

**Chemung County**  
**203-205 Lake Street**  
**Elmira, NY 14902**

**Dental Plan 2**

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## Section One Introduction to Your Dental Benefits Plan

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This part of the booklet explains your dental benefits under the Chemung County Dental Benefits Plan (“Plan”). The Plan is funded by Chemung County. (“Plan Administrator”). EBS-RMSCO, Inc. administers the claims for the dental benefits of the Plan on behalf of the Plan Administrator.

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## Section Two Important Terms and Phrases You Need to Know

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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. **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.
3. **Covered Service.** A covered service is a service or supply specified in the Plan and for which a benefit payment is made.
4. **Medically Necessary or Medical Necessity.** Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
  - a. In accordance with generally accepted standards of medical practice;
  - b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, 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 illness, 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 physicians practicing in relevant-clinical areas, and any other clinically relevant factors.

The fact that any particular physician, dentist, or health care professional may prescribe, order, recommend, or approve a service, supply or technology does not, in itself, make the services medically necessary. Services, supplies, and technologies that are not medically necessary include, but are not limited to, the following:

- a. services provided over a longer period of time than is necessary for effective diagnosis and treatment of your illness or injury;
  - b. services provided, if you fail fully to comply with the medical or dental regime established by the provider of services or the physician or dentist.
5. **Plan Administrator.** The Plan Administrator is Chemung County.
  6. **Plan Year.** The Plan Year begins January 1 and ends December 31.
  7. **Participating Providers.** Participating providers are: individuals licensed to practice dentistry and/or perform oral surgery and other health care professionals who are licensed to provide the services covered under the Plan. Benefits are only provided for services that are usually billed by the provider.

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### **Section Three**

#### **Who Is Covered and When Coverage Begins**

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1. **Eligibility.** You may select coverage for yourself only (individual coverage); or you may select coverage for yourself and your spouse and/or 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 EBS-RMSCO. 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 under family coverage.** 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 the end of the year of their 19<sup>th</sup> birthday (or to the end of the month of their 25<sup>th</sup> birthday - if they are a full-time student).
  - c. an eligible dependent means:
    - 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 EBS-RMSCO that you provide more than 50% of their financial support; and provided at least one of the following has occurred:

- i. the eligible 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.
- d. your unmarried eligible dependents to the end of the month of their 25<sup>th</sup> 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 EBS-RMSCO 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 EBS-RMSCO 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.

- e. 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; before the dependent reached the end of the year of their 19<sup>th</sup> birthday; or before the dependent reached the end of the month of their 25<sup>th</sup>

birthday; 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/or eligible dependents. Remember, you must notify the Plan Administrator when you gain a 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. Eligibility: If you are an active full-time or part-time employee scheduled for 22 or more hours per week, you are eligible to enroll in this plan. Part-time employees pay a proportionate rate (see Plan Administrator for current rates).
  - b. Eligibility date: First day of the month coinciding with or next following your date of hire or on which you moved to part-time or full-time status, scheduled for 22 or more hours per week. Your coverage under the plan will become effective on the first of the month following the Plan Administrators acceptance of your enrollment.
  - c. If you have individual coverage and apply for family coverage due to a Qualified Family Status Change, the Plan Administrator must be notified within 30 days of the Qualified Family Status Change, and family coverage will start on the first day of the month following notification to the Plan Administrator.
  - d. 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).
  - e. 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 for the initial hospital stay of a newborn child you are in the process of adopting, if one of the child's biological parents has coverage for the stay. Also, the Plan will not provide coverage if a notice of revocation of the adoption has been filed, or one of the biological parent's revokes consent to the adoption. If the Plan pays 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.

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**Section Four**  
**Deductible – What You Must Pay First**

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1. **Deductible.** After the Plan has paid \$100.00 of covered expenses for a person under the Plan, that person must pay the next \$50.00 of covered expenses for services. This is each covered person's deductible. If you have family coverage and dental expense deductible amounts for all covered persons total the family deductible of \$150.00, no further deductible will be applied to the family's covered expenses for the rest of that calendar year. The deductible applies each calendar year (January 1<sup>st</sup> – December 31<sup>st</sup>).

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**Section Five**  
**Calendar Year Maximum**

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The maximum amount payable per calendar year (January 1<sup>st</sup> – December 31<sup>st</sup>) for each person covered under this Plan is \$1000.

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## Section Six Dental Care Benefits

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The payments for these benefits are based on the allowable amounts. The reimbursement is calculated according to the following schedule of benefits for the Plan year January 1 through December 31:

For covered services, we will pay 100% of the first \$100.00 of allowable amounts.

We then will apply a \$50.00 deductible towards any allowable amount.

After we have paid the first \$100.00 of covered services and you have met your \$50.00 Deductible (maximum of 3 times \$50.00 for a family), we will then pay 80% of the allowed amount for covered services up to a total annual benefit of \$1,000. The annual maximum we will pay for all covered services, excluding orthodontic care is \$1,000.

### **Orthodontic Benefits**

- Orthodontic benefits for dependents under age 19 are subject to a lifetime maximum amount of \$2,500.00.
- Orthodontic benefits are not subject to the deductible.
- Orthodontic benefits do not apply to the calendar year maximum.

We will pay 80% of the allowable amount for orthodontic services up to a lifetime maximum of \$2,500. We will never pay more than \$2,500 for any member of this plan over the course of your lifetime, even if you leave the plan and re-enter the plan under the same subscriber or another subscriber.

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## Section Seven Exclusions

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

1. **No Coverage.** The Plan does not cover any services incurred for a participant or covered dependent before his Plan coverage begins.
2. **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.

3. **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.
4. **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.
5. **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.
6. **Employer services.** The Plan will not cover any service or care furnished by a medical department or clinic provided by your employer.
7. **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.
8. **Experimental and investigational services.** Benefits will not be provided for any treatment, procedure, facility, equipment, drug, device or supply (collectively, "Service") that is 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 EBS-RMSCO 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 dental or ophthalmology 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.
9. **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.
  10. **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.
  11. **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.
  12. **Special charges.** The Plan will not cover charges for telephone consultations, missed appointments, or fees that may be added for completing a claim form.
  13. **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.

14. **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.
15. **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.

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## Section Eight Coordination of Benefits

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1. **Other dental benefits programs.** This section only applies if you, your spouse, or an eligible dependent is also covered under another dental 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 BlueCross or BlueShield Plan) or a vision 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. following rules apply:
    - ❖ the program covering the patient as a dependent of a person in current employment status pays first,
    - ❖ the program covering the patient as an employee or member pays third.
- c. if a child is covered as a dependent of two people (parents/married or joint custodians of the child without a court decree establishing financial responsibility for health care expenses) under different programs, the following rules apply:
  - i. the program of the parent whose birthday (month and day) is earlier in the year is primary;
  - ii. if both parents have the same birthday, the program that covered a parent longer is primary; however,
  - iii. if the parents are divorced or separated, and joint custody has not been decreed, the special rule in (d) may apply.

However, some programs may not have adopted this “birthday rule.” When the two COB provisions do not agree on which program is primary, the following will be used: if the other program has a rule based on the parent’s gender, the program under which the child is a dependent of a male is primary.

- d. for children of divorced or separated parents, the following rules apply:
  - i. if there is a court decree establishing financial responsibility for the health care expenses of the child of divorced or separated parents, the program that covers the child as a dependent of the parent with financial responsibility will be primary, if the program has actual knowledge of the court decree. If the program has no actual knowledge, the following rules apply.
  - ii. if the parents are divorced or separated, the program that covers the child as a dependent of the parent with custody is primary; provided, the parent with custody has not remarried.
  - iii. if the parents are divorced and the parent with custody of the child has remarried, the primary program is the first of the following to 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.

- e. 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 dental 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, EBS-RMSCO 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 purposes of this section. Neither EBS-RMSCO nor the Plan Administrator will be legally responsible to anyone for releasing or obtaining information. You must furnish to EBS-RMSCO 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.

6. **Payments to other dental benefits programs.** Benefits may be repaid to any other dental 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.
7. **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. EBS-RMSCO also has the right to recover the payment from the other program. You must sign any document that is needed to help recover payment.

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## Section Nine How Your Coverage May End

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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 EBS-RMSCO 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/or eligible dependents will have extended benefits at no further costs for three months after the death. Survivors will be eligible to continue coverage in the Chemung County Employees Health Benefits Program. For information on dependent survivor coverage and its cost, contact the County Insurance Dept. A surviving spouse may continue such coverage until he or she remarries. Surviving children may be covered as long as they otherwise meet the definition of dependent child.
4. **Termination of marriage.** If you have family coverage and you become legally separated or divorced, the coverage of your spouse will end on the last day of the month following notification by the employee. You should notify the Plan Administrator within 30 days of the Qualified Family Status Change.
5. **Termination of coverage of an eligible dependent.** Coverage of your eligible dependent will end on:
  - a. the end of the year of your dependent's 19<sup>th</sup> 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 end of the year of your dependent's 19<sup>th</sup> birthday (or the end of the month of their 25<sup>th</sup> birthday - 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 end of the month of your dependent's 25<sup>th</sup> birthday who is no longer a full-time student.

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## Section Ten Miscellaneous

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1. **General information.** This Plan is maintained for the exclusive benefit or employees of Chemung County. Employees' rights under this Plan are legally enforceable.

It is the intention of Chemung County that this plan be maintained for an indefinite period of time.

2. **Effective date.**

If you are in 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 August 1, 2001.

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

- a. the date the service is provided.

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## Section Eleven COBRA

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Under the federal Consolidated Omnibus 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, ask the Plan Administrator if you qualify.

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## Section Twelve Submitting a Claim

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When you or an eligible dependent has an appointment with a dentist provider you should proceed as follows.

1. Obtain a claim form from the Insurance department of Chemung County. Complete and sign the top portion of the claim form indicating the name of the patient who is to be treated by a dentist provider and the employee's name, and fill in other information requested on the form. You must sign the section authorizing use of claim information. If you sign the section authorizing plan payment to the provider, any Plan payment will be made payable to the provider. If you do not sign this section, any payment will be made directly to you.
2. Whether or not a pre-treatment estimate is requested, the amount of coverage will be determined by the Plan Administrator, in accordance with the terms of the Plan. If for any reason you are unable to obtain a claim form in advance of treatment (for example, if an emergency service is required, or service is required while you are on vacation), you should attach a copy of the providers bill to a claim form obtained as soon afterward as possible. After completing the appropriate portion of the claim form, **YOU MUST SUBMIT IT TO EXCELLUS BENEFIT SERVICES, INC.**
3. The Plan Administrator will pay the applicable benefit amount for all completed services to the provider or directly to you. If you are not entitled to payment, you will receive an explanation of the amount of benefits paid. Upon receipt, the explanation of benefits should be examined for accuracy. Any questions should be directed to the Plan Administrator.
4. When another dental appointment is scheduled, you should obtain another claim form for the provider to complete.
5. The Plan Administrator reserves the right to deny payment relative to any claim form received by the Plan Administrator more than 365 days following the last date of treatment on the form.
6. If any claim for benefits under the Plan is denied, you will be given the reason for denial in writing, usually within 90 days after receipt of the claim by EBS-RMSCO or within 180 days under special circumstances requiring a delay in processing the claim. If an extension is required, you will be given written notice of the extension before the end of the initial 90-day period. This notice of extension shall state the special circumstances that require the extension and the date by which a final decision will be made.

You, or a person on your behalf, may ask for a review of the denied claim in writing within 60 days of receipt of the denial notice. This written request for review should state the reasons why you feel your claims should not have been

denied. It should include any additional documents (medical, vision or dental records, etc.) that you feel support your claim. You may ask additional questions or make comments, and you may review pertinent documents. In normal cases, you will receive the final decision within 60 days of the date that your request for review is received. In special cases requiring a delay, you will receive notice of the decision no later than 120 days after your request for review is received by EBS-RMSCO.

You have the right to appeal any claim denial to your Plan Administrator. The Plan Administrator has the duty and authority to conduct a final full and fair review of any claims denied in full or in part by EBS-RMSCO.

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### **Section Thirteen Your Rights Under ERISA**

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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.

**Plan Administrator**  
Chemung County

**Plan Year**  
January 1<sup>st</sup> – December 31<sup>st</sup>