BENEFIT BOOKLET
FOR THE DENTAL BENEFITS
UNDER THE
SYRACUSE CITY SCHOOL DISTRICT DENTAL GROUP BENEFIT PLAN

EFFECTIVE: JULY 1, 2019

TABLE OF CONTENTS

INTRODUCTION

This booklet explains the dental benefits available to you under the Syracuse City School District Dental Group Benefit Plan (the "Plan"). The Plan is funded by Syracuse City School District (the "Employer" or "Plan Sponsor"). No oral interpretations can change the Plan.

The Plan Sponsor delegates its responsibility with respect to the payment of claims to the Claims Administrator.

The Plan Sponsor fully intends to maintain the Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

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

READ THIS ENTIRE BOOKLET CAREFULLY. IT DESCRIBES THE DENTAL BENEFITS AVAILABLE UNDER THE PLAN. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS BOOKLET. YOU SHOULD KEEP THIS BOOKLET WITH YOUR OTHER IMPORTANT PAPERS SO IT IS AVAILABLE FOR YOUR FUTURE REFERENCE.

IN WITNESS WHEREOF, the Plan Sponsor has caused this booklet to be executed as of the date set forth below.

SYRACUSE CITY SCHOOL DISTRICT

Dated: June 9, 2020

By: Christopher Miller

Name: Christopher Miller, Ed.D.

Title: Chief Human Resources Officer

DENTAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	NON-PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**
PLAN YEAR DEDUCTIBLE		
Individual	None	
Family	None	
DENTAL BENEFITS		
Class I – Preventive and diagnostic services	0% Coinsurance	0% Coinsurance
Class II – Basic services	0% Coinsurance	0% Coinsurance
Class IIA – Basic restorative services	0% Coinsurance	0% Coinsurance
Class III – Major restorative services	0% Coinsurance	0% Coinsurance
Class IV – Orthodontics	0% Coinsurance	0% Coinsurance
Coverage under the Plan is limited to Covered Persons		
CLASS I, II, IIA AND III COMBINED PLAN YEAR MAXIMUM BENEFIT	None	
CLASS IV – ORTHODONTIA LIFETIME MAXIMUM	$1,200/ per Covered Person	

NOTE: The dental benefits provided under the Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the dental benefits under the Plan.

DEFINITIONS

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

Allowed Amount.
The Allowed Amount means the maximum amount the Plan will pay to a Health Care Professional for the services or supplies Covered under the Plan, before any applicable Deductible, Copayments and Coinsurance amounts are subtracted. The Allowed Amount for Participating Providers is based on the Claims Administrator Fee Schedule or the Health Care Professional's actual charge, whichever is less. The Allowed Amount for services of Non-Participating Providers is based on the 50th percentile of the Usual, Customary and Reasonable charge or the Health Care Professional's actual charge, whichever is less. The Non-Participating Provider's actual charge may excess the Allowed Amount. You must pay the difference between the Allowed Amount and the Non-Participating Provider's charge. The Plan reserves the right to negotiate a lower rate with Non-Participating Providers.

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

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

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

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

Claims Administrator. Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield"), 165 Court Street, Rochester, New York, 14647. Excellus BlueCross BlueShield administers claims for benefits under the Plan on behalf of the Plan Sponsor and does not insure your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association.

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

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

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

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

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

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

Dependent. See the "Eligibility" section of this booklet.

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

Employer. Syracuse City School District- 725 Harrison St.- Syracuse, NY 13210.

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

Genetic Information. Information about an individual's genetic tests, the genetic tests of that individual's family members, the manifestation of disease or disorder in family members of the individual, an individual's request for, or receipts of, genetic services, or the participating in clinical research that includes genetic services by the individual or a family member of the individual, or genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual, and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology. Genetic Information will not be taken into account for purposes of determining eligibility for benefits under the Plan, or establishing premium or contribution amounts for coverage under the Plan.

Health Care Professional. An appropriately licensed, registered or certified dentist or optometrist; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law (or other comparable state law, if applicable) requires to be recognized who charges and bills patients for Covered Services. The Health Care

Professional's services must be rendered within the lawful scope of practice for that type of provider in order to be Covered under the Plan.

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

Late Enrollee. A Covered Person who enrolls under the Plan other than during the first 30-day period in which the individual is initially eligible to enroll or during a special enrollment or change in status event.

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

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

The Plan may base its decision on a review of:

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

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of you, your family, or your provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely

provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

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

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

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

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

Plan. Syracuse City School District Dental Group Benefit Plan.

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

Plan Sponsor. Syracuse City School District or any successor thereto.

Plan Year. The 12-month period beginning on July 1 and ending on June 30.

Retiree. A former Employee of the Syracuse City School District that satisfies the Retiree eligibility requirements of the Plan.

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

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

Spouse. A person who is legally married to an Employee. A Spouse does not include someone that is divorced from the Employee but does include someone that is legally separated.

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

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

ELIGIBILITY

Employee Eligibility

An Employee is eligible for coverage under the Plan in accordance with the eligibility rules established by the Employer. Eligibility rules can vary subject to union negotiated settlements or policy changes by your Employer. To be eligible for Plan enrollment, Employees must have been hired for an anticipated full-time employment period of at least three (3) months. Other requirements for eligibility are based on your bargaining unit's contract with your Employer. In addition, even though Employee eligibility requirement may be met, any unenrolled Employee who submits an initial enrollment application while temporarily removed from payroll (i.e. lay-off or leave of absence) will not be eligible for Plan coverage until after he or she is once more on the Employer's payroll.

Coverage under the Plan will take effect for an eligible Employee when the Employee satisfies all eligibility requirements of the Plan. Failure to follow the eligibility or enrollment requirements of the Plan may result in delay of coverage or no coverage at all.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

Please contact your Employer if you have questions with respect to your eligibility for benefits under the Plan.

Retiree Eligibility

A Retiree is eligible for coverage under the Plan in accordance with his or her union contract/agreement. Please refer to your union contract/agreement for Retiree eligibility requirements

Dependent Eligibility

Subject to the permissible eligibility rules of the Employer, your Dependent is eligible for coverage under the Plan, provided he/she is:

(1) Your Spouse.

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

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

The term “institution” does not include on-lines degree programs.

(3) Your unmarried Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation or physical handicap and who became so incapable before reaching the limiting age stated in (2) above. Your Child must have been covered under the Plan prior to reaching the limiting age stated above, be chiefly dependent upon you for support and maintenance and must reside with you for more than one-half of the Calendar Year.

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

Timely Enrollment

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

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

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

Late Enrollment

If you fail to timely enroll, as specified as above, you may request enrollment at a later time and, in such case, you will be considered a Late Enrollee. If you request late enrollment, Plan coverage will begin no sooner than the first day of the third month after the date you complete and submit the required election and enrollment forms to your Employer and your Employer accepts such enrollment. In addition to late enrollment, you may be eligible to enroll in the Plan at a different time if you experience a special enrollment or change in status event, as described below.

Special Enrollment Event

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

(1) **Loss of Other Coverage.** You previously declined coverage for yourself and/or your eligible Dependents because you and/or your Dependents had other health coverage and you submitted a written statement to your Human Resources Department when you were initially eligible declining enrollment under the Plan because of such other health coverage, but that other health coverage was lost as a result of one of the following events:

(a) Legal separation, divorce, death, loss of dependent status, termination of employment, reduction in hours, or any other reason required by HIPAA;

(b) The other health coverage was COBRA and the maximum continuation period available under COBRA has been exhausted; or

(c) Employer contributions for the other health coverage ended.

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

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

You must request enrollment in the Plan by submitting any required enrollment and election forms to your Human Resources Department no later than 30-days after the date your other health coverage was lost. Coverage under the Plan will begin as of the date coverage was lost, provided you request enrollment within the 30-day period described above. Failure to enroll in the Plan will result in no coverage under the Plan. You may elect to enroll in the Plan as a Late Enrollee or in the event you experience another special enrollment or change in status event.

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

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

(a) For a newborn Child (other than a proposed adopted newborn Child), coverage will begin as of the date of birth, provided you request enrollment

within the 30-day period described above.

(b) For a proposed adopted newborn Child, coverage will begin as of the date of birth, provided you request enrollment within the 30-day period described above; and

(i) You take physical custody of the newborn as soon as he/she is released from the Hospital after birth; and
(ii) File a petition for adoption within 30 days after the Child's birth.

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

(c) For an adopted Child (or Child placed with you in anticipation of adoption), coverage will begin as of the date of adoption, provided you request enrollment within the 30-day period described above.

(d) For a newly acquired Dependent as a result of marriage, coverage will begin as of the date of marriage, provided you request enrollment within the 30-day period described above.

Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan. You may elect to enroll in the Plan as a Late Enrollee or in the event you experience another special enrollment or change in status event.

Change in Status Event

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

(1) A change in your marital status or domestic partnership status, including marriage or commencement of a domestic partnership, divorce, legal separation, annulment, termination of a domestic partnership or death of a Spouse or Domestic Partner;

(2) A Dependent loses or gains eligibility under the Plan, such as attainment of a specified age; birth, adoption or placement for adoption of a Dependent; death of a Dependent; or a change in the Plan's Dependent eligibility requirements;

(3) Change in employment status that causes you, your Spouse, Domestic Partner or

Dependent Child to either gain or lose eligibility under the Plan, including commencement or termination of employment; commencement or return from a leave of absence; or any other employment status change that affects the eligibility status of an individual to participate in the Plan, including a change from part-time to full-time status or vice versa, a change from salaried to hourly or vice versa, or a strike or lockout;

(4) Gain or loss of eligibility under the Plan or another employer-sponsored welfare benefit plan;

(5) Significant increase or decrease in the cost of coverage under the Plan, including a new benefit option being added, a benefit option being eliminated or significantly curtailed and a coverage change made under a plan offered by the Employer;

(6) Change in your residence or the residence of your Dependent that is outside the Plan's Service Area;

(7) Change in election under another employer-sponsored welfare benefit Plan during an open enrollment period under another employer-sponsored welfare benefit plan;

(8) You or your Dependent become covered or lose coverage under Medicare or Medicaid.

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

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

Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan. You may elect to enroll in the Plan as a Late Enrollee or in the event you experience another special enrollment or change in status event.

Change in Election Due to Marketplace Coverage

If you have an opportunity to enroll in a qualified health plan through an exchange or marketplace established under the Affordable Care Act ("Marketplace Coverage"), you may change your benefit elections under the Plan to cancel medical coverage under the Plan but only if you (and all Dependents whose coverage under the Plan is being cancelled) are also enrolling in Marketplace Coverage. Cancelling coverage under the Plan based on this rule will be permitted only if the Marketplace Coverage (for all Covered Persons whose coverage under the Plan is being cancelled) is effective no later than the next day after coverage under the Plan would terminate because of the cancellation of coverage. The Plan may rely on your reasonable representation that all

Covered Persons whose coverage is being cancelled have enrolled in or will enroll in Marketplace Coverage to be effective no later than the deadline indicated in the previous sentence, but the Employer, in its discretion, may also require additional documentation of the Marketplace Coverage. Also, note that you are permitted to enroll in Marketplace Coverage only during the annual Marketplace enrollment period or based on a marketplace special enrollment opportunity. Details about the enrollment periods for Marketplace Coverage are available at: https://nystateofhealth.ny.gov/.

WHEN COVERAGE ENDS

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

(1) The date the Plan terminates, in whole or in part;

(2) For ten (10) month Employees, whose employment with the Employer terminates after June 30th or who fail to report to work in September, coverage will end on September 1st;

(3) The 1st or 15th day of the next month following the date of the last payroll period in which contributions for coverage were made. If you are retiring, you may be eligible for Retiree coverage. Please see the Retiree Eligibility section of the Plan for further details;

(4) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA);

(5) The 1st or 15th day of the next month following the date of the last payroll period in which you change to an Employee classification that is not benefits-eligible;

(6) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; or

(7) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of material fact.

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

(1) The date the Plan terminates, in whole or in part;

(2) The date the Employee's eligibility or coverage under the Plan terminates;

(3) The date the Dependent Child no longer qualifies as a Dependent under the Plan;

(4) The date Dependent coverage under the Plan is terminated;

(5) The date the Dependent (or any person seeking coverage on behalf of the Dependent) performs an act, practice or omission that constitutes fraud; or

(6) The date the Dependent (or any person seeking coverage on behalf of the Dependent) makes an intentional misrepresentation of material fact.

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

(1) The date the Plan is terminated, in whole or in part;

(2) The date the Plan no longer provides Retiree coverage;

(3) The last day of the period for which the required contribution has been paid;

(4) The date the Retiree no longer meets the eligibility requirements for Retiree coverage under the Plan;

(5) The date in which a Dependent no longer qualifies as a Dependent;

(6) The date the Retiree or any eligible Dependent (or any person seeking coverage on behalf of the Retiree or any eligible Dependent) performs an act, practice or omission that constitutes fraud; or

(7) The date the Retiree or any eligible Dependent (or any person seeking coverage on behalf of the Retiree or any eligible Dependent) makes and intentional misrepresentation of material fact.

Temporary Continuation of Coverage.
Under the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); Family and Medical Leave Act of 1993 (FMLA); and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) you and your eligible Dependents may be eligible to temporarily continue coverage under the Plan when your coverage would otherwise end. Please contact your Employer to find out if you may be entitled to a temporary continuation of coverage under COBRA, FMLA or USERRA.

DENTAL BENEFITS

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

Covered Dental Benefits

Class I - Preventive and Diagnostic Services

(1) **Clinical Oral Examinations.** The Plan will provide coverage for an oral examination twice in any Plan Year. Coverage will also be provided for emergency oral examinations to treat pain; if an operative procedure is also provided on the same day, coverage for the emergency oral exam is included in the payment for the operative procedure.

(2) **Radiographs.**

a. **Full Mouth or Panoramic.** The Plan will provide coverage for the following complete intra-oral x-rays once every 36 consecutive months: a complete series of bitewings (16 films); or a panoramic film. The Plan will not provide coverage for periapical x-rays when performed on the same date as a complete series or a panoramic x-ray. When the total amount charged for individual periapical x-rays equals or exceeds the Allowed Amount for a complete series, benefits are limited to the Allowed Amount for a complete series.

b. **Bitewings.** The Plan will provide coverage for up to a combination of four (4) bitewing films in a Plan Year. The Plan will not provide coverage for bitewings provided in conjunction with a full mouth series.

c. **Diagnostic Radiographs and Photographs.** The Plan will provide coverage for diagnostic x-rays and photographs. The Plan will only provide coverage for photographs once in a Plan Year.

d. **Facial Images.** The Plan will provide coverage for facial images once in a Plan Year.

(3) **Dental Prophylaxis, Including Cleaning, Scaling and Polishing.** The Plan will provide coverage for prophylaxis twice in a Plan Year. The Plan will provide coverage for cleaning or scaling of teeth performed by a licensed dental

hygienist if such treatment is rendered under the supervision and direction of a Health Care Professional.

(4) **Topical Fluoride Treatments (Office Procedure).** The Plan will provide coverage for topical fluoride treatments twice in a Plan Year.

(5) **Palliative Emergency Treatment.** The Plan will provide coverage for emergency care you receive from a Health Care Professional that is designed only to relieve your dental pain until corrective treatment can be provided.

(6) **Sealants.** The Plan will provide coverage for the topical application of sealants on un-restored, permanent molars for Dependent Children under age 14. Limit of once per tooth every 36 consecutive months.

(7) **Space Maintainers.** The Plan will provide coverage for space maintainers for Dependent Children under age 16. This includes coverage for adjustment and re-cementation within six (6) months after placement.

Class II - Basic Services

(1) **Amalgam and Composite Restorations.** The Plan will provide coverage for amalgam and composite restorations for treatment of cavities. Restorations including multiple surfaces will, for the purpose of providing benefits, be combined; and benefits will be provided according to the number of surfaces treated. Benefits for each surface are allowed once in 12 consecutive months.

(2) **Oral Surgery.** The Plan will provide coverage for simple extractions. Coverage for local anesthesia, routine pre and post-operative procedures, sutures and suture removal are included in the Plan's Allowed Amount for the surgery; and the Plan will not provide additional benefits for such services.

(3) **Debridement.** The Plan will provide coverage for debridement, if required because tooth structures are so deeply covered with plaque and calculus that appropriate examination cannot take place to identify decay, infections or gum disease.

Class IIA - Basic Restorative Services

(1) **Oral Surgery.** The Plan will provide coverage for oral surgery, consisting of: surgical extractions, including removal of impacted teeth; odontogenic cysts, lesions and biopsies; tooth re-implantation; tooth transplantation and alveoplasty. Coverage for local anesthesia, routine pre and post-operative procedures, sutures and suture removal are included in the Allowed Amount for the surgery; and the Plan will not provide additional benefits for such services. Benefits for extraction of impacted wisdom teeth include coverage for IV sedation.

(2) **Endodontics.**

a. **Pulp Caps.** Coverage for direct and indirect pulp caps rendered in conjunction with a restoration is included in the Allowed Amount for the restorative procedure; and the Plan will not provide additional benefits for such services.

b. **Pulpotomy.** The Plan will provide coverage for therapeutic pulpotomy once per tooth, except when performed in conjunction with root canal therapy.

c. **Root Canal Treatment.** The Plan will provide coverage for root canal therapy, including: anesthesia; opening and drainage of pulp chambers and canals; removal of pulp tissue and instrumentation of canals; application of medications; radiographs taken during the course of active treatment; and culture and sensitivity examinations.

i. Coverage for root canal therapy includes the following: any related diagnostic and/or palliative treatment provided during, or 30 days before or after, root canal therapy; and temporary re-cementation of crowns/bridges.

ii. Coverage for root canal treatment will be provided for up to 30 days after termination of your coverage under the Plan for a tooth opened while coverage was in effect.

d. **Apicoectomy.** The Plan will provide coverage for apicoectomy, including: sutures; suture removal; treatment plan; anesthesia; application of medications; treatment radiographs; and routine post-operative treatment.

Coverage includes benefits for any diagnostic and/or palliative treatment related to the apicoectomy that is rendered during, or 30 days before or after, the apicoectomy or retrograde filling.

e. **Hemisection.** The Plan will provide coverage for hemisection, including: sutures; suture removal; treatment plan; anesthesia; application of medications; treatment radiographs; and routine post-operative treatment.

(3) **Periodontic Services.**

a. **Periodontic Surgical Services.** The Plan will provide coverage for the following periodontic surgical services once in any quadrant in any consecutive 36-month period: gingivectomy; osseous surgery; and gingival flap procedures. When more than one of these surgical procedures is rendered at the same time, the Plan will only pay for the most inclusive procedure.

b. **Periodontic Adjunctive Services.** The Plan will provide coverage for periodontic adjunctive services consisting of periodontal scaling and root

planing (per quadrant) once per quadrant in any consecutive 24-month month period. When periodontal scaling and root planning are provided on the same day as a prophylaxis, the Plan will only pay for the most inclusive procedure.

c. **Periodontal Maintenance.** The Plan will provide coverage for periodontal maintenance (periodontal prophylaxis) twice per Plan Year after active therapy and/or surgical treatment. Periodontal scaling performed in presence of gingival inflammation and/or full mouth debridement is not considered active treatment.

(4) **Anesthesia.** The Plan will provide coverage for anesthesia for any Covered Services or procedures under the Plan.

(5) **Occlusal Adjustments.** The Plan will provide coverage for occlusal adjustments once every five (5) years.

Class III - Major Restorative Services

(1) **Removable and Fixed Prosthodontics.** Benefits will be provided for the following removable and fixed prosthodontics: full and partial dentures; and fixed bridgework. The following benefit limitations apply:

a. The Plan will only provide benefits for the replacement of a denture, partial denture or fixed bridgework for which benefits were provided under the Plan with another denture, partial denture or fixed bridge: when the existing prosthetic was placed more than five (5) years ago and cannot be made serviceable.

Benefits for the upgrading from a partial denture to fixed bridgework are limited to the Allowed Amount for a partial denture.

Benefits for replacement of bilateral or multiple missing teeth in the same arch are limited to the Allowed Amount for the partial denture.

b. The Plan will not provide coverage for denture replacement made necessary by reason of loss or theft.

c. The Plan will only provide benefits for adjustments, re-cementation or repairs to full or partial dentures or bridges when the adjustment, re-cementation or repair is performed more than six (6) months after the initial insertion of the prosthesis.

d. Benefits for denture reline or rebases are limited to one (1) in a 36-month period and must occur at least six months after initial placement.

e. Benefits for temporary partial stayplate dentures (flipper) are limited to the replacement of extracted anterior teeth.

f. Benefits for the following are included in the Allowed Amount for the major procedure: tooth preparation; temporary bridges; bases; impressions; anesthesia; preparation of the gingival tissue; or other services that are components of a complete procedure.

g. Removal of part of a root (hemisection) does not qualify as a tooth extraction when determining benefits in connection with installation of removable or fixed prosthetics.

h. A bridge in conjunction with a partial denture in the same arch is considered optional and benefits are limited to the Allowed Amount for a partial denture.

i. The following in connection with a denture, partial denture or bridge are limited to the Allowed Amount for a standard procedure: precision or semi-precision attachments; athletic mouth guards; special techniques or personalized restoration.

j. The Plan will not provide benefits for a denture, partial denture or bridge or the fitting thereof: that was ordered while the Covered Person was not Covered under the Plan; or that was ordered while the Covered Person was Covered under the Plan, but finally installed or delivered to such Covered Person more than 30 days after termination of coverage under the Plan.

(2) **Inlays/Onlays and/or Crowns.** The Plan will provide coverage for inlays/onlays and/or crowns only when teeth cannot be restored by a filling. Coverage for these restorations includes all necessary: bases; pulp medications; liners; gingival preparation; impressions; temporary crowns; finishing; and occlusal adjustments. The following benefit limitations apply:

a. When an inlay/onlay or crown is used to replace an existing filling in the absence of decay, the Plan will only provide benefits that are based on the Allowed Amount for an amalgam or composite filling. When an inlay/onlay or crown is not used to replace an existing filling, the Plan will only provide benefits for an inlay/onlay or crown that is Medically Necessary to treat a tooth due to severe decay and/or fracture.

b. The Plan will only provide benefits for the replacement of an inlay/onlay or crown with another inlay/onlay or crown if more than five (5) years have elapsed since the last placement.

c. The Plan will only provide benefits for re-cementation that is performed more than six (6) months after the initial insertion.

d. The Plan will not provide benefits for an inlay/onlay or crown or the fitting thereof: that was ordered while the Covered Person was not Covered under the Plan; or that was ordered while the Covered Person was

Covered under the Plan, but finally installed more than 30 days after termination of coverage under the Plan.

(3) **Occlusal Guards.** The Plan will provide coverage for occlusal guards once every three (3) years.

Class IV - Orthodontics

(1) **Orthodontic Services.** The Plan will provide coverage for orthodontic services for handicapping malocclusion, consisting of: the initial and subsequent installations of orthodontic appliances; and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and its attendant sequelae through the correction of malposed teeth. Coverage is subject to the following conditions, limitations and exclusions:

a. The need for orthodontic services must be diagnosed by a Health Care Professional and a treatment plan must be submitted to and approved by the Claims Administrator. The diagnosis must indicate that the orthodontic condition consists of handicapping malocclusion which is abnormal and is correctable.

b. The Plan reserves the right to review your dental records, including necessary x-rays, photographs and models, to determine whether orthodontic needs and treatment are within the limitations and exclusions of the Plan.

c. For purposes of determining benefits available for treatment in progress at the commencement or termination of a Covered Person's coverage, all orthodontic services shall be deemed to have been rendered on the date performed.

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

EXCLUSIONS

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

(1) **Anesthesia.** The Plan will not provide coverage for the following forms of anesthesia: regional block; Trigem division block; local analgesia; intravenous sedation; and non-intravenous conscious sedation when not Medically Necessary.

(2) **Antibiotic Injections.** The Plan will not provide coverage for antibiotic injections.

(3) **Bonding.** The Plan will not provide coverage for bonding and/or splinting of teeth.

(4) **Care by more than One Provider.** In the event a Covered Person transfers from the care of one Health Care Professional to that of another Health Care Professional during the course of treatment, or if more than one Dentist renders services for one dental procedure, the Plan will not provide coverage for more than the amount it would have provided if one Health Care Professional rendered the service.

(5) **Cosmetic Services.** The Plan will not provide coverage for any services in connection with elective cosmetic surgery that is primarily intended to improve your appearance and is not Medically Necessary.

(6) **Court Ordered Services.** The Plan will not provide coverage for any service or care (including evaluation, testing, and/or treatment) that is ordered by a court, or that is required by a court as a condition of parole or probation, unless:

A. The service or care would be Covered under the Plan in the absence of a court order;

B. The service or care has been pre-authorized by the Plan, if required; and

C. It is determined, in advance, that the service or care is Medically Necessary and Covered under the terms of the Plan.

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

(7) **Criminal Behavior.** The Plan will not provide coverage for any service or care related to the treatment of an illness, accident or condition arising out of your participation in a felony. The felony will be determined by the law of the state where the criminal behavior occurred. To the extent required by law, this exclusion does not apply to coverage for services involving injuries suffered by a

victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).

(8) **Experimental and Investigational Services.** Unless otherwise required by law, the Plan will not provide coverage for any service or care that consists of a treatment, procedure, drug, biological product, or medical device (collectively, "Service"); an inpatient stay in connection with a Service; or treatment of a complication related to a Service; if the Service is experimental or investigational.

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

A. not of proven benefit for a particular diagnosis or for treatment of a particular condition;

B. not generally recognized by the medical community, as reflected in published, peer-reviewed, medical literature, as effective or appropriate for a particular diagnosis or for treatment of a particular condition; or

C. not of proven safety for a person with a particular diagnosis or a particular condition, e.g., is currently being evaluated in research studies to ascertain the safety and effectiveness of the treatment on the well-being of a person with the particular diagnosis or in the particular condition.

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

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

A. A Service that is a medical device, drug, or biological product must have received final approval of the United States Food and Drug Administration (FDA) to market for the particular diagnosis or for your particular condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once final FDA approval has been granted for a particular diagnosis or for your particular condition, use of the Service (medical device, drug, or biological product) for another diagnosis or condition may require that any or all of the five criteria be met.

B. Published, peer-reviewed, medical literature must provide conclusive evidence that the Service has a definite, positive effect on health outcomes. The evidence must include reports of well-designed investigations that have been reproduced by nonaffiliated, authoritative

sources with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

C. Published, peer-reviewed, medical literature must provide demonstrated evidence that, over time, the Service leads to improvement in health outcomes, i.e., the beneficial effects of the Service outweigh any harmful effects.

D. Published, peer-reviewed, medical literature must provide proof that the Service is at least as effective in improving health outcomes as established services or technology, or is usable in appropriate clinical contexts in which an established service or technology is not employable.

E. Published, peer-reviewed, medical literature must provide proof that improvement in health outcomes, as defined in subparagraph C above, is possible in standard conditions of medical practice, outside of clinical investigatory settings.

(9) **Free Care.** The Plan will not provide coverage for any service or care that is furnished to you without charge, or that would have been furnished to you without charge if you were not covered under the Plan. This exclusion applies even if a charge for the service or care is billed. When service or care is furnished to you by your spouse, brother, sister, mother, father, son or daughter, or the spouse of any of them, it will be presumed that the service or care would have been furnished without charge. You must prove that a service or care would not have been furnished without charge.

(10) **Government Hospitals.** Except as otherwise required by law, the Plan will not provide coverage for any service or care you receive in a Facility or institution which is owned, operated or maintained by: the Veterans Administration (VA); a federal, state, or local government, unless the Facility is a Participating Provider. However, coverage will be provided for services or care in such a Facility to treat an Emergency Condition. In this case, coverage will continue to be provided only for as long as emergency care is Medically Necessary and it is not possible for you to be transferred to another Facility.

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

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

A. **Eligibility for Medicare By Reason of Age.** You are entitled to benefits under Medicare by reason of your age, and the following conditions are met:

i You are in "current employment status" (working actively and not retired) with the Employer; and

ii The Employer maintains or participates in an employer group health plan that is required by law to have the Plan pay its benefits before Medicare.

B. **Eligibility for Medicare By Reason of Disability Other than End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:

i You are in "current employment status" (working actively and not retired) with the Employer; and

ii The Employer maintains or participates in a large group health plan, as defined by law, that is required by law to have the Plan pay its benefits before Medicare pays.

C. **Eligibility for Medicare By Reason of End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Plan will not reduce its benefits, and will provide benefits before Medicare pays, during the waiting period. The Plan will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before the benefits under the Plan are provided.

(12) **Grafting Procedures.** The Plan will not provide coverage for grafting procedures.

(13) **Military Service-Connected Conditions.** The Plan will not provide coverage for any service or care related to any military service-connected disability or condition, if the Veterans Administration (VA) has the responsibility to provide the service or care.

(14) **No-Fault Automobile Insurance.** The Plan will not provide coverage for any service or care for which benefits are available under mandatory no-fault automobile insurance, until you have used up all of the benefits of the mandatory no-fault policy. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy. The Plan will provide benefits for services Covered under the Plan when you have exceeded the maximum benefits of the no-fault policy. Should you be denied benefits under the no-fault policy because it has a deductible, the Plan will provide coverage for the services Covered under the Plan, up to the amount of

the deductible. The Plan will not provide benefits even if you bring a lawsuit against the person who caused your injury and even if you receive money from that lawsuit and you have repaid the medical expenses you received payment for under the mandatory automobile no-fault coverage.

(15) **Non-Covered Service.** The Plan will not provide coverage for any service or care that is not specifically described in the Plan as a Covered Service; or that is related to service or care not Covered under the Plan; even when a Participating Provider considers the service or care to be Medically Necessary and appropriate.

(16) **Oral Hygiene Programs.** The Plan will not provide coverage for training or supplies used for: dietary counseling; tobacco counseling; oral hygiene; or plaque control programs.

(17) **Procedures to Increase Vertical Dimension.** The Plan will not provide coverage for procedures, restorations and appliances to increase vertical dimension or to restore occlusion.

(18) **Replacement of Prosthetic Devices.** The Plan will not provide coverage for replacement of a lost, missing or stolen prosthetic device. Coverage will not be provided for replacement of a prosthetic device for which benefits were provided under the Plan unless the existing prosthetic was placed more than five (5) years ago and cannot be made serviceable.

(19) **Services Charged by other Providers.** The Plan will not provide coverage for services of Health Care Professionals if fees or charges therefore are claimed by hospitals, clinical laboratories or other institutions.

(20) **Services Starting Before Coverage Begins.** If you are receiving care on the effective date of your coverage under the Plan, coverage will not be provided for benefits for any service or care you receive prior to the effective date of your coverage under the Plan.

(21) **Temporomandibular Joint.** The Plan will not provide coverage for appliances, therapy, surgery or any services rendered for the medical treatment of the temporomandibular joint.

(22) **Unlicensed Provider.** The Plan will not provide coverage for any service or care that is provided or prescribed by an unlicensed provider; or that is outside the scope of licensure of the duly licensed provider rendering the service or care.

(23) **Workers' Compensation.** The Plan will not provide coverage for any service or care for which benefits are provided under a workers' compensation or similar law.

COORDINATION OF BENEFITS

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

(1) **When You Have Other Health Benefits.** It is not unusual to find yourself covered by two health insurance contracts, plans, or policies ("plans") providing similar benefits both issued through or to groups. When that is the case and you receive an item of service that would be covered by both plans, the Plan will coordinate benefit payments with any payment made under the other plan. One plan will pay its full benefit as the primary plan. The other plan will pay secondary benefits if necessary to cover all or some of your remaining expenses. This prevents duplicate payments and overpayments. The following are considered to be a health insurance plan:

(a) Any group or blanket insurance contract, plan, or policy, including HMO and other prepaid group coverage, except that blanket school accident coverage or such coverage offered to substantially similar groups (e.g., Boy Scouts, youth groups) shall not be considered a health insurance contract, plan or policy;

(b) Any self-insured or noninsured plan, or any other plan arranged through any employer, trustee, union, employer organization or employee benefit organization;

(c) Any Blue Cross, Blue Shield or other service type group plan;

(d) Any coverage under governmental programs or any coverage required or provided by any statute. However, Medicaid and any plan whose benefits are, by law, excess to those of any private insurance plan or other non-governmental plan shall not be considered health insurance policies; and

(e) Medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional "fault" type contracts.

(2) **Rules to Determine Payment.** In order to determine which plan is primary, certain rules have been established. The first of the rules listed below which applies shall determine which plan shall be primary:

(a) If the other plan does not have a provision similar to this one, then it will be primary;

(b) If you are covered under one plan as an employee, subscriber, or primary member and you are only covered as a dependent under the other plan, the plan which covers you as an employee, subscriber, or primary member will be primary; or

(c) Subject to the provisions regarding separated or unmarried parents below, if you are covered as a child under both plans, the plan of the parent whose birthday (month and date) falls earlier in the year is primary. If both parents have the same birthday, the plan that covered the parent longer is primary. If the other plan does not have the rule described immediately above, but instead has a rule based on gender of a parent and, as a result, the plans do not agree on which shall be primary, then the father's plan will be primary.

(d) There are special rules for a child of separated or unmarried parents:

i. If the terms of a court decree specify which parent is responsible for the health care expenses of the child, and that parent's plan has actual knowledge of the court decree, then that parent's plan shall be primary.

ii. If no such court decree exists or if the plan of the parent designated under such a court decree as responsible for the child's health care expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:

a. First, the plan of the parent with custody of the child;

b. Then, the plan of the spouse of the parent with custody of the child;

c. Finally, the plan of the parent not having custody of the child.

(e) If you are covered under one of the plans as an active employee, neither laid-off nor retired, or as the dependent of such an active employee, and you are covered as a laid-off or retired employee or a laid-off or retired employee's dependent under the other plan, the plan covering you as an active employee will be primary. However, if the other plan does not have this rule in its coordination of benefits provision, and as a result the plans do not agree on which shall be primary, this rule shall be ignored.

(f) If none of the above rules determine which plan shall be primary, then the plan that has covered you for the longest time will be primary.

(3) **Payment of the Benefit When The Plan Is Secondary.** When the Plan is secondary, the benefits of the Plan will be reduced so that the total benefits payable under the other plan and the Plan do not exceed your expenses for an item of service. However, the Plan will not pay more than it would have paid if it were primary.

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

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

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

(4) **Right to Receive and Release Necessary Information.** The Plan, the Employer and the Claims Administrator have the right to release or obtain information that they believe necessary to carry out the purpose of this section. The Plan, the Employer and the Claims Administrator need not tell you or obtain anyone's consent to do this except as required by Article 25 of the New York General Business Law. The Plan, the Employer and the Claims Administrator will not be legally responsible to you or anyone else for releasing or obtaining this information. You must furnish any information that the Plan, the Employer and the Claims Administrator request. If you do not furnish the information, the Plan has the right to deny payments.

(5) **Payments to Others.** The Plan may repay to any other person, insurance company or organization the amount which it paid for your Covered Services and which the Employer and/or the Claims Administrator decide the Plan should have paid. These payments are the same as benefits paid.

(6) **The Plan's Right to Recover Overpayment.** In some cases the Plan may have made payment even though you had coverage under another plan. Under these circumstances, it will be necessary for you to refund to the Plan the amount by which it should have reduced the payment it made. The Plan also has the right to recover the overpayment from the other health benefits plan if the Plan has not already received payment from that other plan. You must sign any document that the Employer and/or the Claims Administrator deems necessary to help the Plan recover any overpayment.

SUBROGATION/REIMBURSEMENT PROVISION

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

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

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

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

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

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

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

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

CLAIM AND APPEAL PROCEDURES

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

When submitting a claim form, include:

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

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

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

Timely Claim Filing Requirement
All claims must be filed with the Plan within 12 months after you receive the services for which payment is being requested. Claims filed after this time period will be denied.

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

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

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

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

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

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

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

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

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

(2) However, if your urgent care claim is missing required information, the Claims Administrator will notify you of the omission and how to correct it within 24 hours

after the urgent care claim was received. You will then have 48 hours to provide the requested information.

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

(1) The Claims Administrator's receipt of the requested information; or

(2) The end of the 48-hour period within which you were to provide the additional information requested.

Concurrent Care Claims

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

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

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

Notice of Adverse Benefit Determination

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

(1) the specific reason or reasons for the adverse benefit determination;

(2) specific reference to those Plan provisions on which the adverse benefit determination is based;

(3) a description of any additional information or material necessary to complete the claim and an explanation of why such material or information is necessary;

(4) notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(5) A statement describing your right to bring an action for judicial review;

(6) In the case of an adverse benefit determination by the Plan:

(a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;

(b) If the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

(7) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

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

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

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

(1) The patient’s name and the identification number from the ID card,

(2) The date(s) of service(s),

(3) The provider’s name,

(4) The reason you believe the claim should be paid, and

(5) Any documentation or other written information to support your request for claim payment.

You may appeal any denial of a claim within 180 days of receipt of such a denial by submitting a written request for review to the Claims Administrator at the following address:

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

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

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

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

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

(1) You may submit a request for an expedited appeal of an adverse benefit determination orally or in writing; and

(2) All necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

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

Appeal Process

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

Appeal Determinations

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

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

For appeals of pre-service claims (as defined above), your appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

For appeals of post-service claims (as defined above), your appeal will be conducted and you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.

(2) **Urgent Claim Appeals**

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

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

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

(1) The specific reason or reasons for the adverse benefit determination;

(2) Reference to the specific Plan provisions on which the adverse benefit determination is based;

(3) A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;

(4) A statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain information about such procedures;

(5) A statement of the participant's right to bring an action for judicial review; and

(6) The following information:

(a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the participant upon request;

(b) If the adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request; and

(c) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Adverse Benefit Determination
For purposes of the Plan's claim procedures, an "adverse benefit determination" is a denial, reduction or termination of, or a failure to provide or make payment (in whole, or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction of termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for

which benefits are otherwise provided because it is determined be experimental and/or investigation or not Medically Necessary or appropriate. Adverse benefit determination also includes a rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Time to Sue

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

Appointment of Authorized Representative

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Enrollment. The Employer will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages and social security numbers of all Covered Persons covered under the Plan, and any other information required to confirm their eligibility for coverage. The Employer will provide the Claims Administrator with the enrollment information including your name, address, age and social security number and advise the Claims Administrator in writing when you are to be added to or subtracted from the list of Covered Persons, on a monthly basis. Retroactive additions to or deletions from coverage in excess of 30 days will only be made on an exception basis if approved by the Employer (or Plan Sponsor).

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

(1) Disclose all facts pertaining to the care, treatment and physical condition of the Covered Person to the Employer and/or the Claims Administrator, or a medical, dental, or mental health professional that the Employer and/or the Claims Administrator may engage to assist the Employer and the Claims Administrator in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

(2) Render reports pertaining to the care, treatment and physical condition of the Covered Person to the Employer and/or the Claims Administrator, or a medical, dental, or mental health professional, that the Employer and/or the Claims Administrator may engage to assist the Employer and the Claims Administrator in reviewing a treatment or claim; and

(3) Permit copying of the Covered Person's records by the Employer and the Claims Administrator.

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

Qualified Medical Child Support Orders: The Plan provides medical benefits in accordance with the applicable requirements of any "Qualified Medical Child Support Order". A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a property settlement agreement) issued by either a court of

competent jurisdiction or through an administrative ruling that has the force and effect of state law which:

(1) Relates to the provision of child support with respect to the Child of an Employee or COBRA Beneficiary under the Plan or provides for health benefit coverage to such a Child, and is made pursuant to a state domestic relations law (including a community property law), and relates to such coverage under the Plan, or

(2) Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to the Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a beneficiary under the Plan. For purposes of this section, an "alternate recipient" shall mean any Child of an Employee or COBRA Beneficiary who is recognized by a Qualified Medical Child Support Order as having a right to enrollment under a group health plan with respect to such an Employee or COBRA Beneficiary.

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

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