Downey Unified School District

Dental Plan

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INTRODUCTION

About This Plan

Downey Unified School District (the Employer) has established an Employee Welfare Benefit Plan. As of October 1, 2011, the dental benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the dental benefit terms described in this booklet. The Plan may be amended from time to time.

If a booklet was issued to you under the Employer's prior plan, this is your new booklet. This new booklet replaces your old booklet in its entirety. If you were covered under the replaced booklet on the day before the effective date of the Plan, you will be covered under this booklet as of the date shown above.

The dental benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Connecticut General Life Insurance Company (CIGNA) processes claims and provides other services to the Employer related to the self-funded benefits. CIGNA does not insure or guarantee the self-funded benefits.

Defined terms are capitalized and have specific meaning with respect to dental benefits, see GLOSSARY.

Discretionary Authority

The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Employer's self-funded dental benefit Plan. The Plan Administrator in his or her discretionary authority, will determine benefit eligibility under such self-funded Plan, construe the terms of the self-funded Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the self-funded Plan, including but not limited to eligibility for participation and determining whether a claim should be paid or denied.

Plan Modification/Termination

The Employer may:

- change the contributions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

DENTAL BENEFITS SUMMARY

This summary provides a general description of your dental benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

Deductible	None
Percentage Payable	
Preventive and Basic Care	
-until the end of the calendar year in which coverage became effective	70%
-during the first full calendar year following the calendar year in which coverage became effective	80%
-during the second full calendar year following the calendar year in which coverage became effective	90%
-during each calendar year thereafter	100%
Major Care	50%
Calendar Year Benefit Maximum	
Preventive, Basic and Major Care	$2,000.00
Accidental Injury	$1,000.00

ELIGIBILITY

■ Eligible Employees

For the purpose of dental benefits, an eligible Employee is a person who is in the Service of the Employer and is a resident of the United States.

A person who is a Retired Employee, as defined below, is also an eligible Employee.

Retired Employees are eligible for dental benefits.

Service

"Service" means work with the Employer on an active, full-time and full pay basis for at least 20.00 hours per week.

For Retired Employees, "Service" means the period during which you are retired according to the definition of "Retired Employee".

Retired Employee

"Retired Employee" means a person defined under the rules and regulations of Downey Unified School District as set forth by the Board of Education.

■ Eligible Dependents

It is your responsibility to notify the Employer when a covered Dependent is no longer eligible for coverage.

Your Dependents must live in the United States to be eligible for coverage.

Eligible Dependents are:

- your legal spouse or, as defined below, your Domestic Partner.
- an unmarried child, as defined below.

The following applies if you and your spouse or Domestic partner are eligible to be covered as Employees:

- If you and your spouse or Domestic Partner are covered as Employees, then each of you may elect to cover the other person as a Dependent for dental benefits. You may elect not to be covered as an Employee, and only be covered as a Dependent of your spouse or Domestic Partner for dental benefits.
- You and your spouse or Domestic Partner, if covered as Employees, may each elect to cover Dependent children.

You may elect to be covered as an Employee, but you cannot be covered as an Employee's Dependent child.

Domestic Partner

"Domestic Partner" means the person named in the Declaration of Domestic Partnership, who:

- is of your same gender or, if either person is over age 62, of your opposite gender; and
- meets domestic partner requirements as defined by California law:
  - have a common residence; and
  - agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership; and
  - not be married to someone else; and
  - not be a Domestic Partner with someone else, when that partnership has not been terminated, dissolved or adjudged a nullity; and
  - be at least 18 years of age; and
  - not be related by blood in a way that would prevent marriage to each other in California Family Code Section 297(b)(3); and
  - be mentally competent to consent to contract; and
  - both file a Declaration of Domestic Partnership with the California Secretary of State or an equivalent document issued by a local agency of California or another state where the partnership was created.

ELIGIBILITY - Continued

Declaration of Domestic Partnership means a copy of a valid Declaration of Domestic Partnership document filed with the California Secretary of State pursuant to California Family Code Section 298, or an equivalent document issued by a local agency of California or another state where the partnership was created.

Child

"Child" means:

- your natural child.
- your stepchild.
- your adopted child. This includes a child placed with you for adoption.

  "Placed for adoption" means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child's placement is considered terminated upon the termination of such legal obligation.
- a child who is recognized under a medical child support order as having a right to enrollment under the Plan.
- a foster child.
- a child of your Domestic Partner.

The child must meet the age requirements described below and depend on you for financial support. The support requirement does not apply to a child who is recognized under a medical child support order as having a right to enrollment under the Plan.

Dependent Child Age Requirements

The child is:

- under age 19.
- over the age limit and end of the month in which a student turns age 24, if a full-time student in an accredited school. Proof of the child's student status must be provided upon request, and may be required before paying a claim.

  If your Dependent child is covered under the Plan as a student, the requirement that the child be a student will be waived if the child is on a Medically Necessary Leave of Absence from a post-secondary educational institution (such as a college, university or trade school).

  Coverage will terminate on the earlier of:
  - the date that is one year after the first day of the Medically Necessary Leave of Absence; or
  - the date on which coverage would otherwise terminate under the terms of the Plan.

  The child must have been covered under the Plan as a student Dependent immediately before the first day of the Medically Necessary Leave of Absence. The Plan must receive written verification from the treating Doctor that the child is suffering from a serious Illness or Injury and that the leave of absence or other change in enrollment is medically necessary.

  A "Medically Necessary Leave of Absence" as used in this provision, is a leave of absence from a post-secondary educational institution, or any other change in enrollment of the child at the institution that starts while the child is suffering from a serious Illness or Injury, is medically necessary as determined by the Doctor and causes the child to lose student status under the terms of the Plan.

Handicapped/Disabled Child

The age limits do not apply to a child who becomes disabled, or became disabled, before reaching the age limits and who cannot hold a self-supporting job due to a permanent physical handicap or mental retardation.

"Physical handicap/mental retardation" means permanent physical or mental impairment that is a result of either a congenital or acquired Illness or Injury leading to the individual being incapable of independent living.

ELIGIBILITY - Continued

"Permanent physical or mental impairment" means:

- a physiological condition, skeletal or motor deficit; or
- mental retardation or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a "handicap" for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

At reasonable intervals, but not more often than annually, the Plan may require a Doctor's certificate as proof of the child's disability.

Medical Child Support Order

A medical child support order is a ***qualified*** medical child support order issued by a state court or administrative agency that requires the Plan to cover a child of an Employee, if the Employee is eligible for coverage under the Plan.

When the Employer receives a medical support order, the Employer will determine whether the order is "qualified".

If the order is determined to be qualified, and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing medical child support orders.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee, Retired Employee or Dependent in ELIGIBILITY will determine who is eligible for coverage under the Plan.

Coverage will begin on the first day of the month coinciding with or next following the date you satisfy any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth; and
- For any other adoptive child, from the date of placement.

Domestic Partner Eligibility

If your Employer accepts your Declaration of Domestic Partnership that has been filed with the state of California, you submit an Application for Membership and make any required contribution, then your Domestic Partner and his or her Dependent children will be covered under this Plan.

Verification of a Domestic Partnership must only be provided if your Employer requires the same verification of marital status.

You must comply with the Internal Revenue, any applicable regulations, and any applicable state laws pertaining to the value of benefits provided to your Domestic Partner. The benefits your Domestic Partner receives generally are treated as taxable.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

Dental Benefits

A late applicant may apply for coverage only during an open enrollment period. The Plan Administrator can tell you when the open enrollment period begins and ends. Coverage for a late applicant who applies during the open enrollment period will begin on the first day of the month following the close of the open enrollment period.

Special Enrollment Rights

For dental benefits, if you or your eligible Dependent experience a special enrollment event as described below, you or your eligible Dependent may be entitled to enroll in the Plan outside of a designated enrollment period and will not be considered a late applicant.

If you are already enrolled for coverage at the time of a special enrollment event, within 31 days of the special enrollment event, you may request enrollment in a different dental benefit option, if any, offered by the Employer and for which you are currently eligible.

A special enrollment event occurs if:

- You did not apply for coverage for yourself or your eligible Dependent within 31 days of the date you were eligible to do so because at the time you or your eligible Dependent was covered under another health insurance plan or arrangement and coverage under the other plan was lost as a result of:
  - Exhausting the maximum period of COBRA coverage; or

- Loss of eligibility for the other plan's coverage due to legal separation, divorce, cessation of dependent status, death of a spouse, termination of employment or reduction in the number of hours of employment; or
- Loss of eligibility for the other plan's coverage because you or your eligible Dependent no longer resides in the service area; or
- Loss of eligibility for the other plan's coverage because you or your eligible Dependent incurs a claim that meets or exceeds the lifetime maximum for that plan; or
- Termination of benefits for a class of individuals and you or your eligible Dependent is included in that class; or
- Termination of the employer's contribution for the other plan's coverage.

You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage.

- You did not apply for coverage for yourself or your eligible Dependent within 31 days of the date you were eligible to do so because at the time you or your eligible Dependent was covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan, and such coverage terminates due to a loss of eligibility. In this situation, you may request coverage for yourself and/or any affected eligible Dependent not already enrolled in this Plan. Coverage must be requested within 60 days of the date Medicaid or CHIP coverage terminated.
- You did not apply for coverage for yourself or your eligible Dependent within 31 days of the date you were eligible to do so and you or your eligible Dependent later becomes eligible for employment assistance under a state Medicaid or CHIP plan that helps pay for the cost of this Plan's coverage. In this situation, you may request coverage for yourself and/or any affected eligible Dependent not already enrolled in this Plan. Coverage must be requested within 60 days of the date the Member is determined to be eligible for such assistance.
- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage for yourself, your spouse and any newly acquired Dependents.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- A court order was issued, coverage will start on the court ordered date.
- You acquire a new Dependent, coverage will start:
  - In the case of marriage, on the date of marriage.
  - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

If you apply within 60 days of the date Medicaid or CHIP coverage is terminated or within 60 days of the date the Member is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start no later than the first day of the month following receipt of your enrollment request.

■ Will My Coverage Change?

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class the first day of the month coinciding with or next following the date the Member's class status changes.

All claims will be based on the benefits in effect on the date the claim was incurred.

WHEN COVERAGE BEGINS & ENDS - Continued

■ When Will My Coverage End?

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The date you are no longer eligible or the last day of the month coinciding with or next following the date your Service ends.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.
- The date Loss of Residence occurs.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends; or
- The date Loss of Residence occurs; or
- The date your Dependent is no longer eligible for benefits; or
- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make; or
- For your Domestic Partner and his or her Dependent children:
  - the date any local or state statute, regulation or ruling in California, makes it illegal to provide such coverage; or
  - the date you file a Notice of Termination of Domestic Partnership with the California Secretary of State pursuant to California Family Code Section 299. You must provide notice to your Employer within 30 days that such termination has been accepted by the state.

  If you enter a new domestic partnership following the date of termination of the prior partnership, then after a date which is at least six months from the date the prior domestic partnership terminated, you may file a new Domestic Partnership Document pursuant to California Family Code Section 298 and Section 298.5 and apply for coverage for your new Domestic Partner as described in the provision "When Will Coverage Begin?". This time period does not apply if the prior partnership terminated due to death or marriage of your prior Domestic Partner.

A Certificate of Creditable Coverage (CCC) will be sent when coverage for a Member ends. In addition, a CCC may be requested from the Plan Administrator at any time while a Member is covered under the Plan and up to 24 months after coverage ends.

■ Can I Continue My Coverage If I Become Ineligible?

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

Continuation of Dental Benefits during an Approved Leave of Absence or Temporary Layoff

If your Service ends due to approved leave of absence or temporary layoff, coverage will continue for 12 MONTHS after your Service terminates.

Your continuation coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

Continuation of Coverage Under California Family Rights Act (CFRA) Leave

If the Employer approves your CFRA Leave, coverage under the Plan will continue during your leave. You may be eligible for a CFRA leave to attend to any of the following:

- The birth or adoption of your child; or
- Placement of a child in your custody for foster care; or
- To care for your spouse, child, or parent with a serious health condition; or
- Your serious Illness that makes you unable to perform the functions of your job. For the purpose of leave provided under CFRA, your own serious Illness will not include pregnancy or medical conditions related to pregnancy or childbirth.

WHEN COVERAGE BEGINS & ENDS - Continued

Contributions must be paid by you and the Employer. If contributions are not paid, your coverage will cease. However, on the date you return to work, coverage will be on the same basis as that provided for any active Member on that date. If you have questions about Family and Medical Leave, see the Plan Administrator.

If you are also eligible to continue coverage under the federal FMLA law, then the continuation of coverage periods under the Federal FMLA and CFRA will run concurrently.

Pregnancy Disability Leave

If you:

- Are employed in California; and
- Are a female Employee who is unable to Work due to childbirth, pregnancy, or related medical conditions;

Then you may be eligible for disability leave under California Government Code Section 12945.

If you are eligible for leave under California Government Code Section 12945, coverage under the Plan will continue during your leave. Contributions must be paid by you and your Employer.

For more information about disability leave under California Government Code Section 12945, please see your Plan Administrator for details.

Continuation of Coverage under Federal Laws and Regulations

If coverage would otherwise terminate under this Plan, you and your Dependents may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES, CONTINUATION OF COVERAGE - FMLA and CONTINUATION OF COVERAGE - COBRA.

■ Can Coverage Be Reinstated?

If your coverage ended because of termination of your Service, you may be eligible for reinstatement of coverage if you return to Service within 12 months after the date your coverage ended.

On the date you return to Service, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

See USERRA RIGHTS AND RESPONSIBILITIES for information about reinstatement of coverage upon return from leave for military service.

DENTAL BENEFITS

■ Allowable Covered Expenses

All dental benefits are subject to allowable covered expense guidelines.

The allowable covered expense is determined by usual and customary guidelines. The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a Dentist and the fee usually charged by other Dentists in the same geographical area for these services and supplies. The Member must pay any amount over usual and customary charges.

For specialist care and any other dental care expected to cost $750 or more, Members are encouraged to ask their Dentist to prepare a treatment plan and call Member Services at (800) 663-8081.

■ What's Covered?

DENTAL BENEFITS SUMMARY shows the payment percentage applicable to various covered expenses.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services.

Services must be Medically Necessary for the diagnosis, prevention or correction of dental disease, defect or Injury. Services must be recommended or prescribed by a licensed Dentist or Doctor, or performed by a dental assistant or dental hygienist working under the direct supervision of a Dentist.

The Plan covers only the least costly procedure that will produce satisfactory results. Expenses are covered only if incurred and completed while a Member is covered for these dental benefits.

Preventive Care

Members may receive the following services twice each calendar year:

- Oral examination.
- Cleaning of teeth.
- Bite wing x-rays.
- Topical application of fluoride solution for Dependent children under 18 years of age.

Preventive care treatment also includes:

- Sealants for Dependent children, covered once per tooth per 3 years and only on specific teeth.
- A full-mouth series of x-rays once in any 12-month period.
- For Members age 14 and under, space maintainers. Space maintainers are covered once per tooth per 3 years and only for specific teeth.

Basic Care

Basic care includes:

- Simple extractions.
- Amalgam, silicate, acrylic, and composite fillings. Silicate, acrylic, and composite fillings are covered only for teeth in front of the molars.
- X-ray and lab services required for dental procedures.
- General anesthesia required for dental surgery when determined to be Medically Necessary.
- Care for relief of dental pain.
- Consultations required by the attending Dentist.
- Crowns, inlays and onlays.
- Endodontic and non-surgical periodontic services.
- Periodontic surgery and complex oral surgery.

DENTAL BENEFITS - Continued

Major Care

Major care includes:

- Fixed bridge restorations.
- Removable partial or complete dentures.
- Repairs to existing dentures.
- Occlusal mouth guard.
- Initial placement of full or partial dentures or bridgework, including abutments.
- Replacement of existing full or partial dentures, bridgework or crowns; or the addition of teeth, inlays, onlays, crowns or gold restorations to these appliances only if:
  - The existing appliance cannot be repaired or restored to use; and
  - At least five years have passed since the last placement; or
  - The replacement:
    * Replaces an existing temporary appliance; and
    * Is placed within 12 months after a temporary appliance was placed; or
    * The replacement:
      - Is needed because of the pulling of additional natural teeth or Injury to natural teeth (except for chewing injuries); and
      - Is completed within 12 months of the extraction or Injury.

If a Member has a partial denture, and a natural tooth adjacent to that denture is pulled, the addition of another tooth to the Member's denture is covered.

BENEFIT LIMITATIONS

Dental Benefit Limitations

No amount will be payable for:

- Dental appliances which have been lost, mislaid or stolen.
- Dental care that does not have ADA endorsement.
- Dental care provided to correct any birth defect or developmental malformation which does not interfere with function.
- Care of craniofacial muscle disorders and temporomandibular disorders.
- Orthodontic treatment.
- Dental care that is cosmetic in nature.
- Services not necessary for the diagnosis, prevention or care of dental disease, defect or Injury.
- Dental care provided for dietary planning for the control of dental disease or for plaque control or for oral hygiene instructions.
- Customized dental procedures.
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.
- Take-home fluoride solutions.
- Local analgesics.
- Extraoral x-rays.
- Vestibuloplasty.
- Occlusal adjustments/equilibration.
- Temporary dentures.
- Sedative fillings.
- Drugs or medications.
- Analgesia, anxiolysis, or inhalation of nitrous oxide.
- Therapeutic drug injections.
- Desensitizing medicaments.
- Application of desensitizing resin for a cervical or root surface.
- Habit-breaking appliances.
- Implants and certain implant related services.

General Benefit Limitations

No amount will be payable for:

- Services, drugs and supplies that are not Medically Necessary.
- Experimental, Investigational or Unproven services and supplies. Any service or supply that is integral or linked to an Experimental, Investigational or Unproven service or supply that, in the absence of the Experimental, Investigational or Unproven service or supply, would not be Medically Necessary, is also not covered.
- Any charge not included as a covered expense under the Plan.
- Charges which would not have been made if the Member did not have coverage.
- Charges which the Member is not obligated to pay, or for which the Member is not billed or for which the Member would not have been billed except that they were covered under the Plan.
- Broken appointments.
- Care provided by a government health plan. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses incurred for care provided by your or your spouse's immediate or extended family.
- Care received for an Illness that is a result of war or engaging in a riot or insurrection.

BENEFIT LIMITATIONS - Continued

- An Injury that occurs while working for pay or profit.
- An Illness for which the Member can receive benefits under any Workers' Compensation or similar law.

CLAIMS & LEGAL ACTION

■ How To File Claims

A claim for benefits and services that have been provided may be filed by a Member, beneficiary or Authorized Representative. An *Authorized Representative* means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission and appeals.

The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's condition will also be automatically recognized as the Member's Authorized Representative for appeals.

All claim forms include instructions on how to complete and submit a claim. Members can request a claim form from the Plan Administrator or visit the website shown on the Member ID card. Complete and accurate claim information is necessary to avoid claim processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

Health Benefits

Dental Benefits

Members must file a claim. Sign the completed form, attach the itemized bill and mail both to the address on the Member ID card.

An Explanation of Benefits (EOB) will be sent to the Member showing how the claim was paid.

For expenses incurred outside the United States, the Member must pay the bill and file a claim.

Claim Decisions

Claims for health benefits and services provided to a Member will be processed within 30 days of the date the claim is received by CIGNA. If a decision cannot be made within this time period for reasons beyond the control of the Plan, the Member will be notified of:

- the reasons for the delay;
- any information needed to perfect the claim; and
- the date by which a decision is expected.

The Member will have 45 days from the date the notice is received to provide the requested information. If the information is received within this time period, a decision will be made within 15 days of the date the information is received, unless the Member agrees to a longer period of time. If the requested information is not provided within this time period, the Member should consider the claim to be denied. The claim will be reconsidered if the information is subsequently received.

■ If A Claim Is Denied

If benefits are denied, in whole or in part, CIGNA will send the Member a written or electronic notice within the established time periods described in "How to File Claims". The Member or Authorized Representative may appeal the denial as described below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits.

The notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

Appeal of a Health Benefit Claim Denial

After receiving notice of a claim denial, in whole or in part, the Member, the Member's beneficiary, provider or other Authorized Representative can appeal a claim denial by submitting a written request within:

- 180 days of the date the notice of denial of the initial claim is received; or
- 60 days of the date the notice of the initial appeal decision is received.

The appeal request must be submitted to Health Claim Appeal at the address on the adverse determination notice. The appeal request should include the Member's and the Employee's name and identification number, the date of service, address and telephone number of the Member and the provider, and a description of the appeal.

The appeal will be reviewed by an individual who was not involved in the prior adverse determination and who is not a subordinate of the individual who made the prior determination. If the prior determination was based on medical judgment, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted and identified.

In connection with the review, the Member has the right to:

- review and request copies of relevant documents, free of charge; and
- submit issues and comments in writing; and
- have a representative act on his or her behalf in the appeal.

The decision on the appeal will be made within 30 days of the date the appeal is received.

In the case of an adverse decision of an appeal, the notice of the decision will include the information described above for a claim denial.

Two appeals are required.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is provided. Voluntary reviews must be requested within 60 days of the date the notice of the appeal decision is received.

There are no voluntary appeal rights following the required appeal process when the denial was based on medical judgment.

The Member may request information regarding voluntary appeal procedures.

For the purposes of health benefits, "medical judgment" includes but is not limited to Medically Necessity determinations.

■ What If a Member Has Other Health Coverage?

A Member may be covered under more than one health plan. For example, coverage may be under this Plan and also under a group health plan sponsored by the Employee's spouse's employer. If this type of duplicate coverage occurs, this Plan uses a method called Coordination of Benefits (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

This COB provision applies if you are covered under this Plan as an Employee and also as a Dependent of an Employee.

The benefits provided by the plans listed below are considered in coordinating benefits:

- This Plan;
- Any other group health plan, including automobile fault or no-fault insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;

CLAIMS & LEGAL ACTION - Continued

- Any individual automobile no-fault insurance plan.

Which Plan Is Primary?

Certain rules are used to determine which of the plans will be primary. This is done by using the first of the following rules that applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent.
- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the birthday rule will be used to determine the order of benefits. Under the birthday rule:
  - the plan of the parent whose birthday falls earlier in a year will be primary; but
  - if both parents have the same birthday, the plan that covered the parent longer will be primary.

  However:
  - If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
  - If the parents are legally separated or divorced, benefits for the child will be determined in this order:
    * first, the plan of the parent with custody of the child will pay its benefits;
    * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
    * finally, the plan of the parent not having custody of the child will pay its benefits.

    However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

    If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.
- A plan that covers a person as:
  - a laid-off or retired employee; or
  - a Dependent of such an employee; or
  - a continuee under a state or Federal law;

  will determine its benefits after the benefits of any other plan covering that person as an employee.

  If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
  - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
  - the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

If this Plan is primary, it will determine its benefits without considering other coverage. The Member should submit the claim first to the Benefit Payment Office listed on the claim form. When the explanation of benefits is received from this Plan, send it, along with the claim and itemized bills, to the secondary plan.

What If This Plan Is Secondary?

Submit the Member's claim first to the primary plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the Member's claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of:

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

Allowable expenses for a Member are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

■ Provision for Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness incurred by a Member (i.e. a Covered Person). A Covered Person is defined to also include the Member's legal representative.

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness;
- the insurer or other indemnifier or guarantor or indemnifier of the party or parties who caused the Illness;
- the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a Workers' Compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness.

Benefits may also be payable under the Plan in relation to the Illness. When this happens, CIGNA may, at its option:

- subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person will transfer to CIGNA any rights he or she may have to take legal action arising from the Illness to recover any sums paid under the Plan on behalf of the Covered Person;
- recover from the Covered Person any benefits paid under the Plan from any payment the Covered Person is entitled to receive from the Other Party.

The Covered Person must cooperate fully with CIGNA in asserting its subrogation and recovery rights. The Covered Person will, upon request from CIGNA, provide all information and sign and return all documents necessary to exercise CIGNA's rights under this provision.

CIGNA will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by CIGNA for the Illness, plus the amount of all future benefits which may become payable under the Plan which result from the Illness. CIGNA will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

No Covered Person shall make any settlement which specifically reduces or excludes, or attempts to exclude, the benefits provided by the Plan.

If the Covered Person:

- makes any recovery from any of the sources described above; and
- fails to reimburse CIGNA for any benefits which arise from the Illness;

then:

- the Covered Person will be personally liable to CIGNA for the amount of the benefits paid under this Plan; and
- CIGNA may reduce future benefits payable under this Plan for any Illness by the payment that the Covered Person has received from the Other Party.

CIGNA's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- an Employee's minor covered Dependent;
- the estate of any Covered Person; or
- on behalf of any incapacitated person.

■ Other Information a Member Needs to Know

Proof of Claim

Send written claim to CIGNA as soon as reasonably possible. A Member must submit a written claim no later than 15 months from the date the claim is incurred, unless legally incapable of doing so.

Complaint Process

For concerns or complaints, contact Member Services at the phone number shown on the ID card. Whether the issue involves health care or the administration of coverage, CIGNA's representatives will do what they can to make sure it's addressed. No retaliatory action will be taken by CIGNA against the Member because of a complaint. CIGNA's goal is for the Member to be completely satisfied with the measures taken to resolve the issue. However, if a Member is not satisfied, CIGNA's representatives can help the Member begin the formal complaint process. If the issue is not resolved to the Member's satisfaction, the Member may appeal.

For complaints involving timely claim payment or a denial of a claim see "How To File Claims".

For all other complaints, including those related to availability, delivery or quality of a health care service, contact Member Services for an explanation of the complaint process.

Legal Actions

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Physical Examinations

The Company, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary.

CLAIMS & LEGAL ACTION - Continued

Benefit Payments

Benefits will be paid to the Member, if living. If not, benefits will be paid to the Member's estate. If any benefit is payable to the Member's estate or to a person who cannot give a valid release, then CIGNA can pay up to $1,000.00 to any relative it considers to be entitled to such payment. The Member may request in writing that payments under the Plan be made directly to the person providing the services.

GLOSSARY

Dentist

A person licensed to practice dentistry.

Dependent

See ELIGIBILITY.

Doctor/Physician

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if:

- He or she performs a service within the scope of his or her license and for which this Plan provides coverage; and
- State law requires such practitioner to be covered.

Employee

See ELIGIBILITY.

Employer

- Downey Unified School District.

Hospital

An institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Illness

An Injury, a sickness, a disease, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

Loss of Residence

Being outside the United States for more than 60 days. However, a Member will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States:

- On vacation;
- To study; or
- To conduct business for your Employer;

For a period of up to, but not exceeding, 60 continuous days.

Maximum Reimbursable Charge

See WHAT'S COVERED? (Covered Expenses).

GLOSSARY - Continued

Medically Necessary/Medical Necessity

Health care services and supplies, such as medication, that a Physician or Dentist, exercising prudent clinical judgment, provides to a Member for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and are:

- In accordance with generally accepted standards of medical or dental practice; and
- Clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Member's Illness, Injury or disease; and
- Not deemed to be cosmetic; and
- Specifically allowed by the licensing statutes which apply to the Physician or Dentist who provides the service or supply; and
- At least as medically effective as any standard care and treatment; and
- Not primarily for the convenience, psychological support, education or vocational training of the Member, Physician, Dentist or other health care provider; and
- Not more costly than an alternative service, supply or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical or dental practice" mean the:

- Standards that are based on credible scientific evidence published in peer-reviewed medical and dental literature generally recognized by the relevant medical and dental community;
- Recommendations of an American Medical Association-recognized Physician specialty society or of an American Dental Association-recognized Dentist specialty society;
- Prevalent practices of Physicians or Dentists in the relevant clinical area; or
- Any other relevant factors.

Medical Management may require satisfactory proof in writing that any type of service or supply received is Medically Necessary. Medical Necessity will be determined solely by Medical Management, in accordance with the definition above.

Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare Advantage plans.

Member

An Employee and any covered Dependent.

Plan

The dental benefits described in this booklet.

Retired Employee

See ELIGIBILITY.

Service

See ELIGIBILITY.

You and Your

An Employee.

USERRA RIGHTS AND RESPONSIBILITIES

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service. This includes the right to continue the dental coverage that you (the Employee) had in effect for yourself and your Dependents.

"Uniformed Service" means the performance of active duty in the Uniformed Services under competent authority which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

Continued Dental Coverage

Under USERRA, you are eligible to elect continued dental coverage for yourself and your Dependents when you terminate Service with the Employer for the purpose of Uniformed Service.

The Employer should establish reasonable procedures for electing continued dental coverage and for payment of contributions. See the Plan Administrator for details.

If you do not provide advance notice of your leave and you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service.

However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if you elect coverage for yourself and your Dependents and pay all unpaid contributions within the period specified in the Employer's reasonable procedures.

If you provide advance notice of your leave but you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service, when the duration of Uniformed Service is at least 30 days.

However, coverage will be retroactively reinstated if the Employer has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and you elect coverage for yourself and your Dependents and pay all unpaid contributions within the time period specified in the procedures.

If the Employer has not established reasonable procedures, then the Employer must permit you to elect continued coverage for yourself and your Dependents and pay all required contributions at any time during the period of continued coverage, and the Employer must retroactively reinstate coverage.

If you elect continued coverage but do not make timely payments for the cost of coverage

If the Employer has established reasonable payment procedures and you do not make payments according to the procedures, then coverage for you and your covered Dependents will terminate as described in the procedures.

Period of Continued Coverage

During a leave for Uniformed Service, the period of continued coverage begins immediately following the date you and your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

Cost of Continued Coverage

If the period of Uniformed Service is less than 31 days, you are not required to pay more than the amount that you paid as an active Employee for that coverage for continued coverage.

USERRA RIGHTS AND RESPONSIBILITIES - Continued

If the period of Uniformed Service is 31 days or longer, then you will be required to pay up to 102% of the applicable group rate for continued coverage.

COBRA Coverage

If you are entitled to COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

Reinstatement of Coverage

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

CONTINUATION OF COVERAGE - FMLA

This provision applies if the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), as amended. If you are eligible for FMLA leave and if the Employer approves your FMLA leave, coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If your coverage ends during FMLA leave, a COBRA qualifying event occurs if you do not return to work on the date you are scheduled to return from your FMLA leave. See the Plan Administrator with questions about FMLA leave.

CONTINUATION OF COVERAGE - COBRA

This provision generally explains COBRA continuation coverage, when it may become available to a Member and what a Member needs to do to protect the right to receive it. COBRA continuation coverage, is a temporary extension of coverage under the Plan, and was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

In some circumstances, COBRA requires that Members who are "qualified beneficiaries" and who lose group Dental plan coverage be given an opportunity to continue that coverage when there is a "qualifying event" that would result in a loss of that Plan coverage. The law permits continuation of the same coverage under which the person was covered on the day before the qualifying event occurred, unless the person moves out of the Plan's coverage area or the Plan is no longer in force. Each qualified beneficiary will have the same rights under the Plan as others who are covered under the Plan, including open enrollment and special enrollment rights.

Only a "qualified beneficiary", as defined by COBRA law, may elect to continue coverage. Depending on the type of qualifying event, qualified beneficiaries can include you (the Employee) and/or your spouse and Dependent children.

Pursuant to federal law, the following individuals are *not* qualified beneficiaries for purposes of COBRA continuation, regardless of whether the individual was covered under the Plan on the day before the qualifying event: domestic partners (including Domestic Partners as defined in the Plan), spouses who do not meet the definition of spouse under federal law, children who have not been legally adopted by the Employee (such as children of a domestic partner, step-children and grandchildren, unless adopted by the Employee). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you (the Employee) elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, coverage for such individuals will terminate when your COBRA continuation coverage terminates. The provision entitled "Extension of COBRA Continuation Coverage" does not apply to these individuals.

CONTINUATION OF COVERAGE - COBRA - Continued

Right to COBRA Continuation Coverage

- As an Employee, you have a right to choose COBRA continuation coverage, if you lose your coverage due to a reduction in your hours of employment, or due to voluntary or involuntary termination of your employment, for any reason except gross misconduct.
- As a qualified beneficiary Dependent spouse, you have the right to choose COBRA continuation coverage, if you lose your coverage due to the Employee's death, or the Employee's termination of employment or reduction in hours of employment, as stated above, or due to your divorce or legal separation. If the Employee cancels your coverage in anticipation of your divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you have lost coverage earlier.
- Your Dependent Child who is a qualified beneficiary, including an alternate recipient under a medical child support order, has the right to choose COBRA continuation coverage if the Dependent Child loses coverage due to the reasons stated above or ceases to be an eligible Dependent under the terms of the Plan.
- As a retired Employee, in addition to COBRA continuation rights as stated above, you have a right to choose COBRA continuation coverage, if you lose your coverage due to and within one year before or after the Employer's filing a proceeding in bankruptcy under Chapter 11 of the Bankruptcy Code. Your eligible Dependents will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Length of COBRA Continuation Coverage

Generally:

- In the case of loss of coverage due to termination of employment or reduction in hours of Service, coverage may be continued for those who elect continuation coverage, for up to 18 months from the date of loss of coverage.
- In the case of loss of coverage due to your death, divorce or legal separation, or a Dependent Child ceasing to be a Dependent under the terms of the Plan, coverage may be continued for those who elect continuation coverage, for up to 36 months from the date of such event.
- If an Employee becomes entitled to Medicare and later has a qualifying event, which is a termination of employment or reduction of hours, within 18 months of entitlement to Medicare, then the maximum coverage period for the Dependent spouse and children will be 36 months which begins from the date the Employee becomes entitled to Medicare.
- With respect to Members qualified for COBRA continuation coverage due to the Employer's bankruptcy filing as described above, those who lose coverage may elect continuation coverage. The coverage will continue for up to:
  - the date of your death, if you are retired; or
  - the date of the surviving spouse's death; or
  - 36 months after your death if your Dependent elected COBRA continuation coverage.
- If, after the occurrence of any event described in the Right to COBRA Continuation Coverage above, the Member is allowed to continue coverage under the Plan (whether or not contributions are required) beyond the Plan's termination of coverage provision for any reason other than to comply with the federal law (i.e. state laws mandating continuation coverage or the Plan's special provisions), such continuation period(s) will be used to reduce the maximum length of COBRA continuation coverage period otherwise available to such person under this provision.

Extension of COBRA Continuation Coverage

- *Disability Extension* - If you lose coverage because of termination of your employment or reduction in your hours of employment, and if anyone in your family unit is determined under Title II or XVI of the Social Security Act to have been Totally Disabled at any time during the first 60 days of COBRA continuation coverage, then the Totally Disabled Member and other qualified beneficiaries who are entitled to COBRA continuation coverage may extend the continuation for 11 additional months.
- *Second Qualifying Event* - If your Dependent:
  - is covered under COBRA because of termination of your employment or reduction in your hours of employment; and
  - while covered under COBRA experiences a second qualifying event, such as a divorce or legal separation or ceasing to be an eligible Dependent;

then such qualified beneficiaries are entitled to up to a maximum of 36 months of COBRA coverage from the date of the first qualifying event.

Health FSA

The maximum COBRA coverage period for a health flexible spending arrangement (Health FSA), if maintained by your Employer, ends on the last day of the Flexible Benefits Plan Year in which the qualifying event occurred.

Notice Requirements

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator of the Employer or the representative of the Employer has been timely notified that a qualifying event has occurred.

When the qualifying event is termination of employment, reduction of hours of employment, death of the Employee or commencement of a proceeding in bankruptcy (applicable only to covered Retired Employees and their Dependents), the Plan Administrator will notify the Employee within 44 days of the later of the date of the qualifying event or the date coverage ends.

Dependents - If your spouse or Dependent children become eligible for COBRA continuation coverage due to divorce or legal separation or end of dependency status, or upon occurrence of a second qualifying event, the Plan Administrator or the representative of the Employer must be notified within 60 days of the first or the second qualifying event. The notice must be provided following Reasonable Notice Procedures, as described below.

If the notice is not provided within 60 days of the qualifying event, your spouse or Dependent children will lose the right to such coverage.

If you have a child or adopt a child while covered under COBRA, and you decide to add the child to your COBRA continuation coverage, then you must notify the Plan Administrator or the representative of the Employer of the birth or adoption within the 30 days of birth, adoption or placement for adoption in order for the child to be considered a COBRA qualified beneficiary. The notice must be provided following Reasonable Notice Procedures, as described below.

Disability Extension - A Member who wishes to continue COBRA continuation coverage under the Disability Extension must notify the Plan Administrator or the representative of the Employer of the Social Security Administration's disability determination within 60 days of such determination and before the end of the initial 18-month COBRA coverage period. If the notice is not provided within the specified timeframe, the qualified beneficiary and the members of the family unit will lose the right to extend COBRA coverage under the Disability Extension.

If the Social Security Administration determines that the qualified beneficiary's disability ceases to exist, then the qualified beneficiary must notify the Plan Administrator or the representative of the Employer of this information within 30 days of such determination.

The notice must be provided following the Reasonable Notice Procedures, as described below.

Reasonable Notice Procedures

Any notice that needs to be provided must be in writing. Oral notice, including notice by telephone, is not acceptable. The qualified beneficiary must mail the notice to the contact person at the address specified below:

Karen Quick
11627 Brookshire Avenue
Downey, CA
90241

The notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name and address of the Employee covered under the Plan and the names and addresses of the qualified beneficiaries, the qualifying event and

the date of the qualifying event. If a qualifying event is a divorce, the notice must include a copy of the divorce decree. In case of a disability, the notice must include the name of the disabled qualified beneficiary, the date of disability and a copy of the Social Security Administration's letter of determination of disability or determination that the qualified beneficiary is no longer disabled. The notice must be provided by the qualified beneficiary, spouse or parent, if applicable, or by an authorized representative of the qualified beneficiary.

Election of COBRA Continuation Coverage

When a qualifying event occurs, the Employer or a representative of the Employer must give the qualified beneficiary the necessary COBRA election form. The qualified beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice or the date the qualified beneficiary would lose coverage, whichever is later. To elect coverage, the qualified beneficiary must follow the procedures specified in the Election Form. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If the qualified beneficiary does not elect coverage within the 60-day election period, the qualified beneficiary will lose the right to elect COBRA continuation coverage. The qualified beneficiary has the right to change a prior rejection of COBRA continuation coverage anytime within the 60-day election period by following the procedures specified in the Election Form. Failure to continue this coverage will affect future rights under federal law, such as the right to purchase individual health insurance policies that do not impose a pre-existing condition exclusion.

Cost of Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the applicable group rate.

If a qualified beneficiary elects to continue coverage, the qualified beneficiary must make the first payment for continuation within 45 days of the election. The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover the entire initial period from the date coverage would have otherwise terminated, up to the date the qualified beneficiary makes the first payment. If the qualified beneficiary fails to make the first payment, they will lose the continuation coverage rights under the Plan. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

After the qualified beneficiary makes the first payment for continuation coverage, they will be required to pay for continuing the coverage for each subsequent month of coverage; they will be given a grace period of 30 days to make each periodic payment. The coverage will be continued as long as payment for that period is made before the end of the grace period.

The Plan may require payments of up to 150% of the applicable group rate if coverage is extended under the *Disability Extension*.

In some situations, the American Recovery and Reinvestment Act of 2009 (ARRA), as amended, may reduce the COBRA premium. A premium reduction may be available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008, and ending with February 28, 2010, or later date as reflected in federal law. If a qualified beneficiary qualifies for a premium reduction, the qualified beneficiary is responsible for paying 35% of the COBRA premium otherwise due. This premium reduction is available for up to a maximum 15 months. If a qualified beneficiary's COBRA continuation coverage is longer than the maximum number of months, the qualified beneficiary is responsible for the full cost of coverage.

Termination of COBRA Continuation Coverage

The COBRA continuation coverage may terminate before the maximum period of continuation runs out if:

- The required contribution is not paid; or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare benefits (except for a person whose continuation coverage right derives from the Employer's filing for reorganization under Chapter 11 of the Bankruptcy Code); or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not impose a pre-existing condition limitation for a pre-existing condition of a qualified beneficiary; or

CONTINUATION OF COVERAGE - COBRA - Continued

- After the date the qualified beneficiary qualifies under the *Disability Extension*, the beneficiary is no longer disabled; or
- All of Employer's group health plans are terminated.

The qualified beneficiary must notify the Employer or its representative of the beneficiary's entitlement to Medicare coverage under another group health plan or that the beneficiary is no longer disabled within 30 days of the event. The notice must comply with the Reasonable Notice Procedures, described above. The Employer or its representative will notify the qualified beneficiary of the termination of coverage if it happens prior to the maximum period of COBRA continuation coverage.

For more information about COBRA continuation of coverage, a Member may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

In order to protect your rights and your Dependent's rights, you should keep the Plan Administrator informed of any changes in the address of family members.

The Trade Act of 2002

The Trade Act of 2002 created a special second COBRA election period for certain displaced workers receiving Trade Adjustment Assistance (TAA) under the Trade Act of 1974. A Member who did not elect COBRA continuation coverage during the initial 60-day election period that was a direct consequence of the TAA-related loss of coverage, may elect COBRA continuation coverage during a second 60-day period that begins on the first day of the month in which the Member is determined to be "TAA-Eligible". The election must be made within 6 months after the date of the TAA-related loss of coverage.

Under the new tax provisions eligible individuals can either take a tax credit or get advance payment of 65% of contributions paid for qualified health insurance, including COBRA continuation coverage. Federal law amended these provisions, including an increase in the amount of the credit to 80% of contributions for coverage before January 1, 2011, and temporary extension of the maximum period of COBRA continuation for eligible individuals.

If you have questions about the new tax provisions you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282.