Dental Benefits for
Hadley Luzerne Central School
Group 996794-8

(12/2003)

THIS IS YOUR EMPIRE BLUECROSS GROUP PLAN

FOR DENTAL CARE BENEFITS

Provided By

EMPIRE BLUECROSS

For Employees of

HADLEY LUZERNE CENTRAL SCHOOL

This is your Empire BlueCross Group Dental Care Plan available to you through an insurance policy issued and underwritten by Empire BlueCross. It is issued to the person named on the Identification Card. Coverage under the Plan begins on the effective date, and will continue unless it is terminated for any of the reasons described in this booklet.

EMPIRE BLUECROSS
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Form: 996794-8 **Rev:** 12/2003

SECTION ONE - INTRODUCTION

1. **Your Coverage Under this Plan.** The employer named on the cover page (referred to as "the group contract holder") has entered into a contract with us to provide group dental insurance benefits. Under that contract we will provide the benefits described in this booklet to members of the group, that is, to employees of the employer or to members of the organization. The benefits under that group contract which we describe in this booklet are referred to as "this Plan". However, this booklet is not a contract between you and us. You should keep this booklet with your other important papers so that it is available for your future reference.

2. **Words We Use.** Throughout this booklet, Empire BlueCross will be referred to as "we", "us" or "our". The word "you" refers to you, the employee or member of the group to whom this booklet is issued and whose name appears on the Empire BlueCross Identification Card; and to any members of your family who are also covered under this Plan.

3. **Care Must Be Medically Necessary.** We will not make payments under this Plan if the service or care was not medically necessary. Examples of this are: (1) your Dentist restores a tooth when a filling would have been appropriate because the loss of tooth structure or level of decay does not justify the restoration with a crown; (2) your Dentist performs a microscopic bacteria evaluation or a hair analysis in connection with periodontic treatment, both of which are services not clinically significant in relation to periodontic treatment. In these situations our determination of medically necessity will be made after considering the advice of trained dental professionals, including dentists. In making the determination we will examine all of the circumstances surrounding your condition and the care provided, including your Dentist's reasons for providing or prescribing the care, and any unusual circumstances. The fact that your Dentist prescribed the care does not automatically mean that the care qualifies for our payments under this Plan. Refer to the General Provisions Section of this Plan for an explanation of guidelines which we may use to determine whether a service is covered under this Plan.

4. **Your Payments Under This Plan.** Some of the benefits under this Plan require you to pay part of the cost of the benefits.

   Coinsurance. Coinsurance is a fixed percentage of the cost that you must pay each time you receive a particular benefit. For those benefits in this Plan where coinsurance applies, the amount of our payment is indicated and you must pay the remaining portion.

5. **Our Payments Under This Plan.** Benefits in this Plan are based on the usual and customary charge for the service or item. The usual and customary charge is a charge which is not more than what we determine is the most common charge for that service or item within the geographic area where it is provided. If the charge to you is greater than the usual and customary charge, you must pay the excess portion. If you are required to make a payment under this Plan for a deductible, copayment or coinsurance, your payment is applied against the usual and customary charge. For example, if a charge to you is $120 but the usual and customary charge is $100 and you must make a $25 copayment, then our payment would be $75. You must also pay the $20 in excess of the usual and customary charge.

If your Dentist participates in our program of direct payment to Dentists under our Matrix One program, our payment for dental services under this Plan will be made directly to the Dentist and you will not have to pay any fee to the Dentist for a service covered under this Plan, except a coinsurance.

If your Dentist does not participate in our program of direct payment to Dentists, we reserve the right to pay either you or the Dentist, or other provider.

The amount of our payment for a procedure includes payment for the necessary related care by the Dentist before and after the procedure. In other words, the one payment covers the dental procedure itself **and** the care before and after the procedure. The one payment also covers any material or appliances the Dentist uses.

SECTION TWO - WHO IS COVERED

1. **Who Is Covered.** You, the employee or member of the group whose name appears on the Identification Card, are covered under this Plan. In addition, if the group contract holder has requested that we cover your family, the following members of your family are also covered:

   A. Your wife, or husband, unless you are divorced, or your marriage has been annulled. (Spousal coverage ends on the last day of the month following a divorce or annulment).

   B. Your unmarried children who are under 19 years of age.

   C. Your unmarried children who are under 19 years of age or older and who are unable to work or support themselves because of mental illness, developmental disability or mental retardation as defined in the New York State Mental Hygiene Law, or because of physical handicap. The condition must have occurred before the child reached the age 19. The child's disability must be certified by a physician. In addition to the physician's certification, we have the right to check whether the child is and continues to qualify as an incapacitated child.

   D. Your unmarried children who are over age 19 but are not yet age 99 and who are enrolled as full-time students at an accredited institution of learning and whose principal residence, when not away at school, is the same as their parents.

Adding of Removing Dependents

If you need to change coverage categories or add or remove a dependent, you should contact your Benefits Administrator for the appropriate forms. All changes to coverage must be in writing. Life events that might cause you to need to add or remove a dependent are:

- Having a baby
- Getting married
- Getting divorced (Spousal coverage ends on the last day of the month following a divorce or annulment.)
- Having your children reach the age limit for coverage, cease to be dependent on you or get married.

If you failed to enroll when you became eligible, you may enroll yourself and your dependents without waiting for the group's open enrollment period if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption (the qualifying event), provided that you apply for such coverage within 30 days after the qualifying event.

Your cost for coverage may change if you add a dependent midyear. Any change affecting payment of your premium should go through your employer.

2. **Other Children Covered Under this Plan.** In addition to your natural children, the following other children are also covered under this Plan if the child meets the above tests for covered children:

   A. a legally adopted child.
   B. a child for whom you are the legal guardian.
   C. a stepchild dependent upon you for support.
   D. a child for whom you are the proposed adoptive parent and who is dependent on you during the waiting period prior to the adoption becoming final.

3. **Your Newborn Child.** If you have family coverage your newborn child will automatically be covered. If you have individual or two-person coverage at the time your child is born, you may switch to family coverage and obtain coverage for your newborn child from the moment of birth. You must notify us of your desire to switch to family coverage and we must receive the applicable family premium for the new coverage within 60 days of the birth. If you decide to switch to family coverage but fail to notify us or we do not receive the applicable premium within 60 days of birth, the coverage will not become effective until the first day of the month following the date the request is received and the applicable premium is paid.

   If a child of yours who is covered by this Plan gives birth, that newborn grandchild will not be covered. If the grandparent adopts or becomes the legal guardian of the child, the child will be covered from the effective date of the adoption or the legal guardianship.

4. **Your Adopted Newborn Child.** If you have family coverage, or switch to family coverage in accordance with paragraph 3 above, we will cover a proposed adoptive newborn from the moment of birth if the following conditions are met:

   (a) You (the proposed adoptive parent) take physical custody of the infant as soon as the infant is released from the hospital after birth; and
   (b) You file a petition pursuant to §115-c of the New York State Domestic Relations Law within 30 days of the infant's birth.

   Notwithstanding the above provisions, we will not cover adopted newborns from the moment of birth if one of the child's natural parents has coverage available to cover the newborn's initial hospital stay, or if a notice of revocation of the adoption has been filed or one of the natural parents revokes their consent to the adoption. If we pay benefits to cover an adopted newborn and the notice of the adoption is revoked, or one of the natural parents revokes their consent, we shall be entitled to recover any sums paid by us for care of the adopted newborn.

5. **Qualified Medical Child Support Order (QMCSO)**

A court order, judgment or decree that:

Provides for child support relating to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or

Enforces a state medical child support law enacted under Section 1908 of the Social Security Act.

A Qualified Medical Child Support Order is usually issued when a parent receiving post-divorce custody of the child is not an employee.

Qualified Domestic Relations Order (QDRO)

A Domestic Relations Order that, at the determination of the Plan Administrator (generally the Employer/Sponsor of the group health plan), meets certain criteria established by law. The Qualified Domestic Relations Order creates or recognizes an alternate payee's right (generally the alternate payee is a spouse, former spouse, child or other dependent of the plan participant), or assigns to an alternate payee the right, to receive plan benefits that otherwise would have been payable to a plan participant.

You may request, without charge, the procedures governing the administration of Qualified Domestic Relations Order determinations from your Plan Administrator (generally the Employer/Sponsor of the group health plan. Your Plan Administrator will notify Empire to process the enrollment for the covered person

6. **When Coverage Begins.** Your coverage under this Plan begins on the effective date. Coverage for new members of your family, such as when you get married, begins on the date they qualify for coverage.

SECTION THREE - DENTAL BENEFITS

1. **Treatment Plan.** After the Dentist's initial examination, the Dentist must prepare a written Treatment Plan which describes the dental diseases or dental problems which are to be treated. We will not make any payments for dental care under this Section unless the Treatment Plan is submitted for our review prior to the care being provided and we then approve the plan. A Treatment Plan is not required for your first visit to the Dentist when the Dentist examines you to determine if further dental care is required.

2. **Preventive Services.** We will pay for the following preventive and diagnostic dental services:

   (a) An oral examination, including a Treatment Plan if further care is required

   (b) Periapical x-rays and bitewing x-rays, when required.

   (c) Application of topical fluoride, if you are 18 or younger.

   (d) Prophylaxis, including cleaning, scaling and polishing.

   (e) Palliative emergency treatments, when needed.

   Payments for Preventive Services.

   Our Payments. We will pay 100% of the usual and customary charge of each procedure.

3. **Restorative Dental Services.** We will pay for the following basic restorative dental services:

   (a) Repair of your dentures.

   (b) Fillings, which may consist of silver amalgam and/or tooth color restorations using synthetic materials.

   (c) Tooth extractions, including surgical extractions.

   (d) Endodontics, which may include pulpotomy, pulp capping, and root canal treatments.

   (e) Space maintainers.

   (f) Oral surgery, which may consist of treatment of fractures and dislocations, diagnosis and treatment of cysts, abscesses and impactions.

   (g) Apicoectomy.

   (h) Crowns, which are not part of a bridge.

   We will not pay for gold foil restorations.

Payments for Restorative Dental Services.

Our Payments. We will pay 100% of the usual and customary charge of each procedure.

4. **Periodontics**. The periodontic care may consist of a surgical periodontic examination; gingival curettage; gingivectomy and gingivoplasty; osseous surgery including flap entry and enclosure; mucogingivoplastic surgery; and management of acute infections and oral lesions.

   Payments for Periodontics.

   Our Payments. We will pay 50% of the usual and customary charge of each periodontic procedure.

5. **Prosthetic Services.** The prosthetics may include: Dentures full or partial; bridges, fixed or removable. We will not pay for the initial replacement of a tooth missing at the time you became covered under this plan. We will not pay for dentures which have been lost or stolen. We only pay for replacement of full or partial dentures for other reasons once every five years. We will only pay for construction of standard dentures; if you select special or personalized procedures we will only pay the amount we would have paid for standard dentures.

   Payments for Prosthetic Services.

   Our Payments. We will pay 50% of the usual and customary charge of each prosthetics procedure.

6. **Orthodontics**. We will only pay for orthodontics for children covered under this Plan. The orthodontics must be for care of a handicapping malocclusion through the use of orthodontic appliances or other orthodontic treatments. We will only make payments for orthodontic services when the services begin within 90 days after we approve the Treatment Plan. If the orthodontic treatments do not begin within 90 days after we approved the Treatment Plan, a new Treatment Plan must be submitted. We will not pay for further orthodontic services, meaning those not included in the original Treatment Plan, until five years after the prior orthodontic services were completed.

   If the Dentist submits a single bill for all the orthodontic services at the time the services begin, we will make one payment every three months during the course of treatment towards the bill for the orthodontic services.

   Payments for Orthodontics.

   Our Payments. We will pay 50% of the usual and customary charge of each procedure.

SECTION FOUR - EXCLUSIONS

In addition to certain exclusions and limitations already described above, we will not make any payments under this Plan when any of the following apply to you:

1. **Workers' Compensation.** We will not pay for any care for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law. Also, we will not make any payments even if you bring a lawsuit against the person who caused your injury or condition and even if you received money from that lawsuit and you have repaid the hospital and other medical expenses you received payment for under the Workers' Compensation Law or similar legislation.

2. **Free Care.** We will not pay for any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this Plan or under any other insurance.

3. **Government Programs.** We will reduce our payment under this Plan by the amount you are eligible to receive for the same service under Medicare or under any other federal, state or local government programs, except that we will pay even though you are eligible for Medicaid. However, we will not reduce our payment if under the Tax Equity and Fiscal Responsibility Act of 1982 you have an option to either remain covered by this Plan or be covered by Medicare, and you choose to remain covered by this Plan. In order to know what you are entitled to receive under Medicare, you should read your Medicare handbook which is available at your local Social Security office.

4. **Hospital Care.** This Plan does not provide any benefits for hospital charges or other institutional charges for room, board or supportive care provided while you are a patient in a hospital in order to receive dental care.

5. **Unnecessary Care.** We will not pay for care under this Plan which we determine was not medically necessary for your proper medical care or treatment.

6. **Cosmetic Surgery.** We will not pay for services in connection with elective cosmetic dental care which is primarily intended to improve your appearance. We will, however, pay for services in connection with reconstructive surgery when such service is incidental to or follows dental care resulting from trauma, disease or infection.

7. **Services Maintained by an Employer.** We will not pay for any service or care furnished by a dental department, clinic, or other similar service maintained by your employer.

8. **Treatments, Procedures, Hospitalizations, Drugs, Biological Products or Medical Devices Which are Experimental or Investigational.** Unless otherwise required by law with respect to drugs which are covered under this Group Plan and which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration, we will not cover any treatment, procedure, drug, biological product or medical device (hereinafter "technology"), or any hospitalization in connection with such technology if, in our sole discretion, it is not medically necessary in that such technology is experimental or investigational. Experimental or investigational means that the technology is:

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

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

   We will also not cover any technology or any hospitalization in connection with such technology if, in our sole discretion, such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of your particular condition.

   Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition.

   We may apply the following five criteria in exercising our discretion and may in our discretion require that any or all of the criteria be met:

   1. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or 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 FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met.

   2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include 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.

   3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e. the beneficial effects outweigh any harmful effects.

4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

5. Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

9. **No-Fault Automobile Insurance.** We will not pay for any service which is covered by mandatory automobile No-Fault benefits.

10. **Payments Available Under Prior Dental Coverage.** We will not pay for any service which is covered under a group dental benefits plan which previously covered your group and which the group contract holder terminated in order to purchase this Plan. In other words, if your group previously had another dental benefits plan which terminates on December 31st, and you received a series of dental treatments from December 10 through January 25 which are all covered under that other dental benefits plan, then we will not make any payments under this Plan even though this Plan may have become effective January 1st.

11. **Charges for Services Provided Pursuant to a Prohibited Referral.** We will not pay for pharmacy services, clinical laboratory services, or x-ray or imaging services furnished by any provider pursuant to a referral prohibited by §238-a of the New York State Public Health Law. Generally, §238-a prohibits physicians and other health care practitioners from making referrals for pharmacy services, clinical laboratory services or x-ray and imaging services to a provider or facility in which the referring physician or practitioner or an immediate family member has a financial interest or relationship.

12. **Services Rendered by an Immediate Family Member.** We will not pay for services rendered to you by a member of your immediate family.