CORTLAND COUNTY
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Cortland, NY 13045

Group Dental Plan

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Table of Contents

Section One
Introduction to Your Dental Benefits Plan

This part of the booklet explains your dental benefits under the Cortland County Dental Benefits Plan ("Plan"). The Plan is funded by Cortland County ("Plan Administrator"). LBS, administers the claims for the dental benefits of the Plan on behalf of the Plan Administrator.

Section Two
Important Terms and Phrases You Need to Know

It is important that you understand all aspects of the Plan in order to get the most out of your coverage. To help make the information easier to understand, the definitions of important words and phrases used throughout the document are described below.

You should understand that information and definitions in one section may be used in later sections.

1. **Active Work (actively at work)**. Active Work means the performance of all duties that pertain to your work at the place where it is normally done, or where it is required by your employer to be done.

2. **Allowable Amount.** Means the maximum amount that will be paid to the provider for services or supplies covered under this Plan, before any applicable deductible, or coinsurance amounts are subtracted. We determine our Allowable Amount as follows:

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

   a. If the Plan has a preferred provider reimbursement schedule, the Allowable Amount for a Covered Service received from a dentist who is a participating provider will be the lower of:

      i. The preferred provider reimbursement schedule amount for the Covered Service, or
      ii. The dentist's billed Charge.

   b. If the Plan has a Maximum Amount Payable (MAP) Fee Schedule, the Allowable Amount for a Covered Service received from a dentist who is a participating provider or a Non-Participating provider will be the lower of:

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

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

   i. A percentage of the reasonable and customary charge, as defined below, or
   ii. The dentist's billed Charge.

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

3. **Charge**. Charge is the amount the provider actually bills for a Covered Service or supply. A Charge for a Covered Service or supply is considered to have been incurred on the date the service or supply was provided to you.

4. **Covered Service**. A Covered Service is a service or supply specified in the Plan and for which a benefit is provided under the Plan.

5. **Dentally Necessary or Medical Necessary** means health care or dental services that a dentist or provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, disease or its symptoms, and that are:

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

   "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendations, the views of prudent providers practicing in relevant clinical areas, and any other clinically relevant factors.

6. **Plan**. The Plan is the Cortland County Dental Plan.

7. **Plan Administrator**. The Plan Administrator is Cortland County.

8. **Plan Year**. The Plan Year begins January 1st and ends December 31st.

9. **Participating Providers**. Participating Providers are providers who have agreed in writing to provide professional provider covered dental services under the Plan. Participating Providers are: individuals licensed to practice dentistry and/or to perform oral surgery, and other health care professionals who are licensed to provide the services covered under the Plan. Benefits are only provided for Covered Services that are usually billed by the provider.

10. **Non-Participating Providers**. Non-Participating Providers are professional providers who have not agreed in writing to provide professional provider Covered Services under the Plan. Non-Participating Providers are: licensed to practice dentistry and/or to perform oral surgery, and other health care professionals who are licensed to provide the services covered under the Plan. Benefits are only provided for Covered Services that are usually billed by the provider.

Section Three
Who Is Covered and When Coverage Begins

1. **Eligibility**. You may select coverage for yourself only (individual coverage); or you may select coverage for yourself and your spouse and/or your eligible dependents (family coverage). You must meet the Plan's eligibility requirements for this coverage.

2. **How to apply for coverage**. To apply for coverage, you must complete a form approved by LBS. The form must state whether you want individual coverage or family coverage. You must give the form to the Plan Administrator.

3. **Who is covered**. Only you are covered under the Plan if you selected individual coverage. If you selected family coverage, you may also cover all of the following:

   a. your legal spouse.
   b. your unmarried eligible dependents to their 19th birthday. An eligible dependent is:

      i. your biological child;
      ii. a child of your spouse;
      iii. a child for whom you are legal guardian; and
      iv. your adopted child and child who have been placed with you for adoption;

      provided you claim them on your federal income tax return or you can prove to LBS that you provide more than 50% of their financial support; and provided at least one of the following has occurred:

      i. the dependent starts living with you in a regular parent-child relationship; or
      ii. a court of law places a child with you for adoption by accepting a consent to adopt and you enter into an agreement to support the dependent; or

iii. a court of law makes you, or your spouse, legally responsible for the support and maintenance of the dependent.

c. your unmarried eligible dependent to their 25th birthday, if they are full-time students. An eligible dependent is a full-time student if the dependent is:

i. registered at, and attending, what LBS determines is an accredited institution of learning. An accredited institution of learning is:

- ♦ an institution that offers courses of study leading to a high school diploma, associate, bachelor or graduate degree; or
- ♦ an institution that provides programs for career training and, upon completion of study, credentials the full-time student through licensing, certification or diploma. Such an institution of learning may include a: business, vocational, technical, trade or mechanical school. It does not include an on-the-job training course or a correspondence school; and

ii. considered by LBS to be a full-time student at an accredited institution of learning and is continuously registered as a full-time student until the completion of the program.

Coverage will be provided during the period of time that an accredited institution of learning recognizes as the recess period between semesters, provided the full-time student is enrolled for the next academic session. Coverage will also be provided to a full-time student during an institution's recognized legal holidays and vacation periods.

d. your unmarried eligible dependents who are unable to work or support themselves. Your dependent must be incapable of working because of mental illness, developmental disability or mental retardation, all as defined in the New York Mental Hygiene Law, or because of physical disability. The condition must have occurred: before the dependent is no longer eligible for coverage under this coverage; before the dependent reached age 19; or before the dependent reached age 25, if a full-time student. For your dependents to be covered under this paragraph, you must notify the Plan Administrator within 30 days of the date your dependent's eligibility would otherwise end.

If you have selected family coverage, all the Covered Services available to you are also available to your spouse, and eligible dependents. Remember, you must notify the Plan Administrator when you gain a spouse or eligible dependent, or when your spouse or eligible dependent no longer qualifies for coverage.

4. **When coverage starts**. The Plan Administrator establishes the date you are eligible for coverage under this Plan.

a. If you apply for coverage before the day you become eligible, your coverage begins on the eligibility day.

b. If you apply for coverage within 30 days after you are eligible, coverage starts on the date the application is accepted by the Plan Administrator.

c. If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to work.

d. If you have individual coverage and apply for family coverage before a person becomes your spouse or eligible dependent (other than a newborn child), family coverage will start on the date the person, except for a newborn child, becomes your spouse or eligible dependent. If you have individual coverage and apply for family coverage within 30 days after a person becomes your spouse or eligible dependent (other than a newborn child), family coverage will start on the date the application is accepted by the Plan Administrator. Coverage for your newborn child is discussed in e. below.

e. If you have family coverage, your newborn child is covered at birth. If you have individual coverage at the time your child is born, you may change to family coverage and obtain coverage for your newborn child from the moment of birth. You must apply for family coverage, and the Plan Administrator must receive the applicable premium for the new coverage, within 30 days of the birth. If you are in the process of adopting the newborn, there are additional requirements (explained below).

f. If you have family coverage, or if you apply for family coverage and the Plan Administrator receives the applicable family premium for the new coverage within 30 days of the birth of a child you intend to adopt, the child will be covered from the moment of birth if:

   i. you take physical custody of the child upon discharge from the hospital or birth center; and
   ii. within 30 days of the child's birth, you file a petition to adopt or for temporary legal guardianship under the New York Domestic Relations Law.

   The Plan will not provide coverage if a notice of revocation of the adoption has been filed, or one of the biological parents revokes consent to the adoption. If the Plan pay benefits for Covered Services for an adopted newborn child and the adoption is revoked, or one of the biological parents revokes consent, the Plan has the right to recover any payments that it made for care of the newborn child.

g. Coverage will not begin until the Plan's next reopening date, which occurs once every six months, if:

   i. the Plan Administrator receives your application for coverage later than 30 days after you meet the eligibility requirements;
   ii. the Plan Administrator receives your application for family coverage later than 30 days after a person becomes your spouse or an eligible dependent; or
   iii. the Plan Administrator receives your reapplication for coverage after you choose to end individual or family coverage.

Section Four
Deductible – What You Must Pay First

Deductible. There is no deductible under this Plan.

Section Five
Coinsurance – Sharing Expenses

What is coinsurance. Coinsurance is a percentage of the dollar amount that is your responsibility to pay. The coinsurance applicable to each covered dental service is explained in other sections of the Plan.

Section Six
Payments

Payments under the Plan are based on the Allowable Amount. The applicable deductible and/or coinsurance amount is subtracted from the Allowable Amount before the payment is made under the Plan. You are responsible for any amounts not paid under the Plan.

When covered dental services are rendered by a Participating Provider or a Non-Participating Provider, Lifetime Benefit Solutions will determine if payment will be made to either you or the provider. For covered dental services, the amount you may have to pay beyond the Plan's payment varies depending on whether the provider is a Participating Provider or a Non-Participating Provider. This is explained below.

1. **Participating Providers**. A participating provider has agreed to accept the Allowable Amount as payment-in-full for covered dental services under the Plan. Any applicable coinsurance amounts will then be subtracted before payment is made under the Plan. You will be responsible to the provider for any coinsurance amounts you may owe.

   To see if a provider is a Participating Provider, you can get the latest listing by contacting Lifetime Benefit Solutions, or a list is available via the Internet at www.lifetimebenefitsolutions.com. Although a provider is a Participating Provider, that provider does not have to accept you as a patient.

2. **Non-Participating Provider**. A Non-Participating Provider has not agreed to accept the Allowable Amount as payment-in-full. Any applicable coinsurance amounts will be subtracted before payment is made under the Plan. The Plan's payment may not equal the Non-Participating Provider's Charge for dental service. If there is a difference between the Plan's payment and the Non-Participating Provider's Charge, you may be required to pay the difference. (in addition to any coinsurance amounts you owe)

3. **More than one payment**. If payments, other than those made under the Plan, are made for the same service, a Participating Provider is not required to accept the Allowable Amount as payment-in-full. This could happen if you receive benefits through a lawsuit or another insurance policy. In such a situation the Participating Provider may Charge you the usual fee, or the Plan's payment plus the other amount you received, whichever is less.

Section Seven
Calendar Year Maximum

The maximum amount payable per calendar year (January 1 – December 31) for each person covered under this Plan is $1,000.00.

Section Eight
Class I – Preventive Services

Participating provider. Payment under the Plan is 100% of the Allowable Amount. A participating provider will accept the Allowable Amount as payment-in-full.

Non-Participating provider. Payment under the Plan is 100% of the Allowable Amount. A Non-Participating provider may not accept the Allowable Amount as payment-in-full. You are responsible for any other amounts not paid under the Plan.

Benefits will be provided for Covered Services when it is determined that they are Medically Necessary and appropriate.

1. **Oral evaluations**. Benefits are provided for 2 routine dental evaluations in any 12 consecutive months. Additional oral evaluations may also be covered, but only when there is a confirmed disease or injury requiring a specific evaluation for treatment.

2. **Cleaning (prophylaxis)**. Benefits are provided for 2 cleanings of teeth in any 12 consecutive months.

3. **Fluoride application**. Benefits are provided for 4 topical applications of fluoride in any 12 consecutive months for a covered dependent under 19 years of age.

4. **Emergency treatment**. Benefits are provided for emergency dental procedures that are performed to temporarily alleviate or relieve acute pain, discomfort, or distress but that do not effect a definite cure.

5. **X-rays**. Benefits are provided for full-mouth x-rays or panorex, but no more than 1 in any 36 consecutive months. Bitewing x-rays are covered, but not more often than 2 sets in any 12 consecutive months. Other dental x-rays are covered if required to diagnose a specific condition requiring treatment. Additional full-mouth series may be covered without regard to the 36-month limitation if they are required to diagnose or treat a specific disease or injury.

6. **Tests and laboratory examinations**. Benefits are provided for bacteriologic culture, pulp vitality, diagnostic carries susceptibility test, and other miscellaneous laboratory tests in connection with examinations.

7. **Sealants**. Benefits are provided for the topical application of sealant on a posterior tooth for a covered dependent under 19 years of age. Treatment is limited to 1 per tooth in any 36 consecutive month period. Benefits will not be provided for oral hygiene, dietary or plaque-control programs.

8. **Periodontal prophylaxis**. Benefits are provided for 2 routine scaling services in any 12 consecutive months. The benefit is provided to prevent periodontal disease in borderline periodontic situations.

9. **Space maintainers**. Space maintainers. Benefits are provided to replace prematurely lost or extracted teeth for a covered dependent under 19 years of age. Benefits are provided for the necessary modification of a space maintainer, if such services are required because of a related change in the condition of the mouth.

   Benefits are not provided for the replacement of a lost, missing or stolen space maintainer.

10. **Dental consultation**. Benefits are payable only if no other services are provided during the visit to the consulting dentist.

Section Nine
Class II – Basic Dental Services

Participating provider. Payment under the Plan is 100% of the Allowable Amount. A participating provider will accept the Allowable Amount as payment-in-full.

Non-Participating provider. Payment under the Plan is 100% of the Allowable Amount. A Non-Participating provider may not accept the Allowable Amount as payment-in-full. You are responsible for any other amounts not paid under the Plan.

Benefits will be provided for Covered Services when it is determined that they are Medically Necessary and appropriate.

1. **Extractions**. Benefits are provided for simple or surgical tooth extractions.

2. **Restorations (fillings)**. Benefits are provided to cover single and multiple surfaces and pin-retained restorations of the teeth. The fillings may utilize amalgam or composite material.

3. **Endodontics**. Benefits are provided for the treatment of diseases of the dental pulp, including root canal therapy.

4. **Oral surgery**. Benefits are provided for alveoloplasty (surgical preparation of ridge for denture); tooth replantation; biopsy of oral tissue and stomaplasty

(removal and restoration of gum tissue). These benefits include Medically Necessary general anesthesia administered by a professional provider.

Section Ten
Exclusions

In addition to the exclusions and limitations described in other sections, the Plan does not cover the following:

1. **Services starting before your coverage begins**. The Plan does not cover any service or care given to you before your coverage begins under the Plan.

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

   a. **VA hospitals**. The Plan will cover service and care for non-service related conditions received in an institution owned or operated by the VA.

   b. **Government hospitals**. The Plan will cover service and care received in institutions owned or operated by a federal, state, or local government if you are a patient in a hospital that is state or municipally owned and operated, and the hospital usually Charges for its services.

   c. **Uniformed service hospitals**. The Plan will cover service and care while an inpatient in a hospital operated by the United States uniformed services for the following covered persons: retired military personnel and their dependents; and dependents of military personnel on active duty.

   d. **Emergency care**. The Plan will cover service and care in any of the above hospitals if:

      i. you suffer a sudden and serious illness or serious injury;
      ii. you are treated immediately at the hospital because of its closeness;
      iii. it is impossible to transfer you to another institution; and
      iv. you stay in that hospital only as long as emergency care is necessary.

3. **Government programs**. The Plan will not cover any benefits that 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 a government program, benefits will be reduced by the amount the government program would have paid for the services. If you are eligible for a government program, this reduction is made even if: you fail to enroll; you do not pay the Charges for the program; or you receive services at a hospital that cannot bill Medicare.

4. **Workers' compensation**. The Plan will not cover any service or care for which you are eligible under a Workers' Compensation Act or similar law. The Plan will not cover the services even if you do not receive benefits because: a proper or

timely claim for the benefits available to you under the Act was not submitted; or you fail to appear at a Workers' Compensation hearing.

5. **No-fault automobile insurance**. The Plan will not cover any service or care that is eligible for coverage by no-fault automobile insurance until you have used up all the benefits under the no-fault policy. If your claim for no-fault benefits is denied, you must file for an arbitration hearing if requested to do so. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under any available mandatory no-fault policy. The Plan will pay for services covered under this contract 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 pay for Covered Services.

6. **Free care**. The Plan will not cover any service or care if furnished to you without Charge, or if it would have been furnished to you without Charge if you were not covered under this Plan.

7. **Employer services**. The Plan will not cover any service or care furnished by a medical department or clinic provided by your employer.

8. **Cosmetic surgery**. The Plan will not cover any service or care related to cosmetic or beautifying surgery. This exclusion applies when it is determined the service is not Medically Necessary and is intended only to improve your appearance. However, the Plan will cover services in connection with reconstructive surgery as a result of an infection, injury or disease. The Plan will also cover reconstructive surgery to correct a functional birth defect of a covered dependent child.

9. **Experimental and investigational services**. Benefits will not be provided for any treatment, procedure, facility, equipment, drug, device or supply (collectively, "Service") that is determined to be experimental or investigational. It may be determined that a Service is experimental or investigational even if it has received governmental approval or is ordered by your professional provider.

   "Experimental or investigational" means:

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

"Reliable Evidence" includes:

a. the views and practices of medical or dental communities throughout the country.
b. reports and articles published in authoritative medical, dental, and scientific literature.
c. the opinion of professional consultants.
d. written protocols used by your professional provider or any other professional provider studying substantially the same Service.
e. informed consent forms used by your professional provider or any other professional provider studying substantially the same Service.

10. **Unnecessary care**. The Plan will not cover any service or care when it is determined that the care is not needed for your proper medical care or treatment. This exclusion applies wherever you receive the service or care.

11. **Criminal behavior**. The Plan will not cover 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.

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

13. **Special Charges**. The Plan will not cover Charges for telephone consultations, missed appointments, or fees that may be added for completing a claim form.

14. **Act of war**. The Plan will not cover an illness or injury that occurs as a result of any war or act of war, whether declared or undeclared.

15. **Accidental injury**. The Plan will not cover services for the treatment of an accidental injury to your sound natural teeth unless you are ineligible to receive these benefits under another group health benefits program.

16. **Care by more than one provider**. If you transfer from one provider to another during a course of treatment, or if more than one provider renders services for the same dental procedure, the Plan will not cover more than it would have if one provider rendered the service.

17. **Diagnostic Casts**. The Plan will not cover diagnostic casts.

18. **Periodontics**. The Plan will not cover periodontics including osseous surgery and other related services.

19. **Restorative services**. The Plan will not cover restorative services such as gold foil, and inlays/onlays.

20. **Prosthodontics.** The Plan will not cover prosthodontics and other services such as implants, tissue conditioners, rebases/relines, crowns and the repair/recement of crowns.

21. **Occlusal adjustments**. The Plan will not cover occlusal adjustments.

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

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

23. **Veneers.** The Plan will not cover Charges for veneers.

24. **Occlusal guards**. The Plan will not cover occlusal guards.

25. **Prescription Medication**. The Plan will not cover Charges for drugs and medications.

26. **Temporomandibular Joint Dysfunction (TMJ)**. The Plan will not cover Charges for or in connection with Temporomandibular Joint Dysfunction (TMJ).

27. **Medical Plan Benefits**. The Plan will not cover Charges for dental services that are payable under a medical benefits Plan sponsored by this employer.

Section Eleven
Coordination of Benefits

1. **Other health benefits programs**. This section only applies if you, your spouse, or an eligible dependent is also covered under another health benefits program that provides dental benefits. These programs, whether insured or self-insured, include the following group programs:

   a. group contracts issued by a hospital service, health service, or medical expense indemnity corporation (such as Blue Cross or Blue Shield Plan) or a dental expense indemnity corporation;
   b. group or group remittance insurance contracts;
   c. HMOs, and other prepayment group practice and individual practice plans;
   d. labor-management, union, employer organization, or employee benefit plans;
   e. blanket contracts, except school accident or similar coverage where the organization pays the premium; or
   f. governmental programs for hospital, medical and surgical benefits offered, required, or provided by law, except Medicare and Medicaid. These programs do not include programs whose benefits, by law, are in addition to any private or nongovernmental health benefits program.

      It also includes health benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts.

2. **Purpose**. Coordination of benefits (COB) means that the coverage provided under this Plan is coordinated with coverage available to you under another health benefits program. The purpose of COB is to avoid both programs paying benefits for the same services.

3. **Payment rule**. When you are covered under this Plan and another health benefits program, you have primary and secondary coverage. Primary means the program that is required to pay its benefits first. Secondary means the program paying second.

   In deciding which program is primary, the first of the following rules that applies will be used:

   a. if a program does not have a COB provision like this one, it is primary;
   b. the program in which the patient is covered as an employee or member (that is, other than as a dependent) is primary, except that:

      i. if the patient is also a Medicare beneficiary; and
      ii. if the rules established by the Social Security Act of 1965, as amended, make Medicare primary to the program covering the patient as an employee or member; and
      iii. if the rules established by the Social Security Act of 1965, as amended, make Medicare secondary to the program covering the patient as a dependent of a person in current employment status (defined as an employee, employer, or person associated with an employer in a

business relationship) with respect to the employer maintaining the program; then

iv. the following rules apply:

- the program that covers the child as a dependent of a parent with custody.
- the program that covers the child as a dependent of the spouse of the parent with custody.
- the program that covers the child as a dependent of the parent without custody.

c. when the above rules do not determine priority, the program that covered the patient for the longest time is primary. The other program is secondary; except when:

i. the program in which the patient is covered as an employee but not as a laid-off or retired employee or the dependent of such an employee is primary; the program in which the patient is covered as a laid-off or retired employee or the dependent of such an employee is secondary; and
ii. if both programs do not have a provision like this for laid-off or retired employees, then this rule will not apply.

4. **How COB affects payments**.

a. **When the Plan is primary**. The plan will pay for Covered Services as if there were no COB provision, when the Plan is primary.

b. **When the Plan is secondary**. The Plan bases its payments, when it is secondary, on allowable expenses during a claim determination period. Allowable expenses are the necessary, reasonable, and customary items of expense for health care that are covered at least in part by one or more health benefit programs. A claim determination period means a calendar year; it does not include any part of a year when you were not covered by this Plan.

The Plan will pay for Covered Services after the payment by the primary program. Benefits may be reduced so the total of all benefits available to you from the Plan and the primary program is not more than the allowable expenses.

The Plan counts as actually paid by the primary program any items of expense that would have been paid if you had made the proper claim. If the primary program claims it is “excess only” or “always secondary,” information will be requested from that program so they can process your claim. If the primary program does not respond within 30 days, it will be assumed that its benefits are the same as under the Plan. If the primary program sends the information after 30 days, payment under the Plan will be adjusted, if necessary. When the Plan is secondary, benefit payment will never be more than the full amount of benefits due under the Plan had the Plan been primary.

5. **Right to receive and release necessary information**. Without your permission and without notice to you, LBS or the Plan Administrator may release to, or obtain from, any person, company or organization information that is believed to be necessary to carry out the purpose of this section. Neither LBS nor the Plan Administrator will be legally responsible to anyone for releasing or obtaining information. You must furnish to LBS or the Plan Administrator any information that they request. If you do not furnish the information to them, benefits may be denied under the Plan until you do.

5. **Payments to other health benefits programs**. Benefits may be repaid to any other health benefits program that were paid for your Covered Services under the Plan, if it is decided that the Plan should have paid. These payments are the same as benefits paid to you, and they satisfy any obligation to you under the Plan.

6. **Right to recover payment**. In some cases, payment may have been made even though you had coverage under another program. If this happens, you must refund the amount of the Plan's payment. LBS also has the right to recover the payment from the other program. You must sign any document that is needed to help recover payment.

Section Twelve
How Your Coverage May End

This section describes how your benefits under the Plan may end and how your coverage stops. When the benefits or your coverage ends, benefit payments stop on the termination date. This applies even if you are receiving benefits under the Plan, except as otherwise specifically provided under the Plan.

1. **If your benefits terminate**. Your benefits may be terminated at any time if the Plan Administrator and LBS agree to end their arrangement.

2. **When you no longer qualify**. When you fail to meet the eligibility requirements of the Plan Administrator, your coverage will end.

3. **On your death**. Your coverage will automatically end on the day after your death. If you have family coverage, your spouse's and eligible dependents' coverage will also end on the day after your death.

4. **Termination of marriage**. If you have family coverage and you become legally separated or divorced, the coverage of your spouse will end automatically on the date the legal separation agreement or decree is actually filed. You should immediately notify the Plan Administrator of your change in marital status.

5. **Termination of coverage of an eligible dependent**. Coverage of your eligible dependent will end on:

   a. your dependent's 19th birthday;
   b. the day your dependent marries;

c. the day you no longer claim the dependent on your federal income tax return, or provide more than 50% financial support;
d. the day your dependent over 19 years of age (or over 25, if a full-time student) no longer has a mental illness, developmental disability, mental retardation or physical handicap, or can support himself or herself.
e. the day your dependent under 25 years of age no longer qualifies as a full-time student or reaches their 25th birthday while attending school.

Section Thirteen
Miscellaneous

1. **General information**. This Plan is maintained for the exclusive benefit of employees of Cortland County. Employees' rights under this Plan are legally enforceable. It is the intention of Cortland County that this Plan be maintained for an indefinite period of time.

2. **Effective date**.

   a. If you are in regular full-time employment on the Plan effective date, and have satisfied all eligibility requirements, you and your dependents will be eligible for coverage on that date. The Plan effective date is November 1, 2003.
   b. If you are not actively at work on the day you would normally become eligible, you will be eligible on the day you return to active work.

3. **When a Charge is incurred**. A Charge is incurred on:

   a. the date the dentures or fixed bridges are completed.
   b. the date the crown has been inserted/seated.
   c. the date the work on the tooth has begun, in the case of root canal therapy.
   d. the date the work is done, in the case of any other work.

Section Fourteen
Claim Procedures and Appeals

Claim Forms
When a participant or Covered Dependent has an appointment with a participating or Non-Participating Provider, the participant should proceed as follows.

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

2. He should give the claim form to the Provider. The Provider must fill out the form upon completion of services and send the form to LBS at the address printed on

the top of the form. If for any reason the participant is unable to obtain a claim form in advance of treatment (for example, if an emergency service is required, or service is required while on vacation), the participant should attach a copy of the Provider's bill to a claim form obtained as soon as possible afterwards.

THE CLAIM FORM MUST BE SUBMITTED TO LBS WITHIN 180 DAYS FOLLOWING THE LAST DATE OF TREATMENT ON THE FORM. CLAIMS FILED AFTER THIS TIME PERIOD WILL BE DENIED.

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

Procedures for all Claims

The Plan's claim procedures are intended to reflect the Department of Labor's claims procedure regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those regulations, those regulations will control. In addition, any changes in those regulations shall be deemed to amend this 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 LBS within 30 days of receipt of the claim, as long as all needed information was provided with the claim. LBS will notify you within this 30-day period if additional information is required to process the claim, and may request a one-time extension not longer than 15 days and put your claim on hold until all information is received.

Once notified of the extension, you have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, LBS 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 LBS within 15 days of receipt of the claim. If you filed a pre-service claim improperly, LBS will notify you of the improper filing and how to correct it within 15 days of receipt of the pre-service claim. You will be given at least 45 days from the receipt of this notice to correct your claim.

LBS will notify you of its determination within 15 days after the claim is received, unless LBS determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time

and the date by which a decision is expected to be made shall be furnished to you prior to the end of the initial 15-day period. If the extension is necessary because of your failure to provide missing information and you are notified of that fact, the extension shall not exceed a period of 15 days beginning on the earlier of (i) the date the missing information is received by LBS or (ii) the end of the period afforded to you to provide the missing information. Otherwise, the extension shall not exceed 15 days from the end of the initial 15-day period.

If all of the needed information is received within the 45-day time frame, LBS 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 LBS receives all necessary information, taking into account the seriousness of your condition.

(2) If you filed an urgent care claim improperly, LBS will notify you of the improper filing and how to correct it within 24 hours after the urgent care claim was received. If additional information is needed to process the claim, LBS will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

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

(1) LBS' 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 LBS 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 Plan 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, LBS 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 LBS 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 correct 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) 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 (2) other similar criterion; or 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;

(6) 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 LBS 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 LBS, 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 for a first level of appeal or 60 days for a second level of appeal of receipt of such a denial by submitting a written request for review to the LBS at the following address:

Lifetime Benefit Solutions, Inc.
Attention: Appeals Department
333 Butternut Drive
Syracuse, NY 13214

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.

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.

The Plan must 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 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.

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.

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. LBS may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You hereby 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), each level of appeal will be conducted and you will be notified by LBS 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), each level of appeal will be conducted and you will be notified by LBS 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 LBS as soon as possible. LBS 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

LBS 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.

Section Fifteen
COBRA

Under the federal Consolidated Omnibus Budge Reconciliation Act of 1985, as amended (COBRA), you and/or your covered family members may have a right to continue your coverage under this Plan, when your coverage would otherwise end. If you are eligible to continue your coverage under COBRA, the Plan Administrator should give you notice. If you do not receive notice, ask the Plan Administrator if you qualify.

Section Sixteen
Your Rights Under ERISA

The Federal Employee Retirement Income Security Act of 1974, as amended (ERISA) provides certain rights and protections to participants whose employer group health plans are subject to the requirements of ERISA. If ERISA applies to this Plan, the Plan Administrator is responsible for complying with its requirements. The Plan Administrator can advise you what rights, if any, you have under ERISA.

Section Seventeen
Excess Payments and Subrogation

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

2. **Subrogation**. The purpose of this Plan is to provide benefits for expenses that are not covered by another party. All payments made under this 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.

   This 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 this Plan, you must contact the Group 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 the 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) who receives the recovery funds from any person or party must hold the funds in constructive trust for the benefit of the Plan.

Plan Administrator

Cortland County

Plan Year

January 1st – December 31st