Upper Dauphin Area School District
Dental Plan
Group # 662

The intent of this dental benefit plan is to provide benefits for eligible dental services that meet professionally acceptable standards for the treatment of the existing dental condition.

School Claims Service, LLC
P.O. Box 812
New Cumberland, PA 17070-0812
Phone # (866) 403-7700
Fax # (866) 403-7701

Please feel free to visit our website at:
www.schoolclaimsservice.com

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

HIPAA requires that certain "covered entities", such as self-insured group health plans that are administered by third parties, comply with HIPAA's privacy and electronic transaction regulations. School entities that offer self-insured dental and vision plans must ensure that those plans comply with HIPAA's privacy and electronic transaction regulations, and are advised to consult with legal counsel regarding their HIPAA compliance obligations.

SCS, as a Third-Party Administrator of dental and vision plans, is not a "covered entity" under HIPAA, and does not bear the legal responsibility to ensure that the school entities' dental and vision plans comply with HIPAA. In order to provide more comprehensive services to our school entity customers, however, SCS will assist our customers in achieving HIPAA compliance for their dental and vision plans, including providing an appropriate Notice of Privacy Practices, a Privacy Policy, executing appropriate business associate contracts, and implementing other measures to ensure that the dental and vision plans of our customers fully comply with the privacy and electronic transaction standards of HIPAA. If a customer desires to have SCS implement these HIPAA compliance measures for its dental or vision plan, SCS will provide these services at no additional charge.

To all full-time employees of Upper Dauphin Area School District:

Upper Dauphin Area School District contributes toward the cost of your dental plan. It asks that you read this booklet so you are aware of your benefits, understand your eligibility and obtain maximum benefit from this plan.

You will receive an explanation of benefits for each finalized claim. **Retain all explanation of benefits.** This is your record of services provided, date of each service and amount paid. An explanation of benefits is essential when coordinating benefits with other dental plans.

If you should need additional information, you may call School Claims Service, LLC between the hours of 8:00 a.m. and 4:30 p.m. on normal business days. The number is (866) 403-7700.

This booklet is not a contract. It explains in nontechnical language the essential features of your employee fringe benefit plan.

Schedule of Benefits

Deductible per calendar year	None

Periodontics	
(treatment of gums and supporting structures of the teeth)	100% of R&C*
Family maximum per calendar year	$1,000
All other covered services	100% of R&C*
Individual maximum per calendar year	$1,000
Orthodontic	
(50% of UCR of $2000	
with a lifetime maximum	
of $1,000 per family member)	

*R&C – Reasonable and customary (see p. 9)

How to File a Claim

A dental claim form must be completed by you and your dentist. After the work is completed, the dentist should submit the claim to School Claims Service, LLC P. O. Box 802, New Cumberland, PA 17070-0802
Claim forms are available at your employee benefits office.

Who Pays for Benefits

This benefit plan is on a contributory basis requiring contributions from you toward its cost. If you cease to contribute toward the plan, your benefits will terminate.

Covered Dental Charges

A charge will be deemed incurred as of the date the service is rendered or the supply is furnished, except for the following:

a. With respect to crowns, on the first date of preparation of the tooth or teeth involved.
b. With respect to endodontics, on the date the tooth was opened for root canal therapy.

Covered dental charges are the charges of a dentist or physician for the services and supplies listed below required for dental care and treatment of any disease, defect or accidental injury, or for preventive dental care. Not included is any charge in excess of the reasonable and customary charge made:

a. For similar services and supplies by dentists or physicians in the locality concerned, or
b. Where alternate services or supplies are customarily available for such treatment, for the least expensive service or supply resulting in professionally adequate treatment.

Preventive Services and Supplies

1. Charges for cleaning and scaling of teeth but not more often than once every six months.
2. Charges for fluoride applications, but not more than once in a calendar year.
3. Charges for space maintainers and their fitting.

Diagnostic and Therapeutic Services

1. Charges for diagnostic services to determine necessary care, but:
    a. Charges for full mouth x-rays are covered only once in a three year period.
    b. Charges for bite-wing x-rays are covered only once in a six month period.
    c. Charges for a diagnostic oral examination are covered only once in a six month period.
2. Charges for emergency treatment for relief of dental pain on a day for which no other benefit other than for x-rays is payable hereunder.
3. Charges for extraction of one or more teeth, cutting procedures in the mouth and treatment of fractures and dislocations of the jaw, but not including additional charges for removal of stitches or post operative examination.
4. Charges for treatment of the gums and supporting structure of the teeth.
5. Charges for root canals and other endodontic treatment.
6. Charges for general anesthetics and their administration in connection with oral surgery, periodontics, fractures or dislocations.
7. Charges for injectable antibiotics administered by a dentist or physician.

Restorative Services and Supplies

Charges for fillings and stainless steel crowns necessary to restore the structure of teeth broken down by decay or injury, but:

a. The charge for a gold filling will be limited to the charge for a silver, porcelain or other filling.
b. The charge for placement of a stainless steel crown or filling is covered only if the crown or filling is more than five years old.

Prosthetic Services and Supplies

1. Charges for adding teeth to an existing denture, if required because of loss of natural teeth while the person is covered for this benefit.
2. Charges for repair and rebasing of existing dentures which have not been replaced by a new denture.

Charges for specialized techniques involving precision attachments, personalization or characterization and additional charges for adjustments within six months from installation are not included as covered dental charges.

Orthodontic Coverage

(50% of UCR of $2000 with a lifetime maximum of $1,000 per family member)

Coverage is prorated for any orthodontic work in progress September 1, 2000.

Orthodontic treatment approved by School Claims Service, LLC will be eligible for the following benefits:

1. Diagnostic services including radiographs and study models.
2. Active treatment, including active treatment.
3. Retention treatment following active treatment.

School Claims Service, LLC shall make payments in accordance with the co-insurance percentage specified above. The lifetime maximum amount payable for any one patient shall be $1,000. The

amount School Claims Service, LLC liability shall be payable over a period not to exceed the length of approved treatment plan. Payments will be made no more often than once every three months. The initial payment shall be equal to no more than 25% of the total School Claims Service, LLC liability. The remaining 75% of School Claims Service, LLC liability will be payable in equal quarterly amounts during the period covered by the approved treatment plan and while the patients coverage is in effect. If the treatment plan is satisfactorily completed in less than the period specified, upon notification from the dentist, payment will be made in the amount of the remaining School Claims Service, LLC liability.

Orthodontic Exclusions and Limitations

1. If, for any reason, the orthodontic services are terminated before completion of the approved treatment, the responsibility of School Claims Service, LLC will cease with payment through the month of termination.
2. A treatment plan must be submitted to School Claims Service, LLC by the dentist with the diagnosis indicating that the orthodontic condition consists of handicapping malocclusion which is abnormal and is correctable.
3. School Claims Service, LLC reserves the right to review the subscriber's dental records, including necessary X-rays and study models, to determine if orthodontic needs and treatment are eligible under this plan.
4. Charges for duplicate devices or appliances, or repair or replacement of any appliance furnished under the treatment plan are **not** eligible for benefits.
5. Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with appliance therapy.

After Benefits Terminate

The benefits described herein also are provided for covered dental charges:

a. For services or supplies furnished within 90 days after benefits terminate if the charges were incurred while benefits were in force, and
b. Incurred within 90 days after benefits terminate if an accident resulting in injury to natural teeth sustained while benefits were in force causes continuous total disability from the date of termination; provided benefits are not payable for such expenses under any other group insurance policy or plan.

Eligibility

Who is Eligible

If you are included in the eligible classes of employees, you will be eligible for the benefits under this plan on the effective date specified below:

Eligible Classes: All full-time employees.

Effective Date: The date you start work.

You will be eligible for the benefits on your dependents on the date you become eligible as stated above or the date you acquire your first dependent, whichever is later.

Eligible Dependents

Dependents who are to be eligible are:

1. Your wife or husband.
2. Your unmarried children under 19 years of age who are wholly dependent upon you for

maintenance and support.

3. Your unmarried children 19 years of age but under 23 years of age who are registered students in regular full-time attendance at school, are principally dependent upon you for maintenance and support, and are not regularly employed by one or more employers on a full-time basis of 30 or more hours per week exclusive of scheduled vacation periods. Full-time students are covered to the end of the month in which they reach their 23rd birthday.
4. Children of your children as described in 2 or 3, residing in the United States of America.

The term "children" will include you or your dependent's own child, stepchild, legally adopted child or one for whom legal adoption proceedings have been initiated, and also will include any other child who is related to you by blood or marriage, principally dependent upon you for maintenance and support and living with you in a regular parent child relationship.

When Your Benefits Begin

You will be covered on the date you become eligible provided you are not away from work due to disability on that date. If you are away from work due to disability, your coverage will not start until your return to active full-time work.

When Your Benefits Terminate

Your benefits under this plan will terminate at the earliest time stated below:

1. When your employment terminates. For plan purposes, your employment is deemed terminated when you cease active work, but the employer may continue your benefits.
    a. If you are absent from work because of injury, sickness or pregnancy, or
    b. If you are absent from work because of a leave of absence or temporary layoff, but only until the last day of the month following the month in which such leave of absence or temporary layoff begins.
2. When this plan is discontinued.

In addition to the above, the coverage terminates with respect to an individual dependent:

1. When such person becomes covered as an employee.
2. When such person ceases to be an eligible dependent.
3. A dependent child will be terminated at the end of the month in which they reach maximum age.

Definitions

When the following terms are used in this booklet these definitions apply:

Active full-time work - Performing all of the regular duties of your job while in permanent active service with the employer. On any day, you will be considered in active service if you performed the regular duties of your job on the last scheduled workday.

Alternate services - If alternate services or supplies may be used to treat a dental condition, covered dental expenses will be limited to the services and supplies which are customarily employed nationwide to treat the disease or injury and which are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the participant's total current oral condition.

Dentist - A person duly licensed to practice dentistry by the governmental authority having

jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

Employee - A person directly employed in the regular business of and compensated for services by the employer who works on a permanent active, full-time basis.

Experimental or investigative - The use of any treatment, procedure, facility, equipment, drug or drug usage, device or supply not accepted as standard dental treatment of the condition being treated by the general dental community, or any such items requiring federal or other governmental agency approval not granted at the time services were rendered.

Maximum benefit - The maximum amount available for all dental expenses for each individual covered under the plan is specified in the schedule of benefits.

Predetermination of benefits - The dental plan contains an optional feature called "predetermination of benefits". Through an interchange of information between School Claims Service and your dentist, it will be possible for you to know exactly what benefits will be paid under this plan before extensive dental work is undertaken. Due to the expensive nature of dental work, it will be to your advantage to avail yourself of this added feature by obtaining a dental claim form from your employer before incurring dental expenses. See claim form for instructions.

Reasonable and customary (R&C)* - A usual charge made by a provider of dental services, medicines or supplies shall not exceed the general level of charges made by others rendering or furnishing such services, medicines or supplies within the area where the charge is incurred for injury or dental care comparable in severity and nature to the injury or dental care being treated, giving due consideration to any medical complications or unusual circumstances which require additional time, skill or experience. The term "area" as it would apply to any particular service, medicine or supply means a county or such greater area as is necessary to obtain a representative cross section of level of charges.

Totally Disabled -

a. Your complete inability to perform any and every duty pertaining to your occupation or employment.
b. Your dependent's complete inability to perform the normal activities of a person of like age and sex.

Treatment Plan - A written report made by a dentist describing the findings of the examinations of a covered person and recommended treatment for the person's dental disease, defect, or accident causing injury to teeth.

Coordination of Benefits Provision

The provision will coordinate the dental benefits payable as described on the preceding pages with similar benefits payable under other plans. The other plans are those providing benefits and services in connection with dental care and treatment which benefits and services are provided by:

1. Group or blanket insurance coverage (other than student blanket insurance), franchise insurance, Blue Cross, Blue Shield, or other prepayment coverage, coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, or employee benefit organization plan, including any federal or state or other governmental plan or law toward the cost of which any employer shall have contributed or shall have made payroll deductions, or

2. Coverage under any plan solely or largely tax supported or otherwise provided for by or through action of any government, except Medicare or Medicaid, or
3. Regulated by or through action of The Pennsylvania Motor Vehicle Financial Responsibility Law.

When this Provision is Applicable

This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this plan and under all other plans covering an individual during a claim determination period exceed the allowable expenses incurred.

An allowable expense is any necessary, reasonable and customary item of expense, which qualifies as a covered dental charge under our plan, at least a portion of which is covered under at least one of the plans covering the individual with respect to whom a claim is made. A claim determination period is a calendar year.

How this Provision Coordinates Benefit Payments

One of the two or more plans involved is the primary plan and the other plans are secondary plans.

If this plan is the primary plan, it pays benefits first and without consideration of the other plans.

If this plan is a secondary plan, the benefits payable under this plan will be reduced to the extent that the total amount of benefits:

a. Payable under this plan in the absence of this provision.
b. Payable under all other plans primary to this plan is not more than the total allowable expenses incurred under this plan and the other plans.

Rules for Determining Which Plan is Primary

A plan which has no coordination of benefits provision is automatically primary.

A plan which covers a person as an employee is primary to a plan which covers the same person as a dependent.

If a person is covered as a dependent under two or more plans, the plan which covers such person as a dependent of a male person is primary. However, the following exceptions may apply in the case of claims made on behalf of a dependent child:

a. When the husband and wife are legally separated or divorced and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody of such child is primary to the plan which covers the child as a dependent of the parent custody.
b. When the husband and wife are divorced and the parent with custody of the child has remarried, the plan which covers the child as a dependent of the parent with custody is primary to the plan which covers the child as a dependent of the stepparent. In addition, the plan which covers the child as a dependent of the stepparent will be primary to the plan which covers that child as a dependent of the parent custody. However, in the event of a court decree that establishes financial responsibility for the medical, dental or other health care expenses of such dependent child, the plan which covers the child as a dependent of the parent with such financial responsibility is primary to any other plan which covers the child as a dependent child.

If the above conditions do not apply, a plan may be primary if it covers the individual the longer period of time and secondary if it covers the individual the shorter period of time.

Information necessary to the administration of this provision will be required at the time a claim is submitted.

If both husband and wife work for the employer and are eligible for benefits, only one may cover the dependent children for the dependents' benefits.

Exclusions

Not covered under any section of these benefits:

1. Treatment by someone other than a dentist or physician, except when performed by a duly qualified technician under the direction of a dentist.
2. Services or supplies cosmetic or experimental in nature.
3. Training or supplies used for dietary counseling, oral hygiene, or plaque control.
4. Procedures, restoration and appliances to increase vertical dimension or to restore occlusion.
5. Services and supplies connected with injury caused by war or international armed conflict.
6. Services and supplies connected with injuries sustained while engaged in an occupation for which Workers' Compensation or similar benefits are payable.
7. Expenses you are not legally required to pay.
8. Lost or stolen appliances, missed appointments or expenses incurred while benefits were not in force.
9. Dental care resulting from active participation in a riot or the commission of a felony.
10. Dental care resulting from any injury not caused by an accident or which is self-inflicted.
11. Claims for services performed over 18 months prior to submission.
12. Services or supplies which are not appropriate or which do not meet professionally recognized standards of quality.
13. Any other services or supplies except as described in this booklet.

Predetermination of Benefits

One of the advantages of this dental plan is that you can find out how much will be paid by the plan before you have the dentist do extensive work. This will eliminate misunderstandings as to what is covered by the plan and so enable you to avoid underestimating what you may owe the dentist. The procedure is called predetermination of benefits and here is how it works...

Customarily before starting extensive work, the dentist will tell you what work need to be done. (Dentists usually call this the treatment plan.) This simply secures the information in writing so that the plan supervisor may indicate, in advance, the benefits allowable as well as your portion of the dentist's charge.

Dental care can be expensive and it is to your advantage to know the benefits before you agree to have the work done.

Predetermination of benefits is not a guarantee of payment. Actual claim payment will be based on the coverage in effect on the date each service is performed.

Appealing Claims if Denied

If your claim should be denied in whole or in part, you will receive written notification.

A claim work sheet will be provided by the plan supervisor showing the calculation of the total amount payable, charges not payable, and the reason.

If you receive denial of your claim you may request a review by filing a written application with School Claims Service, LLC. On receipt of written request for review of a claim, the plan supervisor will review the claim and furnish copies of all documents and all reasons and factors relating to the

decision. You or your authorized representative may reexamine pertinent documents (except as information may be contained therein which the physician or dentist does not wish made known to the claimant) which the plan supervisor has and may submit your comments in writing. Request for review must be filed within 120 days after denial is received; however, we suggest it be filed promptly wherever possible. A decision by the plan administrator will be made within 60 days, unless special circumstances require extension. The decision will also be delivered to you in writing setting forth specific reasons for the decisions and specific references to the pertinent plan provisions upon which the decision is based. This decision will be final.

Proof of Claim Provision

Normally a claim form completed by you and the treating dentist is all that is necessary to initiate a claim for dental benefits. However, on occasion, it is necessary for School Claims Service, LLC to obtain additional information to accurately determine benefits.

School Claims Service, LLC reserves the right to have you or your dependent examined by a licensed dentist of its choice when and as often as may be required to determine eligible benefits under the plan.

School Claims Service, LLC shall have the right to require the treating dentist to provide a complete statement of treatment, study models, pre and post operative x-rays and any additional evidence it deems necessary to determine eligibility of benefits under the plan.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or

- Your employment ends for any reason other then your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, {commencement of a proceeding in bankruptcy with respect to the employer,} or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (<u>divorce</u> or <u>legal separation</u> of the employee and spouse or a <u>dependent child's losing eligibility for coverage</u> as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event,

COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Keeping Administrator Informed

It is imperative that you keep the administrator informed of any address changes for all participates or beneficiaries who are or may become qualified beneficiaries. Likewise it is your responsibility to advise the administrator of any qualifying events such as divorce.

If You Have Questions

Questions concerning your ***Summary*** Plan ***Description*** or your COBRA continuation coverage rights should be addressed to the Contact or contacts identified below.

School Claims Service, LLC
Employee Benefits Division
PO Box 812
New Cumberland, PA 17070-0812
(866) 403-7700