



*WellSpan Population Health  
Dental Benefits*

**Plan Document and Summary Plan  
Description**

January 2024

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## About this Plan Document and Summary Plan Description

This *Guide to Your Dental Benefits* is meant to be informative and easy to understand. It provides you with information about how your dental benefits work so you can use them most effectively. This guide functions as a Plan Document and Summary Plan Description – or SPD. By law, SPDs are required for certain benefits. As a **covered person** under the **Plan**, you are entitled to certain rights under the Employee Retirement Income Security Act (ERISA) of 1974 as amended, as described in the “Administrative Information” section of this guide.

WellSpan Population Health Services reserves the right to change, amend, or terminate any or all of the **Plan** options within the WellSpan Population Health Services Group Health Plan at any time. This Plan Document/Summary Plan Description is not a contract of employment and participation in any of the **Plan** options does not guarantee employment.

This “Introduction to Your Dental Benefits” section of your guide provides information about your dental coverage. The next section — “Participating in the Dental Benefits” — provides important information on how to participate in the **Plan**, including information on eligibility and coverage. Next, you’ll find the section that describes the specific benefits and coverage levels provided under the dental plan benefits. The following section, “Administrative Information,” you will find important information about the WellSpan Population Health Services Group Health Plan. The last section, “Terms You Should Know,” includes definitions to important terms found in this guide and which appear throughout this guide in bolded and italicized text.

Please take a few moments to read through this guide and become familiar with your dental benefits.

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## Important Information

Reading this SPD is a good way to understand your benefits. Understanding your benefits helps you and your family to make good decisions regarding your dental care and out-of-pocket costs. Throughout this SPD, information that is especially important will be shown with the symbol below.



**Information included with this symbol is important. If you would like further details, contact WellSpan Population Health Services Dental.**

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## Important Phone Number and Web Site Information

- **WellSpan Population Health Services Dental**  
(800) 842-1768 or (717) 851-6800  
[www.wellspanpophealth.com](http://www.wellspanpophealth.com)
- **WellSpan Benefits**  
[www.wellspanbenefits.org](http://www.wellspanbenefits.org)

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## Your Eligibility

You become eligible to enroll for coverage as follows:

- Full-time regular **employees** — coverage begins the first day of the month following the first day of active service, provided you make your required contribution. Otherwise, coverage becomes effective on the first day of the second month following the first day of active service.
- Part-time **employees**, and per diem **employees** — coverage begins the first day of the month following the first day of active service provided you make the required contribution. Otherwise, coverage becomes effective on the first day of the second month following the first day of active service.

For information on how to enroll, see the heading “Enrolling for Coverage.”

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## Your Dependents’ Eligibility

You may cover yourself or yourself and your family. These family members are called **dependents**. Your eligible **dependents** include:

- Your **spouse**;
- Your child(ren):
  - Until the end of the month in which they reach age 26;
  - For which you are the legal guardian until the end of the month in which they reach age 18;
  - 
  - Up to any age if physically or mentally **disabled** before age 26. They must be:
    - Incapable of self-sustaining employment because of mental or physical **disability**, which can be expected to be of long-term or indefinite duration; and
    - Must be claimed as a “dependent” for federal tax purposes by the **employee or spouse**.

Both of these tests must be met to continue your child’s eligibility under the **Plan**. If the child is, at any point, no longer **disabled** after their 26th birthday, they will thereafter be ineligible as a covered **dependent** even if a subsequent **disability** is a recurrence of a prior condition. The **Plan Administrator** may require initial and subsequent proof of the child’s **disability** and dependency (but not more than once per year).

An eligible child may be your natural child, legally adopted child, stepchild, child who is the subject of a court order directed to you, or a child for whom you are the legal guardian (until the end of the month in which they reach age 26). In addition, any child named in a “qualified medical child support order” will be covered under the **Plan**.



**A newborn child will be covered under the *Plan* for the first 31 days following birth. If you wish to continue your baby’s coverage after 31 days, you will need to enroll your child during this period. For information on how to enroll your dependents, see the heading “Enrolling for Coverage.”**

At any time, the **Plan** may require proof that a **spouse** or **dependent** child qualifies or continues to qualify as a **dependent** as defined by the **Plan**.

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## Enrolling for Coverage

You will need to enroll for your dental coverage. When you are first hired or when you experience a change in status, such as becoming eligible for benefits due to a job change, you should complete an enrollment form and submit it to Human Resources within 31 days of your employment date or date of your change in status. Once enrolled, you may only change your level of coverage and/or change your dental option as explained below.

You may choose from the following coverage levels:

- You only; or
- You and your family.

### *Open Enrollment Period*

You can change your coverage selections during the open enrollment period. Your changes will take effect the following January 1st. Human Resources will notify you of the open enrollment period. If you don't want to make any changes to your coverage, you do not need to re-enroll during open enrollment.

### *Qualified Medical Child Support Order (QMCSO)*

A qualified medical support order (QMCSO) means any judgment, decree, or order (including approval or settlement agreement) issued by a court of competent jurisdiction or issued through an administrative process established under state law and which has the force and effect of law under applicable state law.

A QMCSO is a court order that creates or recognizes the right of a child (called an *alternate recipient* in the law) to receive health care benefits under your **Plan**. To be considered a QMCSO, the qualified medical child support order must clearly specify the following information:

- Your last known mailing address and the name and address of each child covered by the order;
- A description of the type of coverage to be provided by the **Plan** for each child, or the manner in which the type of coverage is to be determined;
- The period to which the order applies; and
- Each benefit plan to which the order applies.

The **Plan Administrator** is responsible for establishing reasonable, written procedures for determining if the court order is a QMCSO. You may request, free of charge, copies of these written procedures. The **Plan Administrator** must notify you and the child that a court order has been received and within a reasonable time inform you and the child whether or not the court order is a QMCSO. If the court order is determined to be a QMCSO, the child is an *alternate recipient* and is considered to be covered by the **Plan**. Reimbursement of benefit payments under the **Plan** pursuant to a QMCSO may be made to the child, the child's custodial parent, or another designated representative - or if the benefits are assigned, to the provider of care.



The court order may not require the **Plan** to provide any type or form of benefit, or any option not otherwise provided under the **Plan**. If a state has paid for medical or dental services for the child under **Medicaid** for which the **Plan** was liable, the state may seek to recover those amounts paid from the **Plan**.

## *Special Enrollment Rights*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with certain special enrollment rights pertaining to your health care coverage. If you decline enrollment for yourself or your **dependents** (including your **spouse**) because of other health coverage (such as coverage through another employer), you may in the future be able to enroll yourself, your **spouse**, or your child(ren) in the WellSpan Population Health Services-sponsored coverage, provided that you request enrollment within 31 days after the other coverage ends. You must request this enrollment in writing.

Also, in the case of a birth, marriage, adoption, or placement for adoption, there may be a right to enroll in the **Plan**. These requests must also be made within 31 days after the birth, marriage, adoption, or placement for adoption. You must provide documentation of the event.

If you or your **dependents** are entitled to a special enrollment, you are allowed to enroll in all available benefit options and to switch to another option if your **spouse**, or child(ren) have special enrollment rights.

## *Special Enrollment Periods*

If you or your **dependents** (**spouse**, or child) are eligible, but not enrolled in this **Plan**, you may be able to enroll if you experience a loss of eligibility for other coverage due to the following reasons:

- You or your **dependents** were covered under another group health plan or had health coverage at the time coverage under this **Plan** was previously offered (either initially or during an open enrollment period); and
- If required by the WellSpan Population Health Services Group Health Plan, you stated in writing at the time that this coverage was offered that the other health coverage was the reason for declining enrollment; and/or
- You or your **dependents**, who lost coverage, were under **COBRA** continuation coverage and the **COBRA** coverage was exhausted, or you, your **dependent**, had non-**COBRA** coverage and either the coverage was terminated as a result of loss of eligibility or because employer contributions towards the coverage were terminated; and
- You or your **dependents** requested enrollment in this **Plan** not later than 31 days after the date of exhaustion of **COBRA** or the termination of non-**COBRA** coverage due to a loss of eligibility or termination of employer contributions. Coverage will begin on the first day of the month beginning after the date the completed request for enrollment is received (and you make your required contribution).

For special enrollment purposes, a loss of eligibility occurs if:

- You or your **dependents** had a loss of eligibility on the earliest date a claim is denied that meets or exceeds a lifetime limit on all benefits;

- You or your **dependents** had a loss of eligibility due to the other plan no longer offering benefits to a class of similarly situated individuals (for example, part-time **employees**);
- You or your **dependents** had a loss of eligibility when individual coverage is through an HMO, or other arrangement, that does not provide benefits to persons who no longer reside, live, or work in the plan's service area (regardless, if this is your or your **dependents'** choice) and no other benefit package is available; or
- You or your **dependents** had a loss of eligibility when group coverage is through an HMO, or other arrangement, that does not provide benefits to persons who no longer reside, live, or work in the plan's service area (regardless, if this is your, your **dependents'** choice) and no other benefit package is available.



**There is no special enrollment right if you, your child(ren), or spouse lost the other coverage because required COBRA premiums or plan contributions were not made.**

Your **dependents** may have a special enrollment right if:

- You are a participant under this **Plan** (or have met the **waiting period** and are eligible to be enrolled under the **Plan** except for a failure to enroll during a previous enrollment period); and
- A person becomes your **dependent** through marriage, birth, adoption, or placement for adoption.

Your **spouse, dependent** child, or (and if not otherwise enrolled, you) may then be enrolled under this **Plan**. In the case of birth or adoption of a child, your **spouse** may be enrolled if the **spouse** is otherwise eligible for coverage. If you are not enrolled at the time of the event, you must enroll under this special enrollment period in order for your **dependents** to enroll.

## Change in Family Status

In addition to making changes during the open enrollment or special enrollment periods, you (or your covered **dependents**) can also change your benefit elections after a qualified status change. Status changes include:

- Your marriage, divorce, legal separation, or annulment;
- The birth, adoption, placement for adoption, or appointment of legal guardianship of your child;
- Your death;
- The death of your **spouse**, or **dependent** child;
- Your **spouse**, or **dependent** child losing or gaining other coverage;
- A change in your (or your **dependent's**) employment status due to a switch between full-time and part-time, union and management, or exempt and non-exempt status; a strike or lockout; or an unpaid **leave of absence**;

- A significant change in cost or coverage under a health plan;
- An open enrollment for your **spouse's** benefit plans (all benefit changes you make must be consistent with the offerings in your **spouse's** plans);
- A mid-year plan offering through your **spouse's** employer (all benefit changes you make must be consistent with the offerings in your **spouse's** plans);
- A change in your **dependent's** eligibility (for example, due to being over the age limit);
- A change in your (or your **dependent's**) place of residence or worksite;
- Your requirement to cover your **dependent** according to a judgment, decree, or order resulting from your divorce, legal separation, annulment, or change in legal custody;
- Your (or your **dependent's**) eligibility for **COBRA**;
- Your (or your **dependent's**) eligibility for **Medicare** or **Medicaid** (you may change the current election for the eligible person only); or
- Any other event that qualifies as a life status change under the Internal Revenue Code (with the approval of the **Plan Administrator**).



**You will need to change your elections within 31 days of your change in status. Enrollment/change forms are available from the Employee Benefits, WellSpan Health Human Resources Department or are available through the WellSpan INET. You must also provide documentation of the change in status when you request a change in your coverage.**

Any changes you make in your coverage must be consistent with your status change. If you don't change your coverage within 31 days, you will have to wait until the next open enrollment period to make new elections.

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## About Cost

You and WellSpan Health share the cost of your dental coverage. Your share of the cost is paid with pre-tax dollars. By using pre-tax dollars, your contributions are deducted from your pay before federal, state, and local taxes are calculated, so you pay less in taxes. This pre-tax feature is not available for certain positions, such as Per Diem. You will receive cost information when you are first hired and at each open enrollment period. Or, you may contact Human Resources for specific cost information.

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## When Coverage Begins

The date your coverage begins depends on when you become eligible and enroll, as explained in the chart below.

If this is your situation...	You and/or your dependents' coverage will begin:
<p>You are a new full-time employee, part-time, or per diem <b>employee</b> and you enroll within 31 days of your employment date.</p>	<p>→ On the first day of the month following your first day of work if you make your required contribution. Otherwise, your coverage begins on the first day of the second month following your first day of work.</p>
<p>You enroll during open enrollment.</p>	<p>→ On the following January 1st.</p>
<p>Your coverage changes due to a change in family status or special enrollment right.</p>	<p>→ On the first day of the month after your form is received and processed if you make your required contribution. (Coverage for <b>dependents</b> acquired through birth, adoption or placement for adoption begins on the date of birth, adoption or placement for adoption and continues for 31 days. You will need to notify Human Resources during this time if you want to continue coverage).</p>

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## Situations Affecting Your Dental Coverage

### *Employees on Military Leave*

**Employees** going into or returning from military service will have **Plan** rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). The maximum period of coverage of the **employee** and their covered **dependents** under such an election will be the lesser of:

- The 24-month period beginning on the date on which the **employee's** absence begins; or
- The day after the date on which the **employee** fails to apply for a return to a position of employment, as determined by USERRA.

An **employee** who elects to continue coverage under this section will be subject to the *WellSpan Health Leave of Absence Policy*.

An **employee** who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the **Plan** upon re-employment. Upon re-employment and reinstatement of coverage no new exclusions or **waiting period** will be imposed in connection with the reinstatement of such coverage if an exclusion or **waiting period** would normally have been imposed. These rights apply only to **employees** and their covered spouse, or **dependents** covered under the **Plan** before leaving for military services.

## If You Are on a Leave of Absence

If you are on a WellSpan Health-approved **leave of absence** — such as a family or medical leave — you may continue your dental coverage by paying your share of the cost, as defined in the WellSpan Health Leave of Absence Policy. If you do not return to work after your approved **leave of absence** is over, you may be able to continue dental coverage for yourself and your covered **dependents** through a federal law called COBRA. See the heading “Continuation of Coverage Under **COBRA**” later in this section for specific information. Remember, there are time limits within which you must contact the **Plan** when certain **COBRA** qualifying events occur.

## If Your Employment Ends

If your employment with WellSpan Health ends, you may continue the coverage outlined in this guide, for yourself, **spouse**, or **dependent** child(ren) through a federal law called **COBRA**. See the heading “Continuation of Coverage Under COBRA” later in this section for specific information.

## Change in Enrollment Status

When you and/or a **dependent** changes enrollment status, such as:

- Changing status from a **dependent** to an **employee**
- Changing status from an **employee** to a **dependent**, or
- Being rehired by WellSpan Health

the **Plan** will be guided by the following rules:

- When coverage is continued (including **COBRA** coverage) after an enrollment status event and coverage has been continuous, credit will be given for applicable deductibles and amounts applied to benefit maximums;
- When coverage is resumed and less than 6 months have passed since coverage terminated under the **Plan**, credit will be given for applicable deductibles and amounts applied to benefit maximums; or
- When coverage under the **Plan** is resumed after a period of 6 months, it will be treated as “new coverage.” This means that you or your **dependents** will be required to satisfy all eligibility and enrollment requirements and no credit will be given for deductibles or amounts applied to benefit maximums.



**If you or your *dependent* lose eligibility or waive coverage under this *Plan*, while you continue to be an *active employee*, then later regain eligibility or elect coverage, re-enrollment will not be considered an enrollment status event subject to the *Plan* rules explained above. In these cases, credit will be given for applicable deductibles and amounts applied to benefit maximums, regardless of the time between enrollment periods.**

## *If You Retire*

If you retire, you may continue the coverage outlined in this SPD, for yourself, **spouse**, or **dependent** child(ren) through a federal law called **COBRA**. See the heading “Continuation of Coverage Under COBRA” later in this section for specific information.

## *If You Become Disabled*

If you become **disabled**, your dental coverage will continue as defined in the WellSpan Health Leave of Absence Policy. You may be responsible for paying for a portion or the entire cost of the coverage. Contact the Human Resources Department for details. If you do not return to work, you may be able to continue dental coverage for yourself and your covered **spouse**, or **dependent** child(ren) through a federal law called **COBRA**. See the heading “Continuation of Coverage Under COBRA” later in this section for specific information. Remember, there are time limits within which you must contact the Plan when certain **COBRA** qualifying events occur.

## *If You Die*

If you die while an **active employee**, your covered **dependents** may continue dental coverage through a federal law called **COBRA**. See the heading “Continuation of Coverage Under COBRA” later in this section for specific information.

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## **When Coverage Ends**

### *When Your Coverage Ends*

**Your dental coverage ends on the earliest of the following events:**

- The day the **Plan** is terminated;
- The last day of the month in which your **active employment** ends;
- The last day of the month in which you are no longer eligible for coverage under the **Plan**;
- The last day of the month of an FMLA leave, if you do not return to work at the end of the leave; or
- The last day of the month in which your last contribution for coverage is received.



**Under certain circumstances, you may continue your dental coverage. See “Situations Affecting Your Dental Coverage” earlier in this section for additional information.**

### *When Your Dependents’ Coverage Ends*

Your covered **dependents’** coverage will end on the earliest of the following events:

- The day the **Plan** is terminated;
- The day **dependent** coverage is terminated under the **Plan**;
- The day your coverage ends;
- The last day of the month in which you die while an **active employee**;
- The last day of the month in which they are no longer eligible for coverage as **dependents**;  
or
- The last day of the month in which the last contribution for coverage is received.

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## Coordination of Benefits (C.O.B.)

If you or your covered **dependents** have additional dental coverage through another health care plan — such as another employer’s dental plan or **Medicare** — your benefits through that plan will be coordinated with your WellSpan Health Group Health Plan. Be sure to indicate if you have additional coverage when you enroll and when you file any **claim** forms.

### *How Coordination of Benefits Works*

This **Plan** option will always pay either its regular benefits or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of the “allowable expenses” under this **Plan** option. Be sure to indicate if you have additional coverage when you enroll and when you file any **claim** forms.

If the WellSpan Population Health Dental benefits are primary, it will provide the scheduled amount of benefits. If this **Plan** is secondary, it will pay a reduced amount which, when added to the benefits payable by the primary plan, will not exceed 100% of the “allowable expenses.” In no case will this **Plan** pay more than its scheduled amount of benefits.

Reimbursement is limited to the “allowable expenses” under this **Plan**. This means those charges which the **Plan** normally considers eligible for benefits for you or your **dependents**, and not expenses this **Plan** excludes, even if the primary carrier considers it to be an eligible expense under that plan.

When the WellSpan Population Health Dental benefits are secondary, “allowable expenses” will not include any amount that is not payable by the primary plan as a result of a contract between the primary plan and a dental **provider** when that **provider** agrees to accept a reduced payment and not bill the patient. Additionally, allowable expenses do not include charges for services provided to an HMO participant by a dental **provider** that is not a member of that HMO, unless the patient was authorized by the HMO to receive treatment outside of the HMO. Lastly, allowable expenses will not include charges refused by another plan as a penalty assessed because of non-compliance with the plan’s rules.

Below are examples of how C.O.B. is calculated under the WellSpan Population Health Dental benefits.

Without C.O.B.			
Example 1		Example 2	
▪ Total cost of dental services for your spouse	\$300	▪ Total cost of dental services for your spouse	\$800
▪ Spouse not covered by another plan	N/A	▪ Spouse not covered by another plan	N/A
▪ Benefits paid by your plan at 75%	<u>\$225</u>	▪ Benefits paid by your plan at 50%	<u>\$400</u>
▪ Total benefits paid	\$225	▪ Total benefits paid	\$400
▪ Your out-of-pocket cost	\$75	▪ Your out-of-pocket cost	\$400
With C.O.B.			
▪ Total cost of dental services for your spouse	\$300	▪ Total cost of dental services for your spouse	\$800
▪ Benefits paid by spouse's plan at 50% (primary)	\$150	▪ Benefits paid by spouse's plan at 80% (primary)	\$640
▪ Benefits paid by your plan at 75% (secondary)	<u>\$150</u>	▪ Benefits paid by your plan at 50% (secondary)	<u>\$160</u>
▪ Total benefits paid	\$300	▪ Total benefits paid	\$800
▪ Your out-of-pocket cost	\$0	▪ Your out-of-pocket cost	\$0



If you submit a secondary claim for benefits under your dental benefits, and even if no benefits are paid, any visit or quantity limitations will be applied.

## Benefit Determination Order

The rules establishing the order of benefits determination are as follows. If your situation is not explained below, contact WellSpan Health Dental for more information.

- A plan that does not contain a coordination of benefits provision or similar provision will be primary before benefits under this **Plan**.
- The benefits of a plan which covers an employee as primary will be determined before the benefits of the plan that covers the person as a dependent (or secondarily). For example, when both plans have a C.O.B. provision, this is how the primary plan is determined for an employee and spouse.

If you are:	And the second plan is provided by the:	And expenses are for the:	Then the WellSpan Health Group Health Plan is:
Employee	Spouse's Employer	Employee	Primary
Spouse	WellSpan Health Employee	Spouse	Secondary
Adult Dependent Child	Adult Dependent Child's Spouse	Adult Dependent Child	Secondary

- For dependent children whose parents are married or living together (whether or not they have ever been married) the following benefit determination order will be used:
  - The plan benefits of the parent whose birthday falls earlier in the **calendar year** (only month and date) will be primary.



- If both parents have the same birthday, the plan that covered the parent longer will be primary.
- If the other plan determines the order of benefits based on the gender of the parent, instead of using the parents' birthdays, this **Plan** will also use the gender rule to determine which plan is primary.
- For dependent children whose parents are separated or divorced or are not living together (whether or not they have ever been married) the following benefit determination order will be used:
  - If a court decree exists stating that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the same benefit determination rules will apply as those for parents who are married or living together.
  - If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan.
  - If there is no court decree stating which parent has responsibility for the dependent child's health care expenses or health care coverage, the order of benefits are as follows:
    - The plan covering the custodial parent;
    - The plan covering the custodial parent's spouse;
    - The plan covering the non-custodial parent; and then,
    - The plan covering the non-custodial parent's spouse.
  - For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order if benefits are determined, as applicable, as if those individuals were parents of the child.
  - The plan that covers a person as an active employee (who is neither laid off nor retired or as a dependent of an active employee) is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
  - If a person whose coverage is provided through **COBRA** continuation coverage or under a right of continuation due to state or federal law is covered under another plan, the plan covering the person as an employee, subscriber, or retiree or covering the person as a dependent of an employee, subscriber, or retiree is the primary plan and the plan covering the person under the continuation coverage is the secondary plan.
  - If a plan contains order of benefit determination rules that declares that plan to be excess or always secondary to all other plans, this **Plan** will coordinate benefit as follows:
    - If this **Plan** determines itself to be primary based on its C.O.B. rules, it will provide benefits on a primary basis.
    - If this **Plan** determines itself to be secondary based on its C.O.B. rules, it will provide benefits first, but the amount of benefits payable will be determined as if this **Plan** were the secondary plan.
    - When a primary plan that is designed to provide a secondary level of benefits when this **Plan** is secondary, this **Plan** will determine its secondary liability as if the primary plan has provided a primary level of benefits. This **Plan** will calculate its secondary liability by reducing benefits by the amount it would have paid had it been primary.

- If the person has **Medicare** due to age or **disability**, this **Plan** will pay primary, secondary, or last to the extent stated in federal law.

## *Automobile Benefits*

The WellSpan Health Group Health Plan is not to be elected as a primary coverage in lieu of automobile benefits. This **Plan** will always be considered the secondary carrier regardless of the individual's election under an automobile policy.

## *Right to Receive or Release Necessary Information*

To administer C.O.B., this **Plan** may give or obtain information from another carrier, insurer, or from any other organization or person to the extent permitted by law. In many situations, this information may be given or obtained without the consent or notice to any person. You and/or your **dependents** are required to give this **Plan** the information it asks for about any other plans and their payments.

## *Right of Recovery*

If this **Plan** pays benefits that should be paid by another benefit plan, this **Plan** may recover the amount paid from the other benefit plan or from you.

If this **Plan** pays benefits that are later found to be greater than the allowable expense, this **Plan** may recover the amount of the overpayment from the **provider** or **covered person** that it was paid.

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## **When the Plan May Recover Payment (Subrogation)**

WHEN THIS PROVISION APPLIES: If you, your **spouse**, one of your **dependents**, or anyone who receives benefits under this **Plan** becomes ill or is **injured** and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the **Plan** which total in excess of \$5,000 are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the **Plan**.

As a condition of receiving benefits under this **Plan**, the **employee** or **covered person** agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the **Plan** 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. An **employee** or **covered person** may choose any attorney; however, that attorney must agree not to assert the Common Funds or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial, or other sufficiency. If the **injured** person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The **employee** or **covered person** agrees to sign any documents requested by the **Plan** including but not limited to, reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the **employee** or **covered person** agrees to furnish any other

information as may be requested by the **Plan** or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the **Plan** from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical or dental expenses paid by the **Plan**. Any excess after 100% reimbursement of the **Plan** may be divided up between the **employee** or **covered person** and their attorney, if applicable. Any **accident** related claims made after satisfaction of this obligation shall be paid by the **employee** or **covered person** and not the **Plan**.

The **employee** or **covered person** agrees to take no action that in any way prejudices the rights of the **Plan**. If it becomes necessary for the **Plan** to enforce this provision by initiating any action against the **employee** or **covered person**, then the **employee** or **covered person** agrees to pay the **Plan's** attorney's fees and costs associated with the action regardless of the action's outcome.

The **Plan Administrator** has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes, as it deems necessary.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

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## Continuation of Coverage Under COBRA

### *The COBRA Continuation Coverage Option*

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (**COBRA**) requires most employers sponsoring group health plans to offer **employees** and their families the opportunity to temporarily extend their health coverage (continuation coverage) at group rates in certain instances (**COBRA** qualifying events) when coverage under the plan would otherwise end. This notice summarizes your rights and obligations under the continuation of coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.



The **Plan Administrator** is WellSpan Health. The **Plan Administrator** is responsible for administering **COBRA** continuation coverage and can be contacted at the WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402 or 717-851-5959.

### *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 section. **COBRA** continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the **Plan** because of a qualifying event. Depending on the type of qualifying event, **employees**, **spouses** of **employees**, and **dependent** children of **employees** may be qualified beneficiaries. Under the **Plan**, qualified beneficiaries who elect **COBRA** continuation coverage must pay for **COBRA** continuation coverage.

If you or your **dependents** choose continuation coverage, WellSpan Health will provide you with the same coverage provided to **active employees** and their family members under its **Plan**. This means that if the coverage for active employees and their family members is modified, your

continuation coverage will also be modified. You may only continue coverage in plan options you had when **COBRA** rights began, not add coverage in other plan options. If no coverage existed immediately prior to the qualifying events listed below, no **COBRA** continuation coverage is available.

For example, if you had medical and dental coverage while an **active employee**, when you have a qualifying event for **COBRA**, you may only choose to continue medical, dental or both types of coverage, but not add coverage – such as vision. You may be able to change coverage under **COBRA** under certain circumstances, such as when you experience a family status change or during open enrollment.

## *COBRA Qualifying Events*

If you are an **employee** and covered by the WellSpan Health Group Health Plan, you will become a qualified beneficiary if you lose your dental coverage because either one of the following qualifying events occur:

- Termination of your employment for any reason other than for your gross misconduct; or
- Reduction of your hours of employment.

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

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

Your **dependent** children will become qualified beneficiaries if they lose dental coverage because any of the following qualifying events occur:

- The parent-**employee** dies;
- The parent-**employee's** hours of employment are reduced;
- The parent-**employee's** employment ends for any reason other than for their gross misconduct;
- The parent-**employee** becomes entitled to (which means enrollment in) **Medicare** (Part A, Part B, or both);
- The parents become divorced or legally separated;

- The child stops being eligible for coverage under the **Plan** as a **dependent** child, for example, when a child turns 26.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to WellSpan Health, and that bankruptcy results in the loss of coverage of any retired **employee** covered under the **Plan**, the retired **employee** is a qualified beneficiary with respect to the bankruptcy. The retired **employee's spouse**, surviving **spouse**, and **dependent** children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the **Plan**.

## *Your Employer's Responsibility Under COBRA*

The WellSpan Health Group Health Plan will offer **COBRA** continuation coverage to qualified beneficiaries only after the **Plan Administrator** has been notified that a qualifying event has occurred.

The **employer** must notify the **Plan Administrator** of the qualifying event within 30 days of any of these events:

- 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
- Entitlement (which means enrollment) of the **employee** to **Medicare** (Part A, Part B, or both).

## *Your Responsibility Under COBRA*

**You** must notify the **Plan Administrator** for these other qualifying events:

- Divorce or legal separation of the **employee** and **spouse**
- A **dependent** child's losing eligibility for coverage as a **dependent** child.



**You are required to notify the *Plan Administrator* within 60 days after the qualifying event occurs. Notice must be given to the Employee Benefits, Human Resources Department. Notice may be provided by e-mail, letter (certified mail, return receipt requested) or in person at the WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402.**

**If you fail to provide the notice within the 60-day period, the *spouse*, or child's coverage will cease at the end of the month in which the divorce, legal separation, or the child's loss of eligibility status occurs, and coverage cannot be continued under *COBRA*.**

When coverage is lost due to the reasons set forth below, you must provide documentation as shown beside each reason:

- Death of the **employee** - death certificate;
- Legal separation or divorce - copy of legal separation papers or divorce decree;

- Entitlement (which means enrollment) of the **employee** to **Medicare** – copy of **Medicare** identification card.

Once the **Plan Administrator** receives notice that a qualifying event has occurred, **COBRA** continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects **COBRA** continuation coverage, **COBRA** continuation coverage will begin on the date that coverage would otherwise have been lost.

## *Newly Acquired Dependents*

A qualified beneficiary may elect coverage for a **dependent** acquired during **COBRA** continuation coverage. All enrollment requirements that apply to **dependents** of **active employees** apply to **dependents** acquired by qualified beneficiaries during **COBRA** continuation coverage.



**Notice must be given to the Employee Benefits, Human Resources Department within 31 days or during open enrollment. Notice may be provided by e-mail, letter (certified mail, return receipt requested) or in person at the WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402.**

With one exception, newly acquired **dependents** are not considered to be qualified beneficiaries. Their coverage will end when the qualified beneficiary's coverage ends and will not be extended if the qualified beneficiary experiences a second qualifying event. However, if the former **employee** adds a newborn child, an adopted child, or has a child placed for adoption while covered under **COBRA** continuation coverage, that child will be considered a qualified beneficiary.

Adding a newly acquired **dependent** may cause an increase in the amount you must pay for **COBRA** continuation coverage.

## *Length of Continuation Coverage*

You and your qualified **dependents** may elect to continue dental coverage for up to 18 months, if group coverage ends because:

- Your employment is terminated (voluntarily or involuntarily), except if your employment is terminated due to gross misconduct; or
- Your employment hours are reduced.

Your **spouse**, and/or **dependent** children may extend or individually elect dental coverage for up to 36 months if group coverage ends due to:

- Your death;
- Divorce or legal separation; or
- Your entitlement to (which means enrollment in) **Medicare** (Part A, Part B, or both).

Your eligible **dependent** children may individually elect dental continuation coverage for up to 36 months if they lose their **dependent** eligibility because:

- They reach their 26<sup>th</sup> birthday.

Dental coverage may be continued under any one of these qualifying events without proof of good health.

### *Special Rules for Disabled Qualified Beneficiaries*

If you or your covered **dependent** is **disabled**, as determined by the Social Security Administration, at the time of the **COBRA** qualifying event or during the 60-day period following the **COBRA** qualifying event, you or a family member must notify the **Plan Administrator**. This notice should be sent to: Employee Benefits, WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402.

This notification must be made within 60 days of the Social Security Administration's determination of **disability** and before the end of the original 18-month continuation coverage period.

You or any of your eligible **dependents** may continue your **COBRA** coverage for up to 29 months from the date of the qualifying event if your group coverage ends because of one of the **COBRA** qualifying events listed above and:

- You or your **dependent** is considered **disabled** by the Social Security Administration at the time your employment ends; or
- You or your **dependent** is considered **disabled** by the Social Security Administration during the first 60 days of your **COBRA** coverage.

When you (or a **dependent**) receive notice from the Social Security Administration verifying that you are eligible for Social Security disability benefits, you must notify the **Plan Administrator** within 60 days of the determination and within 18 months of the original qualifying event.

If you (or a **dependent**) are receiving Social Security Administration disability benefits, and the Social Security Administration subsequently determines that you are no longer **disabled**, you must notify the **Plan Administrator** within 30 days of the Social Security Administration's final determination.

### *Second Qualifying Event Extension of 18-Month Period of Continuation Coverage*

If your family experiences another qualifying event while receiving **COBRA** continuation coverage, the **spouse**, and **dependent** children in your family can get additional months of **COBRA** continuation coverage (as long as they are considered to be qualified beneficiaries), up to a maximum of 36 months. This extension is available to the **spouse**, and **dependent** children if:

- You (as the former **employee**) dies;
- Your entitlement to (which means enrollment in) **Medicare** (Part A, Part B, or both);

- Your divorce or legal separation; or
- Your child ceases to be eligible as a **dependent** child under the **Plan**.



**These events can be a second qualifying event only if they would have caused a loss of coverage under the *Plan* if the first qualifying event had not occurred. In all of these cases, you must make sure that the *Plan Administrator* is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Employee Benefits, WellSpan Health Human Resources Department, 3350 Whiteford Road, York, PA 17402.**

When the qualifying event is due to the reasons set forth below, you must provide documentation as shown beside each reason:

- Death of the **employee** - death certificate;
- Legal separation or divorce - copy of legal separation papers or divorce decree; or
- Entitlement (which means enrollment) of the **employee** to **Medicare** – copy of **Medicare** identification card.

## *How to Elect COBRA*

When the **Plan Administrator** receives your timely written notice of a divorce or legal separation, or a child's loss of eligibility status, the **Plan Administrator** will send you information on how to elect **COBRA** continuation coverage.

The **Plan Administrator** will automatically send you information on how to elect **COBRA** continuation coverage if you, your **spouse**, and/or your children will lose coverage because of:

- Termination of your employment – except when your employment ends due to gross misconduct;
- Reduction in your hours of employment;
- Your death; or
- Your entitlement to (which means enrollment) **Medicare** (Part A, Part B, or both).



**When you receive this information, read it carefully and respond within the time indicated in the notice.**

To elect **COBRA**, you must complete and return the election form included in the notice you receive, and you must pay the monthly premiums for **COBRA** continuation coverage specified in the notice.



## *If You Fail to Elect COBRA*

If you do not choose **COBRA** continuation coverage within the time allowed, your group dental coverage will end at the end of the month in which the qualifying event occurs.

## *Cost of Continuation Coverage*

Each individual who elects to continue coverage under **COBRA** must pay the full cost of coverage, plus 2% for administrative expenses. You pay for **COBRA** continuation coverage in monthly premiums that are due on the first day of each month. Payments not received within 30 days after your premium is due will result in loss of coverage retroactive to the day before your premium was due. Your first payment must be made within 45 days after you elect **COBRA** continuation coverage and, is retroactive to the date you lost coverage.

An administration fee equal to 50% of the full cost of coverage may be charged for **COBRA** continuation coverage for qualified disabled individuals beginning with the 19th month and continuing until **COBRA** coverage terminates. That means if you were disabled individual, for the first 18 months of **COBRA** coverage, you would pay 102% monthly, and for the remaining coverage period you would pay 150% monthly. This includes a second (different) qualifying event that would allow you up to 36 months of continuation coverage.

However, if a second qualifying event occurs within the original 18-month period of coverage, you cannot be charged more than 102% at any time during the 36-month period.

## *Loss of Continuation Coverage*

There are certain circumstances that will cut short the period during which you, your **spouse**, and/or children can have coverage continued under **COBRA**. These circumstances occur when:

- You fail to pay the monthly premium for the coverage within 30 days of its due date (or within 45 days, if it is the first monthly payment);
- You, your **spouse**, or child, become covered under any other group health plan which does not have exclusions or limitations regarding that person's own pre-existing conditions (if any);
- You, your **spouse**, or child, become entitled to (which means enrollment) **Medicare** (Part A, Part B, or both);
- WellSpan Health ceases to provide any group health plan to its **employees**; or
- You extended coverage for up to 29 months due to your disability, and there has been a determination that you are no longer disabled.

## *Proof of Insurability Not Required for COBRA*

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all the costs for your continuation coverage. You will have a grace period of 30 days in which to pay the premium. The law also says that at the end of the 18-month or 36-month continuation coverage period, you must be allowed to enroll in any individual conversion health plan then provided under the WellSpan Health Group Health Plan for

**employees**, if available. The **Plan** options described in this guide do not have an individual conversion option available.

## *How COBRA Applies if You Are on FMLA Leave*

The Family and Medical Leave Act of 1993 (FMLA) allows you to continue your (and your covered **dependents**) participation in a WellSpan Health-sponsored benefit plan as long as:

- Your leave is approved by WellSpan Health;
- You participate in the **Plan** before you begin your leave; and
- You make the required contributions for your coverage while on leave.

While you are on FMLA leave, your required contributions will be the same as your contributions as an **active employee**. Payments are due by the first of the month for that month's coverage. You must send your payment by the due date to the appropriate person/department to continue your benefits during your leave.

If you add a new **dependent** while you continue your coverage on an approved FMLA leave, your new **dependent** will be eligible for the coverage under the same terms as for **active employees**.

If you do not return to work after your FMLA leave, you may be required to reimburse WellSpan Health for contributions paid on your behalf during your leave.

Your continued coverage while on FMLA leave will end on the earliest of the following events:

- The date you fail to make the required contribution for your coverage;
- The date that WellSpan Health determines your approved FMLA leave is terminated; or
- The date coverage is no longer offered to the group to which you belong.

Your covered **dependents'** continued coverage will not be continued beyond the date it would otherwise end. See the heading "When Your Dependents' Coverage Ends" for a list of events.

If your coverage under the WellSpan Health-sponsored benefit **Plan** ends because your approved FMLA leave is terminated, you may be able to continue your coverage under **COBRA**.

Your continued coverage under **COBRA** will be available under the same terms as though you had stopped working for WellSpan Health on the date your approved FMLA leave ended.

## *Questions*

If you have questions about your **COBRA** continuation coverage, you should contact the Employee Benefits, WellSpan Health Human Resources Department, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security

Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the **Plan Administrator** informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to or receive from the **Plan Administrator**.

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## About the WellSpan Population Health Dental Benefits

The WellSpan Population Health Dental benefits do not utilize a Preferred Provider Organization. You may choose any **dentist** or **physician** to provide you with dental services.

If you have any questions about your coverage or **claims**, call WellSpan Population Health at (800) 842- 1768 or (717) 851-6800.

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## How the Plan Works

Each time you or your covered **dependents** need dental care, you may choose your provider. Your level of benefits will not depend upon which **provider** you choose.

*The following table shows the steps to take when you need dental care.*

<b>Step 1</b>	Choose any dental <b>provider</b> and make an appointment.
<b>Step 2</b>	Go see the <b>dentist</b> or <b>physician</b> . You may have to pay the full amount for services immediately.
<b>Step 3</b>	Complete a <b>claim</b> form for reimbursement using forms available in Human Resources or from WellSpan Population Health.
<b>Step 4</b>	You can pay your bill at the time of service or authorize your <b>provider</b> to file a <b>claim</b> . You are responsible for paying any expenses not covered by your benefits.
<b>Step 5</b>	File <b>claims</b> with WellSpan Population Health Dental. You will be reimbursed according to <b>usual and reasonable</b> fees, after your deductible is satisfied and subject to any coinsurance.



### Terms You Should Know

In this section, terms with **Plan-specific** definitions are shown in bold, italicized text. For example, **lifetime** has a special meaning under the terms of this **Plan**, and will always be shown in bold, italicized text. You can find a list of defined terms at the end of this document, under the section "Terms You Should Know."

## Your Out-Of-Pocket Costs

Your out-of-pocket costs depend on the type of service that you receive. Your out-of-pocket costs include the **calendar year** deductible, coinsurance, amounts that exceed **calendar year** or **lifetime** maximums, and any expenses that exceed the **usual and reasonable charge**.

### Annual Deductible

The annual deductible is the amount you pay each **calendar year** before certain benefits are paid. The WellSpan Population Health Dental benefits have a \$50 individual deductible and a \$150 family deductible. The family deductible can be met by any number of family members — however, one family member may not contribute more than the individual deductible (\$50) toward the family limit.

The chart below illustrates how the family deductible works.

Example 1		
For an employee, spouse and 2 children (4 covered individuals)...	...if the employee, spouse and 1 child each meet the \$50 deductible, (\$50 X 3 = \$150)...	.. then the remaining child would not have a deductible to meet because the family deductible is satisfied.
Example 2		
For an employee, spouse, and 3 children (5 covered individuals)...	...if each family member pays \$30 in deductibles, they would meet the family deductible (\$30 X 5 = \$150)...	...which means that no family member paid the full \$50 deductible individually before the family deductible was satisfied.

This annual deductible also includes a carry-over feature. Here's how it works. Any **covered charges**, with service dates in October, November, or December, that are applied to your deductible will be carried over to reduce the deductible amount for the following **calendar year**.

### Coinsurance

Coinsurance refers to the percentage the **Plan** pays for **covered charges**.

The amount of the coinsurance depends upon the type of service you receive. Generally, if you receive preventive or diagnostic care (Class A) the coinsurance is 100%. Basic dental services (Class B) are considered at 75% and major dental services (Class C) are paid at 50%. If you receive **orthodontic** services (Class D), the coinsurance is 50%.

### Annual Maximum

Each **calendar year**, the dental coverage will pay up to \$1,500 per individual for all eligible dental expenses.



**Class A services including initial examinations, prophylaxis, periodic oral examinations, bitewing x-rays, panoramic x-rays, full mouth series x-rays, and eligible fluoride treatment are exempt from the annual maximum. Additionally, Class D orthodontia expenses do not apply towards the annual maximum.**

## *Orthodontic Lifetime Maximum*

Benefits are limited to a \$1,500 **lifetime** limit, per individual, for **orthodontic** treatment. X-ray and extraction procedures that are incidental (secondary) to the **orthodontic** treatment will not be covered under this maximum but may be covered under Class A or Class B services.

## *Pre-Determination of Dental Benefits*

One of the advantages of the WellSpan Population Health Dental benefits is that you can find out the benefits for expensive dental work before your **professional provider** begins treatment. This is called “pre-determination of benefits.”



**This program is voluntary and is meant to help you understand how much the Plan will pay and how much you may owe your provider.**

Before starting expensive work, your **dentist** or **physician** will complete a treatment plan that explains the services that you need. By putting this information in writing, WellSpan Health Dental can review the treatment plan and let you and your **provider** know, in advance, the benefits allowable under your dental coverage and how much you may be responsible for paying your dental **provider**.

Your **dentist** or **physician** should send a pre-determination of benefits when the estimated charge is more than \$300. A pre-determination of benefits is not a guarantee that **claims** will be paid. The actual payment will be based upon your coverage and benefits on the date each service is performed.

Pre-determination of benefits is recommended for the following procedures:

- Special **restoratives**;
- Removable **prosthodontics**;
- Fixed **prosthodontics**;
- **Endodontics**;
- Oral surgery (except emergency procedures);
- **Periodontal** treatment; and
- **Orthodontic** treatment plans.

## *Alternate Treatment*

If alternate services or supplies can be used to treat your dental condition, **covered charges** will be limited to the services or supplies that are usually used nationwide to treat that **sickness** or **injury**. These alternate services or supplies must be recognized by the dental profession to be an appropriate way to treat dental conditions in accordance with broadly accepted national standards of dental practice, while taking into account your total oral condition.

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## **What Is Covered**

The following services are covered under the WellSpan Population Health Dental benefits

at the level specified. For expenses to be covered, they must be:

- Incurred while you are covered under the **Plan**;
- **Medically necessary** and/or appropriate dental treatment; and
- Provided by a covered health care **provider**, where appropriate.

If you have any questions regarding a specific **covered service**, please call WellSpan Population Health at (800) 842-1768 or (717) 851-6800.

TYPE OF EXPENSE	BENEFITS
<i>MAXIMUM BENEFITS PER INDIVIDUAL</i>	
Preventive and Diagnostic, Basic, and Major services combined (Class A, B, and C)	\$1,500 per <b>calendar year</b>
<b>Certain services under Class A are exempt from the <i>calendar year</i> maximum. See the heading “Class A – Diagnostic and Preventive Care” below for details.</b>	
Orthodontic services	\$1,500 per <b>lifetime</b>
<i>DEDUCTIBLE PER CALENDAR YEAR</i>	
Per Individual Basic, Major, and Orthodontic services combined (Class B, C, and D)	\$50
Per Family Unit Basic, Major, and Orthodontic services combined (Class B, C, and D)	\$150
<b>Deductible carry-over months: October, November, and December</b>	
<i>BENEFIT LEVEL</i>	
Class A - Preventive and Diagnostic services	100% of the <b><i>usual and reasonable charge</i></b>
Class B – Restorative/Basic services	75% of the <b><i>usual and reasonable charge</i></b> after the deductible
Class C - Major services	50% of the <b><i>usual and reasonable charge</i></b> after the deductible
Class D - Orthodontic services	50% of the <b><i>usual and reasonable charge</i></b> after the deductible
<b>Pre-Determination Limit</b>	\$300

## Class A – Diagnostic and Preventive Services

This benefit provides necessary procedures and techniques to assist the **dentist** in evaluating dental conditions and prevent the occurrence of dental abnormalities or disease. Class A benefits are payable at 100% of the ***usual and reasonable charge***. There is a ***calendar year*** maximum of \$1,500 combined with Class B and Class C services.



**Please note that benefits for initial examinations, prophylaxis, periodic oral examinations, bitewing x-rays, panoramic x-rays, full mouth x-rays, and eligible fluoride treatments are not applied toward the *calendar year* maximum.**

## *Routine Oral Examinations and Prophylaxis*

Benefits include two routine oral examinations and two routine prophylaxis - or teeth cleanings each **calendar year**.

## *X-Rays*

Necessary dental x-rays are covered with the following limitations:

- Full mouth and panoramic x-rays, not more than one time every three **calendar years**;
- Supplementary bitewing x-rays, not more than two times each **calendar year**; and
- Other dental x-rays necessary in connection with the diagnosis of a specific condition that requires treatment.

## *Fluoride Treatment*

For children through age 18, benefits include the topical application of fluoride once per **calendar year**.

## *Appliances*

Space maintainers and fixed appliances are covered for children through age 18. They are covered only if used to replace the premature loss of extracted teeth and are not made of precious metals.

## *Emergency Treatment*

The WellSpan Population Health Dental benefits cover emergency and palliative treatment - that is, treatment that relieves pain of acute problems that require immediate care.

## *Sealants*

Benefits are available for the topical application of a sealant, on a posterior tooth, for children through age 13. This benefit is limited to one treatment per tooth every three **calendar years**.

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## **Class B – Restorative/Basic Services**

This benefit includes necessary procedures to restore the teeth other than special **restoratives**. Benefits are payable at 75% of the **usual and reasonable charge** after the annual deductible. There is a **calendar year** maximum of \$1,500 combined with certain Class A services and Class C services.

## *Anesthesia*

Coverage provides benefits for general anesthesia, only when **medically necessary** and in connection with covered oral surgery or other covered dental services. I.V. sedation is covered only when **medically necessary** and when administered in conjunction with complex oral surgical procedures covered under the dental benefits.



## *Fillings*

Amalgams, silicate, acrylic, synthetic porcelain, and composite filling restoration to restore diseased or broken teeth are covered.

## *Endodontics*

Coverage includes benefits for **endodontic** treatment, including a pulpotomy, direct pulp capping, and root canal therapy.

## *Alveolectomy*

The preparation of the mouth for dentures, known as alveolectomy, is a **covered charge** under the dental benefits.

## *Apicoectomy*

Benefits include dental root resection, known as apicoectomy.

## *Gingival Treatment*

Coverage includes benefits for gingivectomy, gingivoplasty, gingival curettage, gingival flap procedure and mucogingivoplastic surgery (treatment of gum disease by conservative and/or surgical technique).

## *Surgery*

The WellSpan Population Health Dental benefits cover certain surgical procedures including;

- Bone (osseous) surgery in connection with **periodontal** disease, including flap entry and closure;
- Simple extractions;
- The surgical removal of maxillary or mandibular intrabony cysts; and
- Biopsies of the hard or soft oral tissue.

## *Periodontal Services*

The WellSpan Population Health Dental benefits cover periodontal scaling, root planning, and periodontal maintenance.

## *Services Related to Dentures*

Certain services related to dentures are covered under Class B. They include:

- Repairs and adjustments to full or partial dentures;
- Refining and rebasing of all or partial dentures, limited to one time every two **calendar years**; and

- Replacement of a broken tooth on a complete or partial denture, but not in connection with other repairs.

### *Repairs*

Coverage is available for repairs or recementing of crowns, inlays, onlays, or fixed partial dentures.

### *Antibiotics*

Antibiotics, which are injected by the attending **physician** or **dentist**, are covered.

### *Consultations by a Specialist*

Benefits cover consultations by a specialist when referred by the attending **dentist** or **physician**, limited to one consultation per consultant.

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## **Class C – Major Services**

This benefit includes necessary special **restorative** services. Benefits are payable at 50% of the **usual and reasonable charge** after the annual deductible. There is a **calendar year** maximum of \$1,500 combined with certain Class A services and Class B services.

### *Restorative*

Special **restorative** services are covered under the WellSpan Population Health Dental benefits. **Covered services** include:

- Single, unconnected crowns, inlay or onlay restorations to restore diseased or accidentally broken teeth. This is only covered when the tooth, as a result of excessive caries (cavities) or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling; and
- Initial installation of fixed dentures (including inlays and crowns as abutments) to replace one or more extracted natural teeth.

If a tooth can be restored with a material such as amalgam and you and your **professional provider** choose another type of restoration (such as gold or baked porcelain), the **covered charges** for the procedure actually performed will be limited to the **usual and reasonable charges** appropriate to the procedure if using amalgam or similar material.

Coverage is only available for charges for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or to restore occlusion are not covered.

### *Prosthodontics (Fixed and Removable Dentures)*

Certain services relating to **prosthodontics**, or dentures, are covered. Benefits include:

- Initial installation of a partial or fully removable denture to replace one or more extracted natural teeth; and

- Replacement of an existing partial or fully removable denture or fixed partial denture by a new denture or by a new fixed partial denture, or the addition of teeth to an existing partial removable denture or to a fixed partial denture. This benefit includes the following limitations:
  - Dental coverage will pay for the replacement or addition of teeth to replace one or more teeth extracted after the existing denture or fixed partial denture was installed; and
  - The existing denture or fixed partial denture cannot be made serviceable and at least five years have passed prior to its replacement. Charges made for adjustments to new dentures or fixed partial dentures during the first six months after they are installed are not covered. Those charges are considered to be included in the cost of the new denture or fixed partial denture. Other extra charges are also not covered under the dental benefits.

If a cast chrome or acrylic partial denture will restore a dental arch satisfactorily and you and your **dentist** select a more elaborate or precision appliance, the **covered charges** for the procedure performed will be limited to the **usual and reasonable charges** appropriate to the cast chrome or acrylic denture.

If you and your **dentist** decide on personalized restoration or specialized techniques as opposed to a standard procedure for complete dentures, the **covered services** for the procedure actually performed will be limited to the **usual and reasonable charges** appropriate to the standard procedure.

Charges for the replacement of an existing denture can be included as a covered dental expense only if the existing denture is not serviceable and cannot be made serviceable. Otherwise, the covered expenses for the replacement will be limited to the **usual and reasonable charges** appropriate for those services that would be necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be covered only if at least five years have passed since the date of the initial installation of the appliance.

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## **Class D – Orthodontic Services**

Benefits are payable at 50% of the **usual and reasonable charge** after the **calendar year** deductible. There is an individual **lifetime** maximum of \$1,500.

### *Comprehensive Orthodontic Treatment*

The dental benefits cover **orthodontic** treatment including:

- Preliminary studies including cephalometric radiographs, diagnostic casts, and treatment plans;
- The first month of active treatment including all active and retention appliances;
- Active treatment per month after the first month;
- Visits for retention and observation; and
- Not more than one appliance, per individual, including:
  - A fixed or cemented appliance for tooth guidance;
  - A fixed or cemented appliance to control harmful habits; or
  - A fixed or cemented retention appliance.

Each month of active treatment will be considered a separate dental service. The **Plan** will make payment over a period of time that will not exceed the length of the approved treatment plan. The first

payment will equal not more than 25% of total payment eligible under the **Plan**. The remaining 75% will be payable in equal quarterly payments during the treatment period and while you or your **dependent** has active coverage under the **Plan**. If the treatment is completed in less time than the original treatment plan, the **Plan** will make payment for the eligible amount remaining.



**If an *orthodontic* treatment plan began before there was coverage under a dental plan option sponsored by WellSpan Population Health, then this *Plan* will make its first payment after one month of active participation under this *Plan*. The maximum amount this *Plan* will pay for this treatment will take into account the period in which you or your *dependent* was covered. This means if there are three months until the end of the treatment, this *Plan* will only make payment for those three months, not for any time prior to coverage under this *Plan*.**

Payments will stop under the **Plan** on the next payment due date following the end of treatment for any reason, the date active coverage ends, or the termination of this **Plan**, whichever comes first.

X-rays and extraction procedures incidental (secondary) to **orthodontic** services are not included under the **orthodontic** benefit. They may be covered under Class A or Class B services.

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## What Is Not Covered

The following expenses are not covered under the WellSpan Population Health Dental benefits. If you have any questions about a specific service, please contact WellSpan Population Health at (717) 851-6800 in York or toll-free at (800) 842-1768.



**Should this *Plan* pay benefits and it is later determined that these benefits should not have been paid based on the exclusions mentioned below, the *Plan* explicitly reserves the right to recover any and all benefits paid in error.**

Charges for the following are not covered:

### *Administrative Charges*

Charges for telephone consultations, missed appointments, or for the completion of forms.

### *Appliance*

An appliance, or modification of one, where an impression was made before the patient was covered; a crown, fixed denture, or gold restoration for which the tooth was prepared before the patient was covered, root canal therapy if the pulp chamber was opened before the patient was covered.

### *Attachments*

Charges for precision attachments or other attachments, except where they represent the sole method of completing a course of treatment.

### *Complication of Non-Covered Treatment*

Care, services, or treatment required as a result of complications arising from treatment that is not covered under these benefits.

## *Cosmetic Services and Surgery*

Care, services, and treatment provided for **cosmetic** reasons, including but not limited to, charges for personalization or characterization of dentures or facings, crowns or pontics behind the second bicuspid.

## *Dentures (Temporary)*

Charges for a temporary denture.

## *Devices*

Prosthetic devices (including fixed and removable dentures), crowns, inlays, and onlays and their fitting, which were ordered while the patient was covered under this **Plan** but are finally installed or delivered more than thirty days after termination of coverage; and ordered, in the case of dentures, impressions that have been taken from which the denture will be prepared; and for fixed dentures, **restorative** crowns, inlays and onlays, means that the restored have been fully prepared to receive the item, and impressions have been taken from dentures, crowns, inlays and onlays will be prepared.

Prosthetic devices, appliances, or restorations for the purpose of splinting, to increase vertical dimension or restore occlusion, or for control of harmful habits (other than appliances that may be necessary in the course of covered **orthodontic** treatment) are not covered by the **Plan**.

## *Duplicate Device or Appliance*

Charges for duplicate prosthetic device or any other duplicate appliance.

## *Education or Training*

Charges for education or training programs regardless of diagnosis or symptoms that may be present (except as specifically provided in this **Plan**) or for services provided by a **dentist** enrolled in an educational program or training program when such services are related to the education or training program.

## *Excess Charges*

The part of an expense for care and treatment of an **accidental injury** or **sickness** that is in excess of the **usual and reasonable charge**.

## *Exceeds Limitations*

Services and expenses that exceed any limits or maximums as found under the heading "What Is Covered."

## *Experimental/Investigational and/or Not Medically Necessary*

Care, treatment, drugs, devices, or other medical/dental services or procedures that are either **experimental/investigational** or are not **medically necessary**.



The *Plan Administrator* has the sole discretion to determine what services and treatment are considered to be *experimental, investigational, or medically necessary*.

## *Government Coverage*

Care, treatment, or supplies furnished by a program or agency funded by any government, except where such exclusion is prohibited by law.

## *Hygiene*

Charges for oral hygiene, a plaque control program, dietary instructions, educational instruction, research, or training programs.

## *Illegal Acts*

Charges for services received as a result of **accidental injury** or **sickness** caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault, or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the **accidental injury** or **sickness** resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

## *Impacted Teeth*

Removal of fully or partially impacted teeth.

## *Implantology*

Charges for implantology, defined as an artificial root inserted into the alveolar bone to form an adjustment on which a restoration (for example, a crown or fixed denture) can be placed.

## *Incomplete Statements*

Charges contained in statements that are incomplete. The documentation submitted by you or your **dependent** (or the **provider** on your behalf) must include itemized statements identifying the patient, date of treatment, type of service provided, the tax identification or other identifier of the **provider**, and the charge for each service. Photocopies, cash register receipts, canceled checks, and similar documents are examples of unacceptable documents.

## *Licensed Dental Practitioner*

Services, treatment, or supplies not furnished by a **licensed dental practitioner**, except x-rays ordered by a **dentist**.

## *Medical Plan*

Any dental service or supply that is covered, in whole or in part, under any medical plan option provided by WellSpan Health in which you or your **dependent** is enrolled. This provision does not apply if you or a **dependent** is not covered under a WellSpan Health medical plan. This dental coverage does not coordinate benefits with any group medical plan option sponsored by WellSpan Health to cover out-of-pocket expenses.

## *Medication*

Charges for drugs or medication, including prescription, other than the injection of antibiotics and the application of desensitizing medication.

## *Military Service*

Care, services, and treatment in connection with **injuries** sustained or a **sickness** contracted while on active duty in military service.

## *Motor Vehicle*

Expenses in connection with an **accidental injury** arising out of or relating to an **accident** involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any **accidental injury** arising out of an **accident** of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance.

However, this exclusion does not apply to a member who is a non-driver when involved in an uninsured motor vehicle **accident**. For the purpose of this exclusion, a non-driver is defined as a member who does not have the obligation to obtain automobile insurance because he/she does not have a driver's license or because he/she is not responsible for a motor vehicle.

## *No Charge*

Care and treatment for which there would not have been a charge if no coverage had been in force.

## *Non-Compliance*

Non-compliance with a patient's primary coverage will result in no payment under this **Plan** as a secondary payer. This would include services to an HMO participant by a facility or **professional provider**, which is not a member of the HMO.

## *Non-Dental*

Services or supplies which are considered not to be dental services or supplies.

## *No Obligation to Pay*

Charges incurred for which the **Plan** has no legal obligation to pay.

## *Not Listed Not Covered*

Any care, treatment, service, or supply that is not described under the heading "What Is Covered."



For more information about covered services, please contact WellSpan Population Health's Customer Service Department.

### *Not Medically Necessary*

Services or supplies which are not appropriate, not necessary, do not meet professionally recognized standards of quality, or which represent a more expensive form of care than is necessary to restore the tooth to normal form and function.

### *Occupational*

Care and treatment of an ***injury*** or ***sickness*** that is occupational in nature as it arises from work for wage or profit and for which the ***covered person*** is required to be covered under Worker's Compensation or similar law. The ***Plan*** will not pay for expenses related to an ***accidental injury*** or ***sickness*** when the ***covered person*** is legally required to be covered under Worker's Compensation coverage, even if such coverage is not in force at the time.

### *Occlusion*

Any work done or appliance used to change the way the top and bottom teeth meet or mesh, other than ***orthodontic*** services listed as covered.

### *Orthognathic Surgery*

Surgery and services for jaw disorders related to anomalies of the jaw, including structure and size.

### *Periodontal*

***Periodontal*** services, except in areas where natural teeth are present.

### *Relative Giving Service*

Professional services performed by a person who ordinarily resides in the member's home or is related to the member as a ***spouse***, parent, child, brother, or sister, whether the relationship is by blood or exists in law.

### *Replacement*

Replacement of duplicate, lost, missing, or stolen appliance or prosthetic device.

### *Sales Tax*

Any sales tax related to care, treatment, services, or supplies.

### *Service Before or After Coverage*

Care, treatment, or supplies for which a charge was incurred before you or your ***dependent*** was covered under this ***Plan*** or after coverage ceased under this ***Plan***.



## *Shipping and Handling*

Any charges for shipping, handling, postage, interest, or financing charges.

## *Temporomandibular Joint Dysfunction (TMJ)*

Treatment of jaw joint disorders including conditions of structure linking the jawbone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

## *Usual and Reasonable*

For charges made which are in excess of **usual and reasonable charges** or for care and treatment not **medically necessary**.

## *Veneers*

Veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the ten upper and lower anterior teeth when not done for **cosmetic** reasons.

## *War*

Any loss that is due to a declared or undeclared act of war.

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## **Filing Claims**

You must file all **claims** for dental services (or make sure your **dentist's** office files one for you). **Claim** forms are available in the Human Resources department or from WellSpan Population Health. You must attach an itemized bill for the services you receive. The bill must include the:

- **Plan** name;
- **Plan's** group number;
- **Employee's** name;
- Patient's name;
- Name, address, and telephone number of the **provider** who provided the care;
- Type of service provided, including procedure codes
- Date the service was provided; and
- An itemized list of the charges.

Mail your completed **claim** form and itemized bill to:

WellSpan Population Health Dental Plan  
P.O. Box 2347  
York, PA 17405

All **claims** should be submitted as soon as possible. No **claims** will be paid when filed 12 months or more after the date of service unless, it was not reasonably possible to submit the **claim** within that timeframe.

## Expenses Incurred Outside the United States

If you or a **dependent** incurs covered medical or dental expenses outside the United States, you must pay the bill and then file a **claim**.

The **claim** must be translated into English and the charges must be in U.S. currency. You are responsible for finding out the exchange rate and determining the correct amount in U.S. dollars. When submitting the **claim**, you must also include a receipt showing that the bill was paid in full.

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## Claims Procedures

The Department of Labor issues regulations that affect how your **claims** are processed. Your **Plan** must follow these regulations. In addition, any changes to those regulations will automatically amend this document effective on the date of those changes.

The date on which WellSpan Health Dental receives a **claim** will determine the **claim's** "receive date" by the **Plan**.



**It is important to understand that if you believe you need *emergency* medical care, you should not forgo that care because you believe that it will not be covered under the dental coverage.**

Wherever the terms "you" or "your" are used, they are meant to include you the **employee**, and any **dependents** that are covered under the **Plan**.



### Terms You Should Know

**In this section, terms with *Plan*-specific definitions are shown in bold, italicized text. For example, *lifetime* has a special meaning under the terms of this *Plan*, and will always be shown in bold, italicized text. You can find a list of defined terms at the end of this document, under the section "Terms You Should Know."**

Following is a description of how the **Plan** processes **claims** for benefits. A **claim** is defined as any request for a **Plan** benefit, made by a person covered under the **Plan** or by an **authorized representative** of the **covered person** that complies with the **Plan's** reasonable procedure for making benefit **claims**. The times listed are maximum times only. A period of time begins at the time it is received by WellSpan Health Dental. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of **claims** and each one has a specific timetable for approval, payment, request for further information, or denial of the **claim**. Contact WellSpan Health Dental with any questions about these procedures.

The definitions of the types of **claims** are:

## Claims Involving Urgent Care



Your **Plan** does not require the pre-certification or pre-approval of **emergency** or **urgent care**. The following is provided for informational purposes only.

A **claim involving urgent care** is any **claim** for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the **covered person**; or the ability of the **covered person** to regain maximum function; or in the opinion of the attending or consulting **physician**, would subject the **covered person** to severe pain that could not be adequately managed without the care or treatment that is the subject to the **claim**. To be a **claim involving urgent care**, the **Plan** must require that the service receive prior approval, which if not received, will result in a reduction of benefits to the **covered person**.

## Pre-Service Claims



Your **Plan** does not require the pre-certification or pre-approval of **dental services**. The following is provided for informational purposes only.

A **pre-service claim** means any **claim** for a benefit under this **Plan** where the **Plan** conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining the medical care.

## Post-Service Claims

A **post-service claim** includes any **claim** for a **Plan** benefit that is not a **claim involving urgent care** or a **pre-service claim**. In other words, a **post-service claim** is a request for a payment under the **Plan** for services already received by the **covered person**.

In the case of a **post-service claim**, the following timetable applies:

- The **covered person** will be notified within 30 days of the benefit determination.
- The **Plan** may extend this time period for up to an additional 15 days due to matters beyond its control.
- If there is insufficient information on the **claim** in order for the **Plan** to make a determination:
  - The **covered person** will be notified of the **claim's** defect within 30 days.
  - The **covered person** then has 45 days to provide the information.
  - After the **Plan's** receipt of the perfected **claim**, a benefit determination will be made within 15 days.
- Upon receipt of a written appeal, the **covered person** will be notified within 60 days of a review of an **adverse benefit determination**.

## Notice of Adverse Benefit Determination

Except with **claims involving urgent care**, when the notification may be given orally, followed by written notification within 3 days of the oral notification, the **Plan** will provide written notification of any **adverse benefit determination**. This **notification of adverse benefit determination** will state, in a manner calculated to be understood by the **covered person**:

- The specific reasons for the denial;
- A reference to the **Plan** provisions upon which the denial was based;
- A description of any additional information or material that the **covered person** must provide in order to perfect the **claim**;
- An explanation of why the additional information is necessary;
- Notice that the **covered person** has the right to request a review of the **claim** denial and information on the steps that need to be taken if he/she wishes to request an appeal of the **claim** denial; and
- A statement of the **covered person's** right to bring civil action under a federal law called "**ERISA**" following any denial or appeal of the initial denial.

In addition, when there is a denial of benefits, the **covered person** must also be provided the following:

- A copy of any rule, guideline, protocol, or similar criterion the **Plan** relied upon in making the **adverse benefit determination** (or a statement that this information will be provided, without charge, upon request from the **covered person**); and
- If the **adverse benefit determination** is based on the **Plan's medical necessity, experimental and/or investigational**, or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the **covered person's** medical circumstances (or a statement that this information will be provided, without charge, upon request from the **covered person**).

If the **adverse benefit determination** concerns a **claim involving urgent care**, the information above may be provided to the **covered person** or his/her **authorized representative** orally within the allowed time frame, provided that a written notification of **adverse benefit determination** in accordance with this section is furnished no later than 3 days after the oral notification.

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## Appeal Procedures

### Reviews of an Adverse Benefit Determination

When a **covered person** receives a **notification of adverse benefit determination**, the **covered person** has 180 days following receipt of the notification in which to appeal the decision. A **covered person** may submit written comments, documents, records, and other information relating to the **claim**. If the **covered person** so requests, he/she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the **claim**.



The appeal must be made in writing and be sent to the **Claims Administrator**, WellSpan Population Health, at P.O. Box 2347, York, PA 17405.

The appeal process will meet the following requirements:

- The **Plan** will provide a review that does not give preferential consideration to the initial **adverse benefit determination** and will be conducted by the **Plan Administrator**, who had not made the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination;
- The **Plan Administrator** will consult with an independent health care professional who has the appropriate training and specific experience in the field of medicine involved before making a decision on a review of any initial **adverse benefit determination** based in whole or in part on a medical judgment, including determinations about whether a treatment, drug or other medical service is **experimental and/or investigational**, or not **medically necessary** or appropriate. This health care professional must not be someone who was consulted in connection with the original determination that is the subject of the appeal, nor be a subordinate of the individual who made the determination; and
- The **Plan** will identify to the **covered person** the medical or vocational experts whose advice was obtained on behalf of the **Plan** in connection with the review determination, without regard to whether the advice was relied upon in making the review determination; and

## Appeal Decision Notices

When the **Plan** completes its review of an **adverse benefit determination**, the **Plan** will give the **covered person**, in writing, a notice containing:

- Its decision;
- The specific reasons for the decision;
- The **Plan** provisions on which the decision was based;
- The statement that the **covered person** is entitled to receive upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the **Plan's** files which is relevant to his/her **claim** for benefits;
- A statement describing the **covered person's** right to bring an action for judicial review under **ERISA** Section 502(a);
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the **adverse benefit determination** on review, a statement that the **covered person** may request a copy, without charge, of the rule, guideline, protocol, or similar criterion;
- If the **adverse benefit determination** on review is based on a **medical necessity, experimental and/or investigational** treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the **Plan** to the **covered person's** medical or dental circumstances, or a statement that this information will be provided to the **covered person**, without charge, upon his/her request; and
- 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."



### Who Is the **Plan Administrator**?

The **Plan Administrator** is the formally identified **Plan** Fiduciary and has the responsibility for final **Plan** determinations. The **Plan Administrator** manages the **Plan** on a day-to-day basis and answers questions about **Plan** details. The **Plan Administrator** for the WellSpan Population Health Dental benefits is WellSpan Population Health. The **Claims Administrator** is responsible for **claims** processing and other administrative duties related to the **Plan**. For more information about the **Plan**

*Administrator, see the section Terms You Should Know.*

## *Plan's Failure to Follow Procedures*

If the WellSpan Health Group Health Plan fails to follow the **claims** procedures described above, you will be deemed to have exhausted the administrative remedies available under the **Plan** and will be entitled to pursue any available remedy under **ERISA** on the basis that the **Plan** has failed to provide a reasonable **claims** procedure that would yield a decision on the merits of the **claim**.

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## **For More Information**

For more information about covered benefits and services under this **Plan**, please contact WellSpan Population Health at (800) 842-1768 or (717) 851-6800.

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## **Administrative Information About Your Benefits**

This section of your guide contains important information about the administration and funding of the WellSpan Health Group Health Plan. Some of the information is required under the Employee Retirement Income Security Act (**ERISA**) of 1974, as amended.



### **Terms You Should Know**

In this section, terms with **Plan**-specific definitions are shown in bold, italicized text. For example, *medically necessary* has a special meaning under the terms of this **Plan**, and will always be shown in bold, italicized text. You can find a list of defined terms at the end of this guide, under the section "Terms You Should Know."

## *Participants Covered*

Generally, the benefits described in this Plan Document/Summary Plan Description cover all full-time, part-time, and per diem **employees** who are eligible for benefits as described in this SPD. For more information about **Plan** eligibility, please see the heading "Your Eligibility" in the section, "Participating in the Dental Benefits."

## *Plan Sponsor and Plan Administration*

Your benefit plan is sponsored by WellSpan Health, the **Plan Administrator**. The **Plan** option that makes up your dental benefits program are subject to the overall administration of the **Plan Administrator**, according to the formal legal documents and any insurance contracts governing the **Plan**. The **Plan Administrator** is located at:

WellSpan Health  
3350 Whiteford Road  
York, PA 17402  
(717) 851-3332

IRS Employer Identification Number: 22-2517863

The **Plan Administrator** establishes the policies, practices, and procedures of this **Plan**. The **Plan Administrator** will administer this **Plan** in accordance with its terms. It is the express intent of this **Plan** that the **Plan Administrator** will have maximum legal discretionary authority to construe and interpret the terms and provisions of the **Plan**, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are **experimental and/or investigational**), to decide disputes which may arise relative to a **covered person's** rights, and to decide questions of **Plan** interpretation and those of fact relating to the **Plan**.

The decisions of the **Plan Administrator** as to the facts related to any **claim** for benefits and the meaning and intent of any provision of the **Plan**, or its application to any **claim**, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this **Plan** will be paid only if the **Plan Administrator**, in its discretion, determines that the **covered person** is entitled to them.

### *Duties of the Plan Administrator*

The duties of the **Plan Administrator** include the following:

- Administer the **Plan** in accordance with its terms;
- Determine all questions of eligibility, status, and coverage under the **Plan**;
- Interpret the **Plan**, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
- Make factual findings;
- Decide disputes which may arise relative to a **covered person's** rights;
- Prescribe procedures for filing a **claim** for benefits and appeals of any denials;
- Keep and maintain the **Plan** documents and all other records pertaining to the **Plan**;
- Appoint and supervise a third-party administrator to pay **claims**;
- Perform all necessary reporting as required by **ERISA**;
- Establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO
- To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the **Plan's** administration.

### *Agent for Service of Legal Process*

If you want to take legal action for any reason related to a benefit **claim**, you may contact the **Plan Administrator**. Whenever you inquire or write about the **Plan**, be sure to use the IRS employer identification number and the **Plan** number.

## Plan Administrator Compensation

The **Plan Administrator** serves without compensation. However, all expenses for **Plan** administration, including compensation for hired services, will be paid by the **Plan**.

## Plan Information

PLAN NAME	PLAN NUMBER	PLAN YEAR	PLAN TYPE	PLAN FUNDING	CLAIMS ADMINISTRATION
WellSpan Population Health Dental Benefits	501	January 1 - December 31	Dental	Self-insured. The plan is funded through contributions from WellSpan Health and participating employees.	WellSpan Population Health Dental Plan P.O. Box 2347 York, PA 17405

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for **Plan** participants, **ERISA** imposes duties upon the people who are responsible for the operation of the **employee** benefit plan. The people who operate your **Plan** are called “fiduciaries,” and they have a duty to do so prudently and in the interest of you and other **Plan** participants and beneficiaries.

No one, including your **employer**, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under **ERISA**.

## Claims Administrator Is Not a Fiduciary

A **Claims Administrator** is not a fiduciary under the **Plan** by virtue of paying **claims** in accordance with the **Plan's** rules as established by the **Plan Administrator**.

## Plan Is Not an Employment Contract

The **Plan** is not to be construed as a contract for or of employment.

## Clerical Error

Any clerical error by the **Plan Administrator** or an agent of the **Plan Administrator** in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a **Plan** reimbursement amount, the **Plan** retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.



## Misrepresentation

If the **covered person** or anyone acting on behalf of a **covered person** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or risks assumed by the **Plan**, or otherwise misleads the **Plan**, the **Plan** shall be entitled to recover its damages, including legal fees, from the **covered person**, or from any other person responsible for misleading the **Plan**, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the **covered person** in making application for coverage, or any application for reclassification thereof, or for service hereunder shall render the coverage under this **Plan** null and void.

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## Important Information About the Plan

### *HIPAA Privacy and Security Standards Compliance*

The WellSpan Health Group Health Plan will use Protected Health Information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, 45 C.F.R. parts 160 through 164 (“HIPAA Privacy Rule”) and 45 C.F.R. parts 160, 162, and 164 (“HIPAA Security Standards”). Specifically, the **Plan** will use and disclose PHI for purposes related to healthcare payment and health care operations. Additionally, the **Plan** will satisfy all obligations with respect to the security of Electronic Protected Health Information. All permitted and required uses and disclosures will be consistent with the HIPAA Privacy and Security Standards Rules.



**The effective date of the HIPAA Privacy Rules provisions was April 14, 2003.  
The effective date of the HIPAA Security Standards Rule was April 20, 2005**

Payment includes activities undertaken by the **Plan** to obtain premiums or determine or fulfill its responsibility for coverage and provision of **Plan** benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, **Plan** maximums and co-payments as determined for an individual’s **claim**);
- Coordination of benefits (C.O.B.);
- Adjudication of health benefit **claims** (including appeals and other payment disputes);
- Subrogation of health benefit **claims**;
- Establishing **employee** contributions;
- Billing, collection activities, and related health care data processing;
  
- **Claims** management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to **covered persons** inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- **Medical necessity** reviews or reviews of appropriateness of care or justification of charges; and

- Utilization review, including **pre-certification**, concurrent care, and retrospective review.

**Health care operations include, but are not limited to, the following activities:**

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, **case management** and care coordination, disease management, contacting health care **providers** and patients with information about treatment alternatives and related functions;
- Rating **provider** and **Plan** performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract reinsurance of risk relating to health care **claims** (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the **Plan**, including **formulary** development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the **Plan** including, but not limited to:
  - Management activities relating the implementation of and compliance with HIPAA's administrative simplification requirements; or
  - Customer service, including the provision of data analyses for policyholders, **plan sponsors** or other customers; and
- Resolution of internal grievances.

The **Plan Sponsor** agrees to:

- Not use or further disclose PHI other than as permitted by the Plan Document/Summary Plan Description or as required by law;
- Ensure that any agent, including a subcontractor, to whom the **Plan Sponsor** provides PHI received from the **Plan** agrees to the same restrictions and conditions that apply to the **Plan Sponsor** with respect to such PHI;
- Not use or disclose PHI in connection with any other benefit or health care plans of the **Plan Sponsor** unless authorized by the individual;
- Not use or disclose PHI in connection with any employment-related actions or decisions of the **Plan Sponsor**;
- Report to the **Plan** any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;

- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books, records relating to the use and disclosure of PHI received from the **Plan** available to the Health and Human Services Secretary for the purposes of determining the **Plan's** compliance with the HIPAA Privacy Rule; and
- If feasible, return or destroy all PHI received from the **Plan** that the **Plan Sponsor** still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

***In accordance with the HIPAA Privacy Rule, only the following employees or classes of employees under the control of the Plan Sponsor may be given access to PHI received from the Plan:***

- Human Resources Department employees;
- The WellSpan Health Benefits Committee;
- Internal Audit Department employees;
- Finance Department employees; and
- The executive staff of WellSpan Health.

This list reflects employees, classes of employees, or other workforce members of the **Plan Sponsor** who receive individual's PHI relating to payment under, health care operation of, or other matters pertaining to **Plan** administration functions that the **Plan Sponsor** provides for the WellSpan Health Group Health Plan. These individuals will have access to PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanction (including termination of employment or affiliation with the **Plan Sponsor**) for any use or disclosure of PHI in violation of, or noncompliance with, the provisions of the HIPAA Privacy Rule.

The **Plan Sponsor** will promptly report any such breach, violation, or noncompliance to the WellSpan Health Group Health Plan and will cooperate with the **Plan** to correct the violation or noncompliance, to impose disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

Where Electronic Protected Health Information (defined as any Protected Health Information that is transmitted or maintained in any electronic media) will be created, received, maintained, or transmitted to or by the **Plan Sponsor** on behalf of the **Plan**, the **Plan Sponsor** shall reasonably safeguard the Electronic Protected Health Information as follows:

- The **Plan Sponsor** shall implement administrative, physical, and technical safeguards and appropriately protect confidentiality, integrity, and availability of the Electronic Protected Health Information that the **Plan Sponsor** creates, receives, maintains, or transmits on behalf of the **Plan**;
- The **Plan Sponsor** shall ensure that the adequate separation that is required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- The **Plan Sponsor** shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Healthcare Information agrees to implement reasonable and appropriate security measures to protect such information; and

- The **Plan Sponsor** shall report, within a reasonable time, to the **Plan** any Security Incidents (defined in the Security Standards Rule as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system) of which it becomes aware.

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## Other Information

### *Updating Your Benefit Records: Basic Information About You*

Be sure to call the Human Resources department with any changes to your name, address, or marital status.

### *Basic Information About Your Dependents*

You should also call Human Resources within 31 days if you marry, divorce, have or adopt a child, or if there is a death in your family which affects your benefits. Also be sure to call if your child becomes ineligible for coverage, or if you have a qualified life status change as described earlier in this guide in the “Participating in the Dental Benefits” section.

### *About Your Benefit Rights: Your Right to Continue Certain Coverage Under COBRA*

Under certain circumstances, you (or your **dependents**) may be able to obtain continued health care coverage for a period of time after your group health care coverage ends. You will be responsible for paying the full contribution plus an additional administrative charge.

This continued coverage is available under the Consolidated Omnibus Budget Reconciliation Act (**COBRA**). Full details on COBRA continuation coverage are found in the “Participating in the Dental Benefits” section.

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## Your Rights Under ERISA

As a participant in the WellSpan Health Group Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (**ERISA**). **ERISA** provides that all **Plan** participants shall be entitled to receive information about the **Plan** and benefits, continue group health plan coverage, and enforce their rights. **ERISA** also requires that **Plan** fiduciaries act in a prudent manner.

### *Receive Information About Your Plan and Benefits*

You are entitled to:

- Examine, without charge, all documents governing the **Plan**. These include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the **Plan** with the U.S. Department of Labor. The Form 5500 may also be obtained from the Public Disclosure Room of the Employee Benefits Security Administration. You are entitled to examine these documents at the **Plan Administrator's** office and at other specified locations, such as worksites.

- Obtain, upon written request to the **Plan Administrator**, copies of documents governing the operation of the **Plan**. These include insurance contracts, the latest annual report (Form 5500), and the updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the **Plan's** annual financial report. The **Plan Administrator** is required by law to furnish each participant with a copy of this summary annual report.

## *Continue Group Health Plan Coverage*

You are entitled to:

- Continue health care coverage for yourself, your **spouse**, or your **dependents** if there is a loss of coverage under the **Plan** as a result of a qualifying event. You or your **dependents** may have to pay for such coverage. It is important to review this Summary Plan Description and the documents governing the **Plan** regarding the rules for exercising your **COBRA** continuation coverage rights.

## *Enforce Your Rights*

If your **claim** for a benefit is denied or ignored, you are entitled to:

- Know why this was done
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules.

Under **ERISA**, there are steps that you can take to enforce your rights. For example, you may file suit in federal court if:

- You request a copy of **Plan** documents or the latest annual report (Form 5500) and do not receive them within 30 days. In such a case, the court may require the **Plan Administrator** to provide the materials and pay you up to \$110 a day until you receive the materials, unless they were not sent for reasons beyond the control of the **Plan Administrator**;
- You have a **claim** for benefits that is denied or ignored, in whole or in part. You may also file suit in state court;
- You disagree with the **Plan's** decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order; or
- The **Plan** fiduciaries misuse the **Plan's** money or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This could occur if the court finds your claim frivolous.

## Assistance with Your Questions

If you have any questions about your **Plan**, you should contact the **Plan Administrator**. If you have any questions about this statement or your rights under **ERISA**, or if you need assistance in obtaining documents from the **Plan Administrator**, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, which is listed in your telephone directory. You may also contact:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue N.W.  
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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## Reservation of Rights

Notwithstanding anything in this Plan Document/Summary Plan Description or in any **Plan** contract, or other document to the contrary, WellSpan Health and its affiliated, subsidiary, and related entities reserve the right to change, modify, or terminate any WellSpan Health-sponsored **employee** or retiree benefit plan option, in whole or in part. Retiree benefits do not serve as deferred compensation and are not vested benefits. If any **Plan** option or part of any **Plan** option is amended, suspended, or terminated, such actions will take place only by decision of a Director of Human Resources, Vice-president of Human Resources and/or the executive staff of WellSpan Health.

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## If a Plan Option Is Terminated

Participants in the **Plan** (including retirees, if any) have no **Plan** benefits after a **Plan** option termination or partial **Plan** option termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of **Plan** option termination or partial **Plan** option termination and except as otherwise expressly provided, in writing, by WellSpan Health and its affiliated, subsidiary, and related companies.

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## A Final Comment

Always keep in mind these important points about your benefit plans and this guide:

- The written terms of the Plan Document/Summary Plan Description (SPD) will always govern;
- This Plan Document/Summary Plan Description (SPD) does not constitute a contract of employment;
- WellSpan Health and its affiliated, subsidiary, and related entities retain the right to amend or terminate the **Plan** or **Plan** options at any time and for any reason; and

- WellSpan Health and/or the Plan Administrator retain discretionary authority to interpret the Plan options and to require whatever documentation it deems necessary to properly adjudicate claims for benefits.

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## Terms You Should Know

This section provides a list of common **Plan** terms and their definitions under the WellSpan Population Health Dental benefits. These definitions may differ from definitions that other dental plans use. If you elect coverage under this **Plan**, you should review the terms carefully, so you are able to better understand your benefits.



When these terms are used in this document, they will appear in bold italicized text.

### *Accidental Injury (Accident)*

An **accidental injury** means physical harm caused by a sudden and unforeseen event at a specific time and place. It is independent of **sickness**, except for infection of a cut or wound.

### *Active Employee*

An **employee** who is on the regular payroll of the **employer** and who has begun to perform the duties of his or her job for the **employer** on a full-time, part-time, PRN, or per diem basis.

### *Adverse Benefit Determination*

This occurs when your **claim** is denied, reduced, or the **Plan** does not make a payment (in whole or in part). This can occur if your **claim** is not paid because of your eligibility or because the service you received is considered to be **experimental/investigational** and/or not **medically necessary**. Also, any **claim** that is not paid at 100% is considered to have had an **adverse benefit determination**; this would include any amounts applied to your deductible or co-insurance, as well as any amount that exceeds a **Plan** limit.

### *Authorized Representative*

This is a person(s) whom you decide may act on your behalf with regard to your group health coverage. This is not the same as an “Assignment of Benefits” that many **providers** ask patients to sign. If you designate an **authorized representative**, this person will have the authority to receive information about your **claims**, any appeals, and request documents and information from your health plan. This means that notifications and other information that would normally go to you could now be sent to your **authorized representative**.

Your **Plan** must receive, in writing, notice from you indicating the name, contact information, and a statement written by you that says you are naming this person(s) as your **authorized representative**. When you decide that you no longer want this person to act as your **authorized representative**, you must again, notify the **Plan** in writing of that decision.

## *Calendar Year*

**Calendar year** means January 1<sup>st</sup> through December 31<sup>st</sup> of the same year.

## *Claim*

When you request a benefit consideration under your **Plan**, and you follow the **Plan's** filing procedures, it is called a **claim**.

## *Claim Involving Urgent Care*

If the **Plan** requires that you pre-certify a medical or dental service before the **Plan** will make payment or will penalize you for not pre-certifying a service and it is the type of service that:

- Could seriously jeopardize the health and life of the patient or the ability of the patient to regain maximum function;
- In the opinion of a **physician** who understands the patient's medical condition, would conclude that the care requested is necessary to alleviate severe pain that cannot be managed without this treatment, or the **physician** determines that the service is a "**claim involving urgent care**;" or
- The **Plan** determines that a person, with an average medical knowledge, would determine that the service is a "**claim involving urgent care**."

Your dental coverage does not require you to pre-certify **emergency** or urgent care; therefore, you cannot incur a **claim involving urgent care**.

## *Claims Administrator*

An entity, selected from time to time by the **Plan Administrator**, providing technical services and advice to the **Plan Administrator** in connection with the operation of the **Plan** and performing such other functions, including processing and payment of **claims**, as may be delegated to it.

## *COBRA*

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

## *Cosmetic Services and Surgery (Cosmetic)*

Medically unnecessary surgical and other procedures, usually, but not limited to, plastic surgery directed toward improving the person's appearance and self-esteem.

## *Covered Charge (Covered Service)*

Means those **medically necessary** services or supplies that are covered under this **Plan**.



## *Covered Person*

**Covered person** is any employee or dependent who is enrolled under the **Plan**.

## *Dentist*

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

## *Dependent*

Refers to a covered **employee's spouse**, or child as defined in the "Participating in the Dental Benefits" section of this document.

## *Disability (Disabled)*

Disability refers to, in the case of an **active employee**, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of **accidental injury** or **sickness**.

Disability refers to, in the case of a **dependent** child, the complete inability as a result of **accidental injury** or **sickness**, such as muscular dystrophy, mental retardation, or spinal cord **injury**, to perform the normal activities of a person of like age and gender in good health.

## *Employee*

Means a person who is directly involved in the regular business of and compensated for services, as reported in the individual's W-2 form, by the **employer**. This definition does not include leased employees.

## *Employer*

WellSpan Health is the **employer**.

## *Endodontics*

The branch of dentistry that deals with diseases of the tooth root, dental pulp, and surrounding tissue.

## *ERISA*

**ERISA** is the federal Employee Retirement Income Security Act of 1974, as amended.

## *Experimental and/or Investigational*

**Experimental and/or investigational** means services, supplies, care, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the individual case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight at the time services were rendered.

The **Plan Administrator**, in consultation with the **Claims Administrator**, must make an independent evaluation of the **experimental/non-experimental** standings of specific technologies, procedures, and therapeutics. The decisions shall be made in good faith and rendered following a factual background investigation of the **claim** and the proposed treatment. The decision of the **Plan Administrator** will be final and binding on the **Plan**. The **Plan Administrator** will be guided by the following principles:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
- If “reliable evidence” shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- If “reliable evidence” shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with a standard means of treatment or diagnosis.

then the drug, device, medical treatment, or procedure will be deemed **experimental and/or investigational** by the **Plan**.

Reliable evidence shall mean only:

- Published reports and articles in the peer-reviewed authoritative **scientific and medical literature** and/or standard evidence-based expert analysis of that literature; or
- The written protocol from the **facility** who published the study using the same drug, device, medical treatment, or procedure and which is consistent with the information in the written informed consent used by the publishing **facility** using the same drug, device, medical treatment, or procedure in persons with the same condition.

Drugs are considered **experimental** if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration.

If any of the entities used to determine the **investigational** status of a drug, device, supply, treatment, or any other medical service reverses, modifies, or establishes its policy for such expenses, and makes such changes retroactively, the **Plan** will not make payment for related retroactive incurred expenses. The **Plan** will not seek refund for its previous payments, nor make payments for any previously denied expenses, affected by such retroactive changes.

## *Injury*

**Injury** means accidental physical harm to the body caused by unexpected external means.

## *Leave of Absence*

A **leave of absence** is a period of time during which the **employee** does not work for the **employer**, but which is of a stated duration and after which time the **employee** is expected to return to active work. A **leave of absence** shall otherwise be limited by the **employer's** standard personnel practices and policies.

## Licensed Dental Practitioner

A **dentist**, dental assistant, dental hygienist, orthodontist, or **physician** who is properly licensed or certified under the laws of the state in which they practice and who is acting within the scope of such license.

## Lifetime

A word that appears in reference to benefit maximums and limitations, as explained throughout this guide. Under no circumstances does **lifetime** mean during the lifetime of the **covered person**.

## Medicaid

Refers to the state program (with federal matching funds provided by Social Security under stipulated conditions) of public health assistance to persons, regardless of age, whose income and resources are insufficient to pay for health care.

## Medically Necessary (Medical Necessity)

Care and treatment that is:

- Recommended or approved by a **physician** or **dentist**;
- Is consistent with the patient's condition or accepted standards of good medical and dental practice;
- Is medically proven to be effective treatment for the condition at issue;
- Is not performed mainly for the convenience of the patient or **provider** of medical or dental services;
- is not conducted for research purposes; and
- Is the most appropriate level of service, which can safely be provided to the patient.

All of the above criteria must be met in order for care to be considered **medically necessary**. The fact that a **physician** recommends or approves care or treatment does not in itself mean it is **medically necessary**. The **Plan Administrator** has discretionary authority to determine whether care or treatment is **medically necessary**.



**Charges that are greater than the charges for an alternative service or supply that could have safely and adequately diagnosed or treated you or your dependent's physical or mental condition will not be considered *medically necessary* under this *Plan*. Call the telephone number on the back of your medical identification card for more information about this provision or about a particular service, before the charge is incurred.**

## *Medicare*

**Medicare** is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

## *Notification of Adverse Benefit Determination*

When there is an **adverse benefit determination**, the **Plan** must notify you of the **claim** decision and the reasons why the **claim** was denied, reduced, or not paid at 100%. In many cases, this notification will be called an “Explanation of Benefits” (EOB).

## *Orthodontic*

The branch of dentistry that specializes in the diagnosis, prevention, and treatment of dental and facial irregularities. The practice of orthodontics involves the design, application, and control of corrective appliances (braces) to bring teeth, lips and jaws into proper alignment and achieve facial balance.

## *Periodontics (Periodontal)*

The branch of dentistry concerned with the prevention, diagnosis and treatment of diseases affecting the gums and supporting structures of the teeth.

## *Physician*

A person who is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), is licensed and legally entitled to practice medicine in all of its branches, perform surgery, and dispense drugs.

## *Plan*

When used in this guide, the term **Plan** is meant to be the WellSpan Health Group Health Plan including the WellSpan Population Health Dental benefits.

## *Plan Administrator*

The **Plan Administrator**, WellSpan Health, will interpret the **Plan** in accordance with its terms and their intended meaning, and benefits under the **Plan** will be paid only if the **Plan Administrator**, in its discretion, decides a participant or beneficiary is entitled to them. The **Plan Administrator** will have the discretion to make any findings of fact needed to administer the **Plan** or determine benefits **claims** and to construe ambiguous, unclear, or implied (but not stated) terms in any way it deems appropriate. The **Plan Administrator's** earlier exercise of its discretionary authority granted under the **Plan** shall not require it to exercise that authority in the same manner thereafter. If any **Plan** provision, on account of errors in drafting, does not accurately reflect its intended meaning, as determined by the **Plan Administrator** in its sole discretion, the provision will be considered ambiguous and will be construed by the **Plan Administrator** in a manner consistent with the intended meaning. All actions taken and determinations made in good faith by the **Plan Administrator** under this Plan Document/Summary Plan Description will be final and binding on all persons.

## *Plan Sponsor*

Refers to an **employer** that establishes or maintains any **employee** benefit plan. WellSpan Health is the **Plan Sponsor** of the WellSpan Health Plans.

## *Post-Service Claim*

This includes all **claims** that are not considered to be **claims involving urgent care** or pre-service **claims**. This will generally include **claims** where you have already received the medical or dental service and a **claim** has been sent to the **Plan** for benefit consideration.

## *Pre-Service Claim*

If the **Plan** requires you to pre-certify or pre-approve a medical or dental service before the **Plan** will make a payment or will penalize you for not pre-certifying, the **claim** is considered to be a pre-service **claim**. It is a **claim** for benefits for a service that you have not yet received. It only includes those services that are not considered to be a **claim involving urgent care**.

Your dental coverage does not require you to pre-certify treatment; therefore, you will not have a **pre-service claim**.

## *Professional Provider (Provider)*

**Professional provider** is a **physician** or other health care professional or **facility** that is licensed, registered, or certified as required by the state in which the services were received to provide a medical service or supply and who does so within the lawful scope of that license, registration, or certification.

## *Prosthodontics*

The branch of dentistry that deals with the replacement of missing teeth and related mouth or jaw structures by fixed dentures, removable dentures, or other artificial devices.

## *Restorative Dentistry (Restoratives)*

The branch of dentistry that deals with the restoration of diseased, injured or abnormal teeth to normal function, as with fillings or crowns.

## *Sickness*

**Sickness** is a person's illness, disease, or **pregnancy**.

## *Spouse*

Refers to the husband or wife of the **employee** under a legally valid (according to the laws of the state in which the **employee** lives) existing marriage.

## *Temporomandibular Joint Dysfunction (TMJ)*

The treatment of jaw joint disorders, including conditions of structure linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

## *Usual and Reasonable (U&R) Charge*

Refers to the fee assessed by a **provider** that will not exceed the general level of charges made by others rendering or furnishing such services within the area where the charge is incurred and is comparable in severity and nature to the **sickness** or **injury**. Due consideration will be given to any medical complications or unusual circumstances which require additional time, skill, or experience. The **usual and reasonable charge** is determined from a statistical review and analysis of the charges for a given procedure or service in a given area. The term "area" as it would apply to any particular services means a zip code area or such greater area as is necessary to obtain a representative cross-section of the level of charges.

**If a provider submits a charge that is lower than the U&R charge for a service, the Plan will reimburse the provider for the actual amount of the charge.**

**The Plan Administrator has discretionary authority to decide whether a charge is usual and reasonable.**

## *Waiting Period*

This is the time period which must pass before an employee or dependent is effective for benefits under the **Plan**. If an employee or dependent enrolls on a special enrollment day, any period before such special enrollment is not a waiting period.