**URGENT CARE CLAIM/CLAIM INVOLVING URGENT CARE.** Any Pre-Service Claim for medical care or treatment for which application of the time periods for non-urgent care determinations:

- Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or

**Note:** *Except as provided for Claims that a Physician determines to be urgent care shown below; the determination whether a "Claim Involving Urgent Care " is made by an individual, acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.*

- In the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

**Note:** *Any Claim that a Physician with knowledge of the Claimant's medical condition determines is a "Claim Involving Urgent Care " within this meaning shall be treated as an Urgent Care Claim.*

## 2. Plan Notifications .

- a. **Claimant Failure to Follow Plan Procedures for Filing Pre-Service Claims** (Non-urgent or Urgent Care Pre-Service Claims). The Plan will notify the Claimant when communications from the Claimant failed to follow the Plan procedures for filing a Pre-Service Claim. Notification of failure may be oral unless the Claimant or authorized representative requests written Notification. Plan Notification is not required for general inquiries about the Plan.
- b. **Communications from Claimant or Authorized Representative.** Notification requirement applies in the case of a failure by the Claimant to follow Plan filing procedures for Pre-Service Claims that:
  - Is a written communication (written or oral for urgent pre-service claims) by a Claimant or an authorized representative of a Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; **and**
  - Is a communication *that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.*
- c. **Notification Timelines Pre -Service Claims.** Plan Notification of such failure must be provided to Claimant as soon as possible but not later than:
  - **24 Hours for Urgent Care Claims**
  - **5 calendar days for Non-Urgent Claims**
- d. **Plan Notification Timelines for Claim Determination (Adverse or not).** The Plan will send written (oral or written for Urgent Care) or electronic Notification for Adverse Benefit Determinations. See *Manner and Content of Notification* described later.
  - 1) **Calculating Time Periods for Plan Notice of Determination.** Time periods start at the time the Claim is filed in accordance with reasonable requirements of the Plan *without regard*

to whether all necessary information accompanies the filing. When period is extended due to Claimant's failure to provide necessary information, the period is tolled (not counted) from the date the Notification of extension is sent to the Claimant until the date the client responds to request for additional information. Then countdown continues. *Days and hours are counted on calendar day basis rather than business day basis.*

- 2) **Timelines Based on Type Claim.** The timelines for the Plan Notice of benefit determination varies based on whether Claim is considered an Urgent Care Claim; Pre-service Claim or Post-Service Claim. The Plan Notification will be sent to the Claimant as soon as possible after receipt of a Claim, taking into account medical circumstances, but not later than timelines shown below:

Type Claim	Timeline for Notice of Initial Benefit Determination
<p><b>Urgent Care</b></p>	<p><b><u>“Clean Claims” (does not require additional info from Claimant)</u></b></p> <ul style="list-style-type: none"> <li>• <b>Within 72 Hours</b> for Plan Notice whether Adverse Benefit Determination or not. <b><u>Claimant Fails to Provide Necessary Information.</u></b></li> <li>• <b>Within 24 Hours</b> for Plan Notice of Claimant's failure to provide necessary information. (<i>Claimant will be given reasonable time to respond, but not less than 48 hours to provide specified information.</i>)</li> <li>• <b>Within 48 hours</b> for Plan Notice, whether Adverse Benefit Determination or not, after the earlier of:  <ul style="list-style-type: none"> <li>The Plan's receipt of the specified information, <b>or</b></li> <li>The end of the period given for providing information.</li> </ul> </li> </ul> <p><b><u>Concurrent Claims Request to Extend Course of Treatment Involving Urgent Care</u></b></p> <ul style="list-style-type: none"> <li>• <b>Within 24 Hours</b> for Plan Notice whether Adverse Benefit Determination or not (when request is made for care at least 24 hours prior to expiration of the current prescribed period of time or number of treatments).</li> </ul>
<p><b>Pre-Service (Claims involving Non-Urgent Care)</b></p>	<p><b><u>“Clean Claims”</u></b>  <b>Within 15 calendar days</b> for Plan Notice whether Adverse Benefit Determination or not.</p> <p><b><u>One Time Extension</u></b></p> <ul style="list-style-type: none"> <li>• <b>Up to 15-calendar days extension</b> due to matters beyond control of Plan Administrator (or Claims Administrator acting for the Plan Administrator).</li> <li>• Notice of such delay will be sent to Claimant <i>before the end of the initial 15-day period.</i> Notice will include circumstances requiring extension and the date by which the Plan expects to render a decision.</li> </ul> <p><i>If extension is due to failure of the Claimant to submit necessary information, then Notice of extension shall specifically describe required info and the Claimant shall be given at least 45 days from receipt of the Notice to provide the information.</i></p>
<p><b>Post-Service</b></p>	<p><b><u>“Clean Claims”</u></b>  <b>Within 30 calendar days</b> for Plan Notice of Adverse Benefit Determination.</p> <p><b><u>One Time Extension</u></b></p> <ul style="list-style-type: none"> <li>• <b>Up to 15-calendar days extension</b> due to matters beyond control of Plan Administrator (or Claims Administrator acting for the Plan Administrator).</li> <li>• Notice of such delay will be sent to the Claimant <i>before the end of the initial 30-day period</i> and will include the circumstances that required the extension.</li> </ul> <p><i>If extension is due to failure of the Claimant to submit necessary information, then Notice of extension shall specifically describe required info and the Claimant shall be given at least 45 days from receipt of the Notice to provide the information.</i></p>

- e. **Manner and Content of Plan Notification.** According to the federal regulations, a Claimant must be provided with written or electronic Notification of any Adverse Benefit Determination. Any electronic Notification must comply with the standards imposed by federal regulations concerning electronic Notifications. The Plan may provide its written notice on the Explanation of Benefits or as a separate written notice.

**Note:** *In the case of an Adverse Benefit Determination by the Plan concerning a Claim involving Urgent Care, the information described below may be given to the Claimant orally provided that a written or electronic Notification is furnished to the Claimant not later than 3 days after the oral Notification.*

- 1) **Notice Contents.** Plan Notifications will be written in a manner designed to be understood by the Claimant and will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of the ERISA Retirement Income Security Act following an Adverse Benefit Determination on review. (Section 502 (a) of the Act provides that Participants and beneficiaries may bring a civil action to clarify their rights to benefits);
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; *or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;*
- If the Adverse Benefit 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 Claimant's medical circumstances, *or a statement that such explanation will be provided free of charge upon request.*
- In the case of an Adverse Benefit Determination by the Plan **concerning a Claim Involving Urgent Care**, a description of the expedited review process applicable to such Claims.

3. **Claimant Appeals of Adverse Benefit Determinations.** According to the regulations, a Claimant must be provided a reasonable opportunity to appeal an Adverse Benefit Determination. The Plan appeal procedures must provide for a **full and fair review** of the Claim and the Adverse Benefit Determination.

- a. **Claimant Time Line for Appeal.** If a Claim for Benefits is denied in, whole or in part, or if the applicant had no response to such Claim within the timelines shown above for type of Claim (in which case the Claim for Benefits will be deemed to have been denied), the claimant may appeal the denial to the Claims Administrator. All Claim appeals must be submitted within 180 days after the date the Claim is deemed denied. **Note:** *Failure to send a written appeal within 180 days from the date such Claim is deemed to be denied could result in continued denial without further Claim review by the Plan Administrator or Claims Administrator*

- b. For Pre-Service Urgent Care.** To obtain full and fair review, the Claimant or his/her authorized representative may submit a request for an expedited appeal of an Adverse Benefit Determination orally or in writing. All necessary information, including the Plan benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.
- c. All other Adverse Benefit Determinations .** To obtain a full and fair review, the Claimant or his/her authorized representative must send a written appeal of an Adverse Benefit Determination **within 180 days** after the date the Claim is deemed denied. The written appeal should include written comments, documents, and other information that support the appeal. The written request should be sent to the Claims Administrator: POMCO; **Sound Shore Dental Claim Appeals; P.O. Box 6329; Syracuse, NY 13217-6329.**
- d. Full and Fair Review.** To comply with the federal regulations concerning Full and Fair Review procedures, the Plan will provide the Claimant or the Claimant's authorized representative:
- The opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits.
  - Upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claim for Benefits.
  - A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim for Benefits, without regard to whether such information was submitted or considered in the initial benefit determination.
  - A review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
  - That, in deciding an appeal of any Adverse Benefit Determination that is based, in whole or in part, on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
  - The identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
  - The health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and
  - ***In the case of a Claim Involving Urgent Care***, provide for an expedited review process pursuant to which a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; **and** all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

e. **Timelines for Plan Notification of Appeal Determinations.** The Plan must send written or electronic Notification for Adverse Benefit Determinations. See *Manner and Content of Notification* described later.

1) **Calculating Time Periods for Plan Notice of Determination Upon Review (Appeals Review).** Time periods start at the time the appeal is filed in accordance with reasonable requirements of the Plan without regard to whether all necessary information accompanies the filing.

When period is extended due to Claimant’s failure to provide necessary information, the period is tolled (not counted) from the date Notification of extension is sent to the Claimant until the date the client responds to request for additional information. Then countdown continues. *Days and hours are counted on calendar day basis rather than business day basis.*

2) **Timelines for Plan Notification.** Claimants shall be notified of the Plan’s benefit determination upon review *as soon as reasonably possible considering medical circumstances but not later than the following timelines:*

Type Claim	Timeline for Plan Notice of Benefit Determination Upon Review
<b>Urgent Care (Includes Concurrent Care involving Urgent Care)</b>	<b>Within 72 Hours</b> after Claimants appeal of Adverse Benefit Determination for Plan Notice upon review, whether Adverse Benefit Determination or not.
<b>Pre-Service (Claims involving Non-Urgent Care)</b>	<b>Within 30 calendar days</b> after Claimants appeal of Adverse Benefit Determination for Plan Notice upon review, whether Adverse Benefit Determination or not.
<b>Post-Service</b>	<b>Within 60 calendar days</b> after Claimants appeal of Adverse Benefit Determination for Plan Notice upon review, whether Adverse Benefit Determination or not.

f. **Manner and Content of Notification of Benefit Determination upon Plan Review.** The Claimant will be provided with written or electronic Notification of any Adverse Benefit Determination. Any electronic Notice must comply with the standards imposed by federal regulations concerning electronic Notifications.

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits.
- A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures and a statement of the Claimant's right to bring civil action in a court to clarify their right to benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; and
- If the Adverse Benefit 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 Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

## **F. Legal Proceedings**

No action at law or inequity shall be brought to recover under the Plan before the expiration of 30 days after the exhaustion of all appeal rights under this Section V of the Plan, nor shall any such action be brought at all unless commenced within two years from the date the covered service or supply was incurred. However, in the event this self-funded Plan is being canceled 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 such notification, or 90 days from the date of the Plan cancellation. The Plan's agent for service of legal process is the Administrative Manager or any officer of Sound Shore Medical Center of Westchester, 16 Guion Place, New Rochelle, NY 10802 Telephone: (914) 632-5000.

## **SECTION VI - OTHER PROCEDURES AND PROVISIONS**

### **A. Not an Employment 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 Plan Sponsor 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 Plan Sponsor or to any benefits not specifically provided by the Plan.

### **B. Verification of Claim Information**

The Plan Administrator and the Claims Administrator have the right to request from you or your Eligible Dependents, dentists, doctors or other Providers any dental or medical records or information that is necessary 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 such 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/medical records.

### **C. Right of Examination**

The Plan Administrator shall have the right, to require an independent oral/dental examination for you or your Eligible Dependent when and so often as it may reasonably require such examination during the determination of a claim. The Plan pays full costs of such examinations.

### **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 and supplies are incurred.

### **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, such 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 should not have been paid according to Plan provisions, the Plan Administrator shall have the right to demand a full refund or may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such covered people or other present or future amounts payable to such people, or recover such amounts by any other appropriate method that the Plan Administrator, in its sole discretion, shall determine. Each Covered

Person hereby authorizes the deduction of such excess payment from such 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. Right of Reimbursement/Subrogation**

The conditions shown below do not apply to benefits paid under Medicare coverage nor to any payments made under any insurance policy, plan or certificate issued to you or your Dependents.

This Plan specifically does not provide any coverage with respect to any illness or Injury for which a third party may be liable or legally responsible. If you or your Dependent receive payment or expect payment from a third-party insurance, surety or other type plan, not owned by or issued to you or your Dependent, for medical expenses resulting from such illness or Injury, you should not submit a claim under this Plan for such medical expenses. Any Plan benefits paid against such claims will be considered an overpayment. The Plan will exercise its right to full reimbursement for resulting overpayments. However, if for some reason the third-party claim payment or settlement is delayed for an extended time, the Plan Administrator may, at its option, authorize Plan benefits for medical expenses that would otherwise be covered by this Plan. The rules shown below govern how this Plan pays benefits in such situations.

- 1. Conditional Benefit Payment.** If a Covered Person has medical expenses resulting from an Injury, accident or illness for which a third party is, or may be, held responsible and such third-party payment or settlement is withheld for an extended period, the Plan Administrator may, at its option, authorize conditional interim benefit payments for medical expenses that would otherwise be covered by the Plan. However, any advance payments are subject to the Plan's reimbursement rights. Before such benefits are conditionally made, you and/or your Eligible Dependent, or authorized representative, if a minor, must execute an agreement that acknowledges and affirms (a) the conditional nature of such benefit payments and (b) the Plan's rights of subrogation/reimbursement, as shown below.
- 2. Reimbursement Agreement.** If benefits are paid or payable by this Plan as the result of an action of a third party, this Plan will be subrogated to all rights of recovery of any Covered Person under this Plan in respect to such action. In addition, once it is determined that a third party is liable in any way for the Injuries or illness giving rise to these expenses, in order to receive benefits, or to continue receiving benefits from this Plan, you must take the following steps or all benefit payments to you will be stopped.

You are required to advise this Plan in writing of any expenses for which a third party may be liable. You and/or your Eligible Dependent, or authorized representative if a minor or if unable to sign, must execute and deliver such documents, notices or papers as may be required and must do whatever else is needed to secure the Plan rights, including the following:

- a. You and/or your Eligible Dependent, or legal representative must agree, in writing, to provide the Claims Administrator with written notice whenever a claim is asserted or could be asserted against and/or recovery is received from any third party (or insurer or surety thereof) for damages as the result of the illness or Injury; and
- b. You and/or your Eligible Dependent, or legal representative must agree, in writing, on a form acceptable to the Claims Administrator, to reimburse this Plan for any benefits paid by this Plan

due to such illness or Injury for which a third party recovery is received. Such Plan benefits must be reimbursed 100% from any settlement, judgments or other payment that you obtain from the liable third party, before they take out any other expenses, including attorney's fees, court costs or other disbursements; and

- c. You and/or your Dependent, or legal representative must provide, in writing, an assignment of proceeds or a lien against such proceeds, in favor of the Plan in the amount of any benefits paid by the Plan due to such illness or Injury; such assignment to be valid against any judgment, settlement, or recovery in any manner that is or will be received from such third party or such third party's insurer or surety.

If you or your Dependent fail to tell this Plan that you or your Dependent has a claim against a third party; if you or your Dependent fail to assign your claim against the third party to the Plan when required to do so (and to cooperate with this Plan's subsequent recovery efforts); if you or your Dependent fail to require any attorney subsequently retained to sign the Plan's lien forms; if you and/or your Dependent and/or authorized representative or attorney fail to fully reimburse this Plan out of any payment obtained from the third party or fail to fully reimburse the Plan, then you are personally liable to this Plan for the reimbursement owed this Plan as the result of the third party payment or settlement. This Plan may then request reimbursement from you and offset the amount you owe from any future benefit claims for any Covered Family Member or if necessary, take legal action against you.

The Plan reserves the right to deny benefits for any charges that are or could be considered subject to the Plan's right of reimbursement in the case of failure by you and/or your Eligible Dependent or legal representative to comply with the above conditions.

#### **H. Amendments or Cancellation of the Plan**

The Plan Administrator, in its sole discretion, reserves the right to Amend, reduce, revise or cancel, any or all of the benefits, limitations, provisions, inclusions or exclusions of the Plan. If the Plan cancels, coverage will end for all persons enrolled under the Plan.

#### **I. Severability**

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

#### **K. Named Fiduciary and Plan Administrator**

A fiduciary is a person or entity that exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders advice to the Plan or has discretionary authority or responsibility in the administration of the Plan. The named fiduciary for the Plan is the Plan

Administrator, Sound Shore Medical Center. The Plan Administrator may appoint others to carry out fiduciary responsibilities under the Plan. These other persons or entities become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to others, the named fiduciary shall not be liable for any act or omission of such person or entity unless either the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary; establishing the procedures to appoint the fiduciary or continuing either appointment of the procedures; or the named fiduciary breached its fiduciary responsibility under Section 405 (a) of ERISA. The agent for service of legal process is the Human Resources Manager of SSMC or any officer of SSMC at 16 Guion Place; New Rochelle, NY 10802.

#### **L. Federal and State Laws**

This Plan shall be governed and construed according to Federal laws such as the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the Health Insurance Portability and Accountability Act, as amended, and the Laws of the State of New York, to the extent not preempted by ERISA. Federal or state laws will affect the provisions of this Plan only when directed at this type of self-funded health Plan for Plan Sponsors regulated by the laws. You may seek assistance or information about your rights under ERISA or the Health Insurance Portability and Accountability Act by contacting the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory or contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210. You may also call the Department of Labor Toll-Free Participant and Compliance Assistance Number at 1-866-275-7922 for assistance with your questions and to request certain PWBA publications.

#### **M. Statement of ERISA Rights**

As a participant in the SSMC Employee Dental Benefits Plan, you are entitled to certain rights and protection under the federal law, Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan Participants shall be entitled to:

- 1. Receive Information about Your Plan And Benefits.** Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including Plan contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may require a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

- 2. Continue Group Health Plan Coverage.** Continue Plan coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and

your Dependents may have to pay for such coverage. You are entitled to review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You are entitled to reduction or elimination of exclusionary periods for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan; when you become entitled to elect COBRA continuation coverage; when your COBRA continuation coverage ceases; if you request it before losing coverage; or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting exclusions for up to 12 months (up to 18 months for late enrollees) after your enrollment date, as imposed by a health plan.

- 3. Prudent Actions by Plan Fiduciaries.** In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently, and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit, or exercising your rights under ERISA.
- 4. Enforce your Rights.** If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps that may be taken to enforce these rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent due to circumstances beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- 5. Assistance With Your Questions .** If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory or contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210. You may also call the Department of Labor Toll-Free Participant and Compliance Assistance Number at 1-866-275-7922 for assistance with your questions and to request certain PWBA publications.

## **N. Headings**

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

## SECTION VII - DEFINITIONS

Certain words and phrases applicable to or used in this Plan description are listed below with the definition or explanation of the manner in which the terms are used to determine Plan coverage and benefits.

**ACCIDENTAL INJURY** – Non-occupational bodily Injuries caused by an event that is sudden and not foreseen, and is exact as to time and place.

**ALLOWABLE FEES** - The Usual Customary and Reasonable Charges or scheduled amount that is designated as the maximum allowable charges for a covered dental Procedure. The Plan Participant is responsible for the payment of charges that are more than the Allowable Fees.

**ALLOWABLE SERVICES OR SUPPLIES** - See Covered Services or Supplies.

**AMEND/AMENDMENT** – A formal document executed and signed by the Plan Administrator that shows a change, revision, deletion or addition to the Plan Document and Summary Plan Description.

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

**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.

**COLLEGE OR UNIVERSITY** - An institution listed in the current American Council on Education publication of Accredited Institutions of Post-Secondary Education.

**COVERED EXPENSES** - Allowable Fees charged by Dentists for dental care that is covered according to Plan provisions, limitations and exclusions. The Enrollee or participant is responsible for payment of any expenses not covered by the Plan.

**COVERED FAMILY MEMBER** -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, according to Plan provisions, limitations and exclusions.

**DENTAL HYGIENIST** – A person licensed and performing dental hygiene, such as prophylaxis, within the state of jurisdiction; employed by a licensed Dentist and performing covered services under the direction of the Dentist.

**DENTAL ILLNESS** - Any sickness or disease of the teeth or oral cavity that manifests treatable symptoms and requires dental treatment.

**DENTIST** - A person holding the degree of Doctor of Dentistry (DDS or DMD) or Doctor of Medicine (MD) and legally licensed to practice dentistry or to do dental surgery and performing a covered dental service within the scope and jurisdiction of that license.

**DEPENDENT** - An Enrollee's Spouse or an Enrollee's child who meets the conditions shown in **Section II - Eligibility and Enrollment**.

**EFFECTIVE DATE** - The date coverage is effective with respect to an eligible Employee or eligible Dependent.

**ELIGIBLE DEPENDENTS** - See Dependents.

**EMPLOYEE** - Any person who is considered an Employee of SSMC as set forth in **Section II - Eligibility and Enrollment**.

**ENROLLEE** or Covered Enrollee - An Employee who is eligible and enrolled in the Plan; A person whose social security number is used for COBRA continuation.

**ERISA** - Employee Retirement Income Security Act of 1974 (ERISA), as amended.

**EXPERIMENTAL** - See Investigative.

**FULL-TIME** - A basis of employment that requires the Employee to be at work for at least the qualifying hours per week based on criteria decided by the employer or by negotiated agreement.

**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 Employee, Enrollee or Covered Person relatives:

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

**INCURRED DATE** - The date the actual service or supply was rendered or received.

**INJURY** - A non-occupational accidental oral/dental Injury of a covered person that was caused by an external force that is unrelated either directly or indirectly to all other causes.

**INVESTIGATIONAL 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 based upon recognized standards of dental or health care.

**LIFETIME** - Any reference to Lifetime shown in this Plan means all periods during which the person is covered under the Plan. Under no circumstances, does the Plan pay benefits for any period during which the person does not meet Plan eligibility or continuation requirements.

**MEDICARE** - The coverage of health care costs provided under the provisions of the Federal Social Security Act (42 USC 1395 et seq.), as amended.

**NONOCCUPATIONAL DISEASE OR INJURY** - A disease 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.

**PLAN PARTICIPANT** - See Covered Person.

**PROVIDER** - Any Dentist legally licensed and doing a covered service within the scope of such license and in the state of such license.

**SPOUSE** - The legal wife or husband of the eligible Employee.

**USERRA** - The Uniformed Services Employment and Reemployment Rights Act, a federal law.

**USUAL, CUSTOMARY AND REASONABLE CHARGE** - The lowest of:

1. The actual charge for the Covered service or supply;
2. The usual charge by the Dentist for the same or similar service or supply; or
3. The usual charge of Dentists in the same or similar geographic area for the same or similar service or supply (prevailing fee).

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 means 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 makes the determination of the Usual, Customary and Reasonable Charges for covered dental services or supplies based on the above rules.

**WAITING PERIOD** - The time between the Employee's date of eligibility and/or hire and the date the Employee becomes covered under the Plan.