

**POUGHKEEPSIE PUBLIC SCHOOLS
TEACHERS' ASSOCIATION
POUGHKEEPSIE NY**

**Dental Benefit Summary Plan Description
7670-03-413273**

Revised 01-01-2021

BENEFITS ADMINISTERED BY



A UnitedHealthcare Company

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POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION

GROUP DENTAL BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as with information on a Covered Person's rights and obligations under the POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION Group Dental Benefit Plan (the "Plan"). You are a valued Employee of POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your dental care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION is named the Plan Administrator for this group dental Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR, Inc. (hereinafter "UMR") to process claims and handle other duties for this self-funded Plan. UMR, as the Third Party Administrator, does not assume liability for benefits payable under this Plan, since it is solely a claims-paying agent for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with capital letters, even though it normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this group dental Plan.

Each Individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan Document. Therefore it will be referred to as both the SPD and the Plan Document. It is being furnished to You in accordance with ERISA.

This document became effective on May 1, 2018.

PLAN INFORMATION

This Plan is a self-funded Plan that is considered exempt from state insurance laws and is administered under the terms of the Plan and Voluntary Employee Benefit Trust (VEBA) established under §501(c)(9) and §115 of the Internal Revenue Code (IRC). Payment of all benefits shall be made out of the Plan/Trust assets and as provided by any stop loss reinsurance coverage. This Plan is administered by UMR as an independent third party administrator (TPA) appointed by the Board of Trustees. The Board of Trustees are ultimately responsible for the overall administration and operation of the Plan, including the delegation of specific duties.

Plan Name	POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION GROUP DENTAL BENEFIT PLAN
Name And Address Of Employer	POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION 40 GARDEN ST STE 207 POUGHKEEPSIE NY 12601
Name, Address, And Phone Number Of Plan Administrator	POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION 40 GARDEN ST STE 207 POUGHKEEPSIE NY 12601 845-471-3376
Named Fiduciary	POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION
Claims Appeal Fiduciary For Dental Claims	UMR
Employer Identification Number Assigned By The IRS	14-1773337
Plan Number Assigned By The Plan	501
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group dental benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for dental claims.
Name, Title, And Address Of The Principal Place Of Business Of Each Trustee Of The Plan (If The Plan Has A Trust)	Debra Kardas, Stephanie Green, Laura Tietz, Heather Martino, Donald Stark, Christopher King
Name And Address Of Agent For Service Of Legal Process	POUGHKEEPSIE PUBLIC SCHOOLS TEACHER'S ASSOCIATION 40 GARDEN ST STE 207 POUGHKEEPSIE NY 12601

Funding Of The Plan

Employer and [Retiree](#) Contributions

Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer.

Collective Bargaining Provisions

The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of each agreement may be obtained upon written request to the Plan Administrator, and each agreement is available for examination.

Benefit Plan Year

Benefits begin on July 1 and end on the following June 30. For new [PPSTA Members](#) and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through June 30 of the same Benefit Plan Year.

ERISA Plan Year

January 1 through December 31

ERISA And Other Federal Compliance

It is intended that this Plan comply with all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator, and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

SCHEDULE OF BENEFITS

Benefit Plan 001

Effective: 07-01-2021

Benefits for You and Your Dependents are listed below.

This coverage provides for the use of a Preferred Provider Organization (PPO). Certain benefits are paid at different levels if the service is not provided by a Participating Provider.

SUMMARY OF BENEFITS	PPO PROVIDER (In-Network)	NON-PPO PROVIDER (Out-of-Network)
Maximums <ul style="list-style-type: none"> • Plan Year Benefit Maximum, including Preventive and Diagnostic Services, Basic Services and Major Services • Lifetime Orthodontic Maximum • Lifetime Maximum, Temporomandibular Joint Treatment 	Individual \$2,000 \$3,000 \$1,500	Individual \$2,000 \$2,500 \$1,500
Participation Percentage: <ul style="list-style-type: none"> • Preventive Services And Diagnostic Services: Routine Cleanings, Fluoride Treatments, And Sealants. Oral Exams And Bitewing And Full-Mouth X-Rays. Refer To Covered Expenses For Any Limitations. • Basic Services: Fillings, Endodontics, Periodontics, And Oral Surgery. Refer To Covered Expenses For Any Limitations. • Major Services: Inlays, Onlays And Crowns, Bridges, Dentures. Refer To Covered Expenses For Any Limitations. • Orthodontic Services: Orthodontic Diagnosis, Treatment, And Appliances. Refer To Covered Expenses For Any Limitations. • Temporomandibular Joint Treatment: Refer To Covered Expenses For Any Limitations. 	The Plan Pays	
	100%	85%
	90%	70%
	80%	60%
	60%	45%
	50%	50%

OUT-OF-POCKET EXPENSES AND MAXIMUMS

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. Generally, the applicable Deductible must be met before any benefits will be paid under this Plan.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts, as applicable.

ADDITIONAL OUT-OF-POCKET EXPENSES

In addition to the Deductible, if applicable, and Plan Participation percentage, the Covered Person is also responsible for the following costs:

- Co-pays.
- Any remaining charges due to the provider after the Plan's benefits are determined.
- Full charges for services that are not covered benefits under this Plan.
- Penalties, legal fees, and interest charged by a provider.
- The difference between the provider's contracted fee for the service that was actually provided and the fee for the alternate benefit that the Plan approved.

For example, if the provider placed a resin (white) filling in Your tooth, but an amalgam (silver) filling would have been sufficient to restore the tooth, You will need to pay the difference between the cost of the resin filling and the cost of the amalgam filling.

INDIVIDUAL PLAN YEAR MAXIMUM BENEFIT

All Covered Expenses will count toward the Covered Person's individual dental Plan Year Maximum Benefit that is shown on the Schedule of Benefits, as applicable.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses may not be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your [Benefit Trust](#). The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated [PPSTA Members](#).

ELIGIBILITY REQUIREMENTS

An **eligible PPSTA Member** is a person who is classified by the [Benefit Trust](#) on both payroll and personnel records as a [PPSTA Member](#) who regularly works full- time or part-time per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the [Benefit Trust](#) in its sole discretion:

- Leased [PPSTA Members](#).
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the [Benefit Trust](#).
- Members of the [Benefit Trust's](#) Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. A [PPSTA Member](#) may retain eligibility for coverage under this Plan if the [PPSTA Member](#) is temporarily absent on an approved leave of absence, which is combined with the [Benefit Trust's](#) short-term disability policy, with the expectation of returning to work following the approved leave as determined by the [Benefit Trust's](#) leave policy, provided that contributions continue to be paid on a timely basis. COBRA is not applicable until short-term disability is exhausted. The [Benefit Trust's](#) classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the [Benefit Trust](#) agrees to such reclassification, will change a person's eligibility for benefits.

An eligible [PPSTA Member](#) who is covered under this Plan and who retires under the [Benefit Trust's](#) formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. Retirees may continue coverage under this Plan until [death](#).

Note: Eligible [PPSTA Members](#) and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An **eligible Dependent** includes:

- Your legal spouse. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- A Dependent Child until the Child reaches his or her 26th birthday. The term “**Child**” includes the following Dependents:
 - A natural biological Child;
 - A stepchild;
 - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
 - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
 - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
 - A grandchild, as long as the **PPSTA Member's** covered Dependent is the parent of the grandchild. A grandchild is eligible for a limited time only, unless the **PPSTA Member or the PPSTA Member's Spouse** has legal custody or guardianship over such Child and legal documentation is provided to the Plan within 60 days of court approval. The newborn must be enrolled within 30 days of birth. The COBRA date of the event will be the birth of the Child and COBRA premiums will begin as of the first day of the month following the birth of the Child. If COBRA is not elected and the newborn is timely enrolled, the newborn will be covered for the first 30 days of birth only.
 - A foster Child.
 - An unmarried Child over the limiting age can be covered under the Covered **PPSTA Member's /Retiree's** (parent's) **PPSTA Member** health Plan through age 29, even if he or she is not financially dependent on the parent, or does not live with the parent, or is not a student. The following criteria must be met:
 - The parent must be covered under the Plan as a **PPSTA Member**; and
 - The Dependent cannot be covered under or be eligible for any other Benefit Trust sponsored group health plan or policy or be covered under Medicare; and
 - The Dependent must reside or work in New York State; and
 - Be under 29 years of age.

- A Dependent does not include the following:
 - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
 - A Domestic Partner;
 - Any other relative or individual unless explicitly covered by this Plan.

Note: A **PPSTA Member** must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 or over must be dependent upon the **PPSTA Member** for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the **PPSTA Member's** divorce or separation decree.
- A Totally Disabled Dependent Child age 26 or over must be unmarried.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible **PPSTA Member** will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 29th birthday; or
- The Dependent Child is a Dependent of a [PPSTA Member](#) newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 29 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The [PPSTA Member](#) must still be covered under this Plan.

A Totally Disabled Dependent Child older than who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or [PPSTA Member](#) for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

[PPSTA Members](#) have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF [PPSTA MEMBER'S](#) COVERAGE

Your coverage will begin on the later of the following dates:

- [If the enrollment form is received by the Trust within 30 days following date of hire \(or rehire\), coverage is effective date of hire. However, if the enrollment form is received by the Trust more than 30 days from date of hire \(or rehire\), but within 60 days from date of hire, then coverage is effective as of the date the Trust receives the enrollment form; or](#)
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth in the Special Enrollment Provision section if application is made within 30 calendar days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 30 calendar days of acquiring the Dependent; or
- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 30 calendar days following the event; or
- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible [PPSTA Members](#) will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered [PPSTA Members](#) will be able to make changes in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered [PPSTA Members](#), and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The [Benefit Trust](#) will give eligible [PPSTA Members](#) written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage will be July 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

LOSS OF DENTAL COVERAGE

If You or Your Dependents lose other dental insurance or group dental coverage and are otherwise eligible under this Plan, and did not enroll when first eligible because You or Your Dependents had other dental coverage, then You or Your Dependents may enroll for dental coverage under this Plan if You meet the following conditions:

- You or Your Dependents were covered under a group dental plan or dental insurance policy at the time coverage under this Plan was first offered; and
- You or Your Dependents stated in writing that You declined coverage due to coverage under another group dental plan or dental insurance policy; and
- The coverage under the other group dental plan or dental insurance policy was:
 - Under a federal COBRA continuation provision and that coverage was exhausted; or
 - Under another type of coverage and that coverage terminated as a result of:
 - Loss of eligibility for the coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; or
 - The current or former [Benefit Trust](#) no longer contributing toward the coverage; and
 - Not terminated due to the person's failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact.

You or Your Dependent must apply for coverage under this Plan no later than 30 days after the date the other coverage ended.

You and/or Your Dependents were covered under a Medicaid plan or state child health plan and coverage for You or Your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current [PPSTA Member](#) and his or her Dependents may be eligible for a special enrollment period if the [PPSTA Member](#) and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The [PPSTA Member](#) must request coverage under this Plan within 60 days after the date the [PPSTA Member](#) and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current [PPSTA Members](#) and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status. Retired [PPSTA Members](#) who are Covered Persons have special opportunities to enroll newly acquired Dependents for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption, or Placement for Adoption, the [PPSTA Member](#), spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The [PPSTA Member](#) must request and apply for coverage within 30 calendar days of the marriage, birth, adoption, or Placement for Adoption.

A Retiree who has single coverage at the time of retirement may enroll a spouse and/or Dependent within 60 days of the date of acquiring new Dependents. If a Retiree's spouse dies and the Retiree remarries, they can add the new spouse and any Dependents within 60 days of the date of acquiring the new Dependents. Otherwise, new Dependents can only be added during open enrollment.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, [not later than the first day of the first month beginning after the date of the completed request for enrollment is received](#) (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, [no later than the first day of the first calendar month following the date the completed enrollment form is received](#); or
- In the case of loss of coverage, [no later than the first day of the first calendar month following the date the completed enrollment form is received](#).

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the [Benefit Trust's](#) Section 125 Cafeteria Plan. Please refer to the [Benefit Trust's](#) Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

PPSTA MEMBER'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the [Benefit Trust](#) except as follows:
 - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to [the period the PPSTA Member is receiving a paycheck](#). [If you are absent you are using your accrued sick time or for some they apply to our sick bank](#), provided the applicable [PPSTA Member](#) contribution is paid when due.
 - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends except that in the event that the [PPSTA Member](#) dies, coverage for the Dependent may continue for 30 days following the death of the [PPSTA Member](#) / Retiree, provided the Dependent pays the applicable contribution when due; or

[Subject to COBRA rules, COBRA coverage is available for the first 36 months for any Spouse who would lose coverage due to divorce or death. The initial COBRA period can be extended under this Plan subject to the following rules:](#)

- [If the divorced spouse has been married to the Retiree for five or more years, been covered under the Plan for five or more years and is at least 55 years old or older, coverage can be continued at COBRA rates for the spouse's lifetime, as long as the Plan remains in effect; or](#)

- A widowed spouse of a Retiree can continue COBRA coverage for his/her lifetime following the death of the Retiree, at COBRA rates. If the spouse remarries, additional dependents or a new spouse cannot be added after the initial COBRA period (36 months) expires. During the initial COBRA period, the spouse can add a new spouse or Dependents but they may only be covered during the initial COBRA period and are not eligible for extended coverage beyond the initial COBRA period. COBRA rules, with respect to payment and lapse of coverage will continue to apply to extended COBRA coverage under this paragraph. The Enrollee must request continued coverage under this option and make monthly payments to retain continued coverage, subject to COBRA rules. Dependent Children covered at the time of the event (Qualified Beneficiaries) would be eligible for continued coverage after the initial COBRA period only if family coverage is maintained.
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or
- If Your Dependent Child qualifies for extended Dependent coverage as a Full-Time Student, the last day of the month in which Your Dependent Child no longer qualifies as a Full-Time Student unless failure to attend is due to Illness or Injury – (see Extended Dependent Coverage section for more information) unless the Dependent Child qualifies for a Medically Necessary leave of absence (see Extended Dependent Coverage section for more information) or the last day of the month Your Dependent Child turns 29, whichever is earlier; or
- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan or until the Dependent turns age 29, whichever is earlier; or
- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The last day of the month in which the Dependent becomes covered as a [PPSTA Member](#) under this Plan; or
- The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all the requirements of a new [PPSTA Member](#). Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

COBRA CONTINUATION OF COVERAGE

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your [Benefit Trust](#) or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits (including dental benefits) beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another [Benefit Trust](#) -sponsored group health plan or are enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are a [PPSTA Member](#), You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage may be extended. See the section below entitled “The Right to Extend the Length of COBRA Continuation Coverage” for more information.)

Your spouse will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The PPSTA Member dies	up to 36 months
• The PPSTA Member's hours of employment are reduced	up to 18 months
• The PPSTA Member's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The PPSTA Member becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• The PPSTA Member and spouse become divorced or legally separated	up to 36 months

Your Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The parent- PPSTA Member dies	up to 36 months
• The parent- PPSTA Member's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent- PPSTA Member's hours of employment are reduced	up to 18 months
• The parent- PPSTA Member becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child loses eligibility being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA continuation coverage for Retired [PPSTA Members](#) and their Dependents is described below:

Qualifying Event	Length of Continuation
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- If You are a Retired **PPSTA Member** and Your coverage is reduced or terminated due to Your Medicare entitlement, and as a result Your Dependent's coverage is also terminated, Your spouse and Dependent Children will also become Qualified Beneficiaries. up to 36 months
 - If You are a Retired **PPSTA Member** and Your **Benefit Trust** files bankruptcy under Title 11 of the United States Code, the bankruptcy may be a Qualifying Event. If the bankruptcy results in the Retired **PPSTA Member's** Loss of Coverage under this Plan, then the Retired **PPSTA Member** is a Qualified Beneficiary. The Retired **PPSTA Member's** spouse or surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.
- | | |
|-------------------------------|-----------|
| ➤ Retired PPSTA Member | Lifetime |
| ➤ Dependents | 36 months |

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, who is acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered **PPSTA Members** and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the **PPSTA Member** and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your **Benefit Trust** or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, current address and complete phone number,
- The group number and the name of the **PPSTA Member's Benefit Trust**,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

Send all notices or other information required by this Summary Plan Description in writing to:

**UMR
COBRA ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206
Phone Number: (800) 207-1824**

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

BENEFIT TRUST OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your [Benefit Trust](#) will give notice to the COBRA Administrator when coverage terminates due to the [PPSTA Member's](#) termination of employment or reduction in hours, the death of the [PPSTA Member](#), or the [PPSTA Member's](#) becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your [Benefit Trust](#) will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

PPSTA MEMBER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the [PPSTA Member](#) and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered [PPSTA Member](#) or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the [Benefit Trust](#), the covered [PPSTA Member](#) or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP DENTAL COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of his or her election in writing in order to continue group dental coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group dental coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group dental coverage will be reinstated retroactively to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the [Benefit Trust](#) and [PPSTA Member](#) contributions. This cost may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). The cost of continuation coverage is subject to change at least once per year.

If Your [Benefit Trust](#) offers annual open enrollment opportunities for active [PPSTA Members](#), each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him or her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, the occurrence will be treated as non-payment and the Qualified Beneficiary(ies) will lose coverage under the Plan in accordance with the Plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.
- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.
- A final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- Any Qualified Beneficiary becomes covered by another group dental plan.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For PPSTA Members and Dependents: 18 months from the Qualifying Event if due to the [PPSTA Member's](#) termination of employment or reduction of work hours. (If an active [PPSTA Member](#) enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the [PPSTA Member's](#) termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:
 - The [PPSTA Member's](#) death.
 - The [PPSTA Member's](#) divorce or legal separation.
 - The former [PPSTA Member's](#) enrolled in Medicare.
 - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.
- For Retired PPSTA Members and Dependents of Retired PPSTA Members only: If bankruptcy of the [Benefit Trust](#) is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries may elect COBRA continuation coverage for the following maximum period, subject to all COBRA regulations. The covered Retired [PPSTA Member](#) may continue COBRA coverage for the rest of his or her life. The covered spouse or surviving spouse or the Dependent Child of the covered Retired [PPSTA Member](#) may continue coverage until the earlier of:
 - The date the Qualified Beneficiary dies; or
 - The date that is 36 months after the death of the covered Retired [PPSTA Member](#).

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA Administrator as soon as possible, but no later than the **required** timeframes stated below.

Social Security Disability Determination (For [PPSTA Members](#) and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the [PPSTA Member](#) or former [PPSTA Member](#) dies, becomes entitled to Medicare (Part A, Part B, or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit <https://www.medicare.gov/medicare-and-you>.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The [Benefit Trust](#) ceases to maintain a group dental plan for any [PPSTA Members](#). (Note that if the [Benefit Trust](#) terminates the group dental plan under which the Qualified Beneficiary is covered, but still maintains another group dental plan for other, similarly-situated [PPSTA Members](#), the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group dental plan, although benefits and costs may not be the same.)
- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group dental Plan immediately before the Qualifying Event. A Qualifying Beneficiary may be a [PPSTA Member](#), the spouse of a covered [PPSTA Member](#), or the Dependent Child of a covered [PPSTA Member](#). This includes a Child who is born to or Placed for Adoption with a covered [PPSTA Member](#) during the [PPSTA Member's](#) COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered [PPSTA Member](#).
- Voluntary or involuntary termination of the covered [PPSTA Member's](#) employment (other than for gross misconduct).
- A reduction in work hours of the covered [PPSTA Member](#).

- Divorce or legal separation of the covered **PPSTA Member** from the **PPSTA Member's** spouse. (Also, if a **PPSTA Member** terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former **PPSTA Member** becomes enrolled in Medicare.
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in **PPSTA Member** cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, and for more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
 POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION
 40 GARDEN ST STE 207
 POUGHKEEPSIE NY 12601

The COBRA Administrator:
 UMR COBRA ADMINISTRATION
 PO BOX 1206
 WAUSAU WI 54402-1206

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Benefit Trusts are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. **PPSTA Members** on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated **PPSTA Members** on leaves of absence or furloughs. If a **Benefit Trust** has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to **PPSTA Members** on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the **PPSTA Member** fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

A **PPSTA Member** or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the **Benefit Trust** that the **PPSTA Member** intends to leave the employment position to perform service in the uniformed services. A **PPSTA Member** should provide notice as far in advance as is reasonable under the circumstances. The **PPSTA Member** is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, **PPSTA Members** will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the **PPSTA Member** is not required to pay more than the amount he or she would have paid as an active **PPSTA Member**. For periods of 31 days or longer, if a **PPSTA Member** elects to continue dental coverage pursuant to USERRA, such **PPSTA Members** and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

PPSTA Members and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by a **PPSTA Member** on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the **PPSTA Member** will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word "**Network**" means an organization that has contracted with various providers to provide dental care services to Covered Persons at negotiated fees. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from in-network providers; however, this Plan does not limit a Covered Person's right to choose his or her own provider of dental care at his or her own expense if a dental expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

The preferred provider organization is POMCO Dental With DenteMax.

PROVIDER DIRECTORY INFORMATION

Each covered [PPSTA Member](#), COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The [PPSTA Member](#) should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

Information on participating providers can also be accessed at the following website:

www.UMR.com

ALTERNATE BENEFITS PROVISION

Many dental conditions can be treated in more than one way. This Plan has an “alternate benefits provision” that governs the amount of benefits that this Plan will pay for covered treatments. If a patient chooses a more expensive treatment than is needed to correct a dental condition according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam (silver) filling is sufficient to restore a tooth, but the patient and the Dentist decide to use a resin (white) filling, the Plan will base its payment on the Usual and Customary charge or the maximum fee schedule for the amalgam filling. The patient will be responsible for paying the difference in cost.

PRE-TREATMENT ESTIMATE OF BENEFITS

One of the advantages of this dental Plan is that it enables a Covered Person to see the amount payable by the Plan prior to having the Dentist begin any extensive treatment. Through this process, Covered Persons can prevent any misunderstandings as to what is covered by the Plan. A Covered Person can accurately estimate what he or she will owe the Dentist. This procedure is known as "Pre-Treatment Estimate of Benefits." Here is how the process works:

Usually, before beginning any extensive treatment, the Covered Person will be advised as to what the Dentist intends to do. This plan of action is referred to as the Treatment Plan. The Dentist will submit the Treatment Plan to UMR prior to performing the services. UMR will then notify the Covered Person and the Dentist, in advance, regarding what benefits are payable under this Plan, and how much the Covered Person will be responsible for paying.

Obtaining a Pre-Treatment Estimate of Benefits is recommended whenever a Dentist's estimated charge is \$250 or more. This feature is not mandatory; however, dental care can be expensive. A Covered Person may want to have an idea of how much this Plan will pay before agreeing to have the treatment performed.

Note: The Pre-Treatment Estimate of Benefits is not a guarantee of payment and is valid for 12 months after the notice date. Benefits are payable if coverage is in effect on the date the services are performed (subject to all Plan provisions) and if the claim is submitted to the Plan within the timely filing period. If additional procedures are performed, the claim will be reviewed in its entirety.

COVERED EXPENSES

The Plan will pay for the following Covered Expenses Incurred by a Covered Person, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits, and to all other provisions as stated in this SPD. Benefits are based on the Usual and Customary charge, fee schedule, or Negotiated Rate. Any procedure that is not specifically listed as covered is excluded.

General Overview

This Plan provides dental benefits under several categories of dental services. Within each category, there are a number of subcategories of covered services.

PREVENTIVE SERVICES

- Cleanings (routine prophylaxis) – limited to two per plan year.
- Topical fluoride treatments - covered for Dependent Children under the age of 18 only. Limited to two per plan year. A cleaning performed with a fluoride treatment is a separate dental service.
- Space maintainers - fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.
- Sealants - covered for Dependent Children under the age of 18 only. Limited to permanent molar teeth only once every 36 consecutive months. Not covered for primary teeth.

DIAGNOSTIC SERVICES

- Oral exams - limited to two exams per plan year.
- Full-mouth X-rays - limited to one every 36 consecutive months, unless necessary due to an Injury, combined with panoramic / panorex X-rays.
- Panoramic / panorex X-rays - limited to one every 36 consecutive months, unless necessary due to an Injury combined with full-mouth X-rays.
- Bitewing X-rays - limited to two per plan year.
- Ancillary - emergency oral exams and palliative treatment for relief of dental pain.
- X-rays - all other dental X-rays when Medically Necessary as part of the treatment of a Covered Expense.
- Periodontal maintenance - limited to two treatments per year.
- Occlusal guard - (only in conjunction with periodontal surgery or bruxism - limited to one every 12 months age 13 and older).

Temporomandibular Joint Disorder

- Treatment of disturbances of the temporomandibular joint.
- Arthrogram, including injection.
- Other temporomandibular joint radiographic images, by report.
- Tomographic survey.
- Noninvasive physical therapies.

BASIC SERVICES

An alternate benefit may apply to specific services, refer to the Alternate Benefits section in this SPD for more details.

- Restorative fillings – amalgam, silicate, acrylic, synthetic porcelain, and composite fillings.
- Preformed stainless steel crowns – limited to Dependent Children with deciduous primary teeth only.
- Endodontics – root canal treatments, root canal fillings, pulp vitality tests, and other related procedures.
- Periodontics – debridement and exams and other related procedures necessary to treat a disease of the supporting tissues of the teeth. Periodontal splinting is not a covered expense.
- Occlusal adjustment - (only in conjunction with periodontal surgery or bruxism - limited to four quadrants per Treatment Plan - limited to four quadrants per Treatment Plan).
- Oral surgery – extractions and other oral surgery including preoperative and postoperative care.
- Local anesthesia when Medically Necessary.
- General anesthesia – when administered by a Dentist due to oral or dental surgery when Medically Necessary.
- Rebase procedures for denture or bridges. Not covered during the first six months after initial placement.
- Reline procedures for dentures or bridges. Not covered during the first six months after initial placement.

MAJOR SERVICES

An alternate benefit may apply to specific services. Refer to the Alternate Benefits section in this SPD for more details.

The alternate benefit of a filling may be applied if there is not enough evidence to support major decay or traumatic Injury.

If more than one implantation is performed in the same arch, the alternate benefit of a bridge or partial may be allowed.

If two or more teeth are missing in the same arch or two or more bridges are being performed in the same arch, an alternate benefit of a partial denture may be applied.

- Inlays or onlays.
- Crowns.
- Implants and implant-related services.
- Installation of removable or fixed bridgework.
- Installation of partial and complete dentures, including six-month post-installation care.

Replacement of an implant, abutment, retainer, or denture is limited to once every five years.

Replacement of an inlay, onlay, or crown will be covered only if the appliance was installed at least five years prior to its replacement. This provision will not apply if replacement is due to an Accidental Injury that occurred while You were covered under this Plan. This provision will not apply if replacement is required due to the involvement of an additional tooth surface.

Replacement of a bridge or denture will be covered only if the appliance was installed at least five years prior to its replacement. This provision will not apply if:

- Replacement is Medically Necessary due to the placement of an initial opposing full denture;
- Replacement is Medically Necessary due to the extraction of additional natural teeth. Such extraction must leave the bridge or partial denture unserviceable;
- The bridge or denture is damaged beyond repair while in the oral cavity. The Injury must occur while You are covered under this Plan; or
- The existing denture is a temporary denture, placed while You were covered under this Plan. Replacement by a permanent denture must be required and performed within 12 months of the date the temporary denture was placed.

Expenses Incurred for prosthodontic services performed on teeth other than permanent teeth are not covered.

Expenses Incurred at any time to replace a bridge or denture that meets, or can be made to meet, commonly held dental standards of functional acceptability are not covered.

The initial installation of a bridge or denture, replacing natural teeth that were extracted prior to Your effective date, is not covered. Such installation will be covered if Medically Necessary due to the loss or extraction of additional natural teeth after Your effective date.

ORTHODONTIC BENEFITS PROVISION

The Plan will pay Covered Expenses for Orthodontic Procedures. This benefit is subject to Medical Necessity and all other Plan provisions.

With respect to each Covered Person, the Lifetime Maximum Benefit payable under this Provision for all covered orthodontic expenses will not exceed the orthodontic Maximum Benefit shown in the Schedule of Benefits.

ORTHODONTIC PROCEDURE

Orthodontic Procedure means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth. Orthodontic Procedure includes minor treatment to control harmful habits and diagnostic services (casts, consultations, exams, x-rays, and related photos taken by the Dentist).

ORTHODONTIC TREATMENT PLAN

The Treatment Plan is a Dentist's report, on a form satisfactory to the Plan, that:

- Provides a classification of the malocclusion;
- Recommends and describes necessary treatment by Orthodontic Procedures;
- Estimates the duration over which treatment will be completed;
- Estimates the total charge for such treatment; and
- Is accompanied by cephalometric x-rays, study models, and such other supporting evidence as the Plan may reasonably require.

COVERED ORTHODONTIC EXPENSES

In order to be payable, orthodontic treatment must be needed for one or more of the following conditions:

- Overbite or overjet of at least four millimeters; or
- Upper and lower arches in either protrusive or retrusive relation of at least one cusp; or
- Cross-bite; or
- An arch length difference of more than four millimeters in either the upper or lower arch.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has dental coverage under more than one Plan, as defined below. It does not, however, apply to prescription benefits. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred. When a Covered Person is enrolled as a Dependent by two different [PPSTA Members](#), then this Plan will internally coordinate benefits

The order of benefit determination rules below determine which plan will pay first (i.e., which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. Up to total of 100% of charges Incurred may be paid between the plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group dental plans, whether insured or self-insured.
- Group health plans, whether insured or self-insured.
- Specified disease policies.
- Foreign policies.
- Medical coverage related to dental care under group or individual automobile policies (including no-fault policies). See the order of benefit determination rules (below).
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply.

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments related to dental care are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.
- If an individual is covered under one plan as a Dependent and another plan as a [PPSTA Member](#) or subscriber, the plan that covers the person as a [PPSTA Member](#) or subscriber (that is, other than as a Dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any [PPSTA Member](#) plan beneficiary to be eligible for primary benefits from his or her [Benefit Trust's](#) benefit plan.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. See continuation coverage below.
- If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.
- If one or more plans cover the same person as a Dependent Child:
 - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage.
 If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the Child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.
 - If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the non-custodial parent; and then
 - The plan of the spouse of the non-custodial parent.
- Active or Inactive [PPSTA Member](#): If an individual is covered under one plan as an active [PPSTA Member](#) (or Dependent of an active [PPSTA Member](#)), and is also covered under another plan as a retired or laid-off [PPSTA Member](#) (or Dependent of an active or laid-off [PPSTA Member](#)), the plan that covers the person as an active [PPSTA Member](#) (or Dependent of an active [PPSTA Member](#)) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.
- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law, and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies.
- Longer or Shorter Length of Coverage: The plan that has covered the person as a [PPSTA Member](#), subscriber, or retiree the longest is primary.
- If an active [PPSTA Member](#) is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active [PPSTA Member](#) or subscriber is considered primary.
- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

TRICARE

If an eligible [PPSTA Member](#) is on active military duty, TRICARE is the only coverage available to that [PPSTA Member](#). Benefits are not coordinated with the [PPSTA Member's](#) dental insurance plan.

In all instances where an eligible [PPSTA Member](#) is also a TRICARE beneficiary, TRICARE will pay secondary to this [Benefit Trust](#)-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers’ Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or Injuries.
 - Making court appearances.
 - Obtaining our consent or our agents’ consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.
- By participating in and accepting benefits from the Plan, You agree that:
 - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
 - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
 - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

The Plan does not pay for expenses Incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in this SPD as covered dental benefits based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Acts of War:** Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
2. **Appointments Missed:** Appointments the Covered Person did not attend.
3. **Athletic Mouth Guards.**
4. **Before Effective Date and After Termination:** Services, supplies, or expenses Incurred before coverage begins or after coverage ends under this Plan.
5. **Cosmetic:** Services or treatment for cosmetic purposes as determined by the Plan, including, but not limited to bleaching. This exclusion does not apply to Accidental Dental Injury or to orthodontic services.
6. **Denture Duplication.**
7. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical or dental reports and itemized bills.
8. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.
9. **Experimental or Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment.
10. **Fractures:** Treatment of fractures not including teeth or alveolar processes.
11. **Illegal Acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a riot or public disturbance or an illegal act, felony, or attempting to commit a criminal or illegal act. For the purpose of this exclusion, it is not necessary that criminal charges be filed and the crime could be punishable by any term of imprisonment. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
12. **Interest and Legal Fees.**
13. **Medications,** whether prescription or over-the-counter, other than those administered while in the Dentist's office as part of treatment.
14. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.
15. **Multiple Surgical and Periodontal Procedures** in the same area. Benefits will be limited to the most extensive and inclusive procedure.
16. **Myofunctional Therapy.**
17. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary.

18. **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Payment will not be made even if you or your Dependents do not claim the entitled benefits.
19. **Orthodontic Services**, unless covered elsewhere in this document.
20. **Orthognathic Surgery**, unless covered elsewhere in this document.
21. **Preventive Control Programs** including oral hygiene instruction; plaque control; dietary planning; lab tests; anaerobic culture, except in connection with periodontal disease; sensitivity testing; and bite registrations.
22. **Professionally Recognized Standards:** Procedures that are not necessary and that do not meet professionally-recognized standards of care.
23. **Programs** for oral hygiene or plaque control.
24. **Replacement** of lost, missing, or stolen appliances regardless of any other provision of this Plan.
25. **Services At No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.
26. **Services Not Furnished By a Dentist or Dental Hygienist** who is acting under a Dentist's supervision and direction, except for x-rays ordered by a Dentist.
27. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of "Close Relative."
28. **Splints** unless necessary as the result of an Accidental Injury.
29. **Supplies** for plaque control or oral hygiene that can be purchased over-the-counter.
30. **Treatment** for the purpose of altering vertical dimension, restoring occlusion, splinting, or replacing tooth structure lost as a result of abrasion, attrition, or erosion, unless covered elsewhere in this document.

Benefits not specifically included in the Covered Expenses section of this document are considered excluded.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claims Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group dental identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to [PPSTA Member](#)
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider

- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto accident, or another accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

HOW DENTAL BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group dental Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the lesser of the billed charges, a Negotiated Rate, or based on Usual and Customary amounts.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual And Customary (U&C) is the amount that is usually charged by dental care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90th percentile of MDR. As it relates to charges made by a network provider, the term "Usual and Customary" means the Negotiated Rate as contractually agreed to by the provider and network (see above)

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group dental identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the dental Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group dental Plan.
- Termination of the group dental Plan.
- The [PPSTA Member](#), Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not covered benefits under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The [PPSTA Member](#) or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision, and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision, and may not be supervised by the dental care professional who was involved. If the Plan has consulted with dental or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 45 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based, in whole or in part, on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the dental care professional who was involved. If the Plan has consulted with dental or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative) or other details, please contact the Plan. Refer to the Statement of ERISA Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Appeal request forms are available at www.UMR.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

Send dental appeals to:
 UMR
 CLAIMS APPEAL UNIT
 PO BOX 30546
 SALT LAKE CITY UT 84130-0546

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

Post-Service Claim: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits), or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your [Benefit Trust](#) fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your [Benefit Trust](#) will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the [PPSTA Member's](#) name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a qualified dental expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your [Benefit Trust](#). UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical or dental records;
- All other documents relied upon by UMR and/or Your [Benefit Trust](#) in making a decision on the case; and
- All other information or evidence that You or Your physician has already submitted to UMR or Your [Benefit Trust](#).

If there is any information or evidence that was not previously provided and that You or Your physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your [Benefit Trust](#) with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, a Covered Person has the right to further appeal an Adverse Benefit Determination by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section of this SPD for more details. **No such action may be filed against the Plan later than three years from the date the Plan gives the Covered Person a final determination on his or her appeal.**

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek dental treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If a [PPSTA Member](#) is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her [Benefit Trust](#) will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The [PPSTA Member](#) has a written, approved leave from the [Benefit Trust](#).

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

A [PPSTA Member](#) may choose not to retain group health coverage during an FMLA leave. When the [PPSTA Member](#) returns to work following the FMLA leave, the [PPSTA Member's](#) coverage will usually be restored to the level the [PPSTA Member](#) would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

This group dental Plan also complies with the provisions of the:

- Employee Retirement Income Security Act regarding coverage of Dependent Children in cases of adoption or Placement for Adoption.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's 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). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or [PPSTA Member](#) benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;
- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following [PPSTA Members](#), classes of [PPSTA Members](#), or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Benefits Manager

This list includes every [PPSTA Member](#), class of [PPSTA Members](#) or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these [PPSTA Members](#) or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the [PPSTA Members](#) or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;

- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical or dental records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical (or dental) review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your [Benefit Trust](#).

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons will have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.
- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP DENTAL COVERAGE

Covered Persons have the right to continue dental care coverage if they experience a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons have a right to know why this was done, to obtain copies of documents related to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a [PPSTA Member](#) can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to \$110 per day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If You have any questions about this Plan, contact the Plan Administrator. If You have any questions about this statement or about a Covered Person's rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the [Benefit Trust](#) reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Contact Your Human Resources or Personnel office for information regarding distribution of assets upon termination of Plan.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the [Benefit Trust](#).

GLOSSARY OF TERMS

Accidental Dental Injury / Injury means damage to the mouth, teeth, and supporting tissues due directly to a blow from outside the mouth.

Accredited Institution of Higher Education means, for the purposes of this Plan, a two-year or four-year degree-granting college or university and which is accredited in the current publication of Accredited Institution of Higher Education.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Child (Children) means any of the following individuals with respect to a **PPSTA Member**: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the **PPSTA Member's** or spouse's Legal Guardianship; a grandchild as long as the **PPSTA Member's** covered Dependent is the parent of the grandchild, **a grandchild is eligible for a limited time only, unless the PPSTA Member or the PPSTA Member's Spouse has legal custody or guardianship over such Child and legal documentation is provided to the Plan within 60 days of court approval. The newborn must be enrolled within 30 days of birth. The COBRA date of the event will be the birth of the Child and COBRA premiums will begin as of the first day of the month following the birth of the Child. If COBRA is not elected and the newborn is timely enrolled, the newborn will be covered for the first 30 days of birth only;** a foster Child; a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent"); or **an unmarried Child over the limiting age can be covered under the Covered PPSTA Member 's/Retiree's (parent's) PPSTA Member health Plan through age 29, even if he or she is not financially Dependent on the parent, or does not live with the parent, or is a not a student.**

Close Relative means a member of the immediate family. Immediate family includes the **PPSTA Member**, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives a Covered Person the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a qualifying event.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving an eligible benefit under this Plan.

Covered Person means a **PPSTA Member**, Retiree or Dependent who is enrolled under this Plan.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the dental care benefits to which it applies.

Dental Hygienist means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

Dentist means a person who is licensed to practice dentistry, and who is practicing within the scope of such license. The term also includes any physician who furnishes any dental services that such physician is licensed to perform.

Dependent – see the Eligibility and Enrollment section of this SPD.

Domestic Partner means an unmarried person of the same or opposite sex with whom the covered [PPSTA Member](#) shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

Effective Date means the first day of coverage as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency Dental Care means care of a dental condition that is required unexpectedly and immediately because of an Injury or Illness.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™, or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Illness means a bodily disorder, disease, or physical sickness affecting the mouth, teeth, or gums.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the [Benefit Trust](#) as an Independent Contractor, or an entity or individual who performs services to or on behalf of the [Benefit Trust](#) who is not a [PPSTA Member](#) or an officer of the [Benefit Trust](#), and who retains control over how work is completed. The [Benefit Trust](#) who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury that meet all of the following criteria as determined by the Plan:

- In accordance with *Generally Accepted Standards of Dental Practice*; and
- The health intervention is for the purpose of treating a dental condition; and
- It is the most appropriate supply or level of service, considering potential benefits and harm to the patient; and
- It is known to be effective in improving dental outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- It is cost-effective for a specific condition, compared to alternate interventions, including the option of no intervention. The term "cost-effective" does not necessarily mean for the lowest price; and
- It is not primarily for the convenience or preference of the Covered Person, of the Covered Person's family, or of any provider; and
- It is not Experimental, Investigational, cosmetic, or custodial in nature; and
- It is currently, or at the time the charges were Incurred, recognized as acceptable medical practice by the Plan.

The fact that a Dentist has performed, prescribed, recommended, ordered, or approved a service, Treatment Plan, supply, medicine, equipment, or facility, or the fact that such service is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, Treatment Plan, supply, medicine, equipment, or facility Medically Necessary.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Pediatric Dental Services means services provided to individuals under the age of 19.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the POUGHKEEPSIE PUBLIC SCHOOLS TEACHERS' ASSOCIATION Group Dental Benefit Plan.

Plan Year Maximum Benefit means the maximum amount of covered benefits payable during a Plan Year while a person is covered under this Plan. Once the Plan Year Maximum Benefit is met, no further covered benefits will be available for the remainder of that Plan Year for that Covered Person.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means a [Benefit Trust](#) who sponsors a group dental plan.

PPSTA Member – see the Eligibility and Enrollment section of this SPD.

QMSCO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Retired PPSTA Member / Retiree means a person who was employed full-time by the [Benefit Trust](#) who is no longer regularly at work and who is now retired under the [Benefit Trust's](#) formal retirement program.

Third Party Administrator (TPA) means a service provider hired by the Plan to process dental claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That a [PPSTA Member](#) is prevented from engaging in any job or occupation for wage or profit for which the [PPSTA Member](#) is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in activities of daily living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Treatment Plan means the Dentist's report to the Plan that:

- Lists the dental care recommended by the Dentist for the Covered Person; and
- Shows the Dentist's normal fee for each dental procedure; and
- Includes preoperative x-rays and all other diagnostic materials needed by the Plan; and
- Is prepared on a form acceptable to the Plan.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

Waiting Period means a period of time that must pass before coverage becomes effective for a [PPSTA Member](#) or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this plan to determine if a Waiting Period applies.

You / Your means the [PPSTA Member](#).