KEEP THIS BOOKLET FOR FUTURE REFERENCE

OAKLAND FIREFIGHTERS HEALTH AND WELFARE TRUST

SUMMARY PLAN DESCRIPTION (SPD) AND PLAN DOCUMENT FOR THE DENTAL BENEFITS

Effective January 1, 2018

OAKLAND FIREFIGHTERS
HEALTH AND WELFARE TRUST

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IMPORTANT NOTICES

CAUTION – FUTURE PLAN AMENDMENTS

Future amendments to the Plan may have to be made from time to time to comply with new laws or amendments passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Board of Trustees. You will be notified if there are important amendments to the Plan. Before you decide to retire, you may want to contact the Trust Fund Office to determine if there have been Plan amendments or other developments that may affect your retirement Plans.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENT

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights.

You are not entitled to rely upon oral statements of Employees of the Trust Fund Office, a Trustee, an Employer, and Union officer, or any other person or entity. As a courtesy to you, the Trust Fund Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits.

If you wish an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Trust Fund Office. **To make their decision, the Trustees must be furnished with full and accurate information concerning your situation**.

You should further understand that, from time to time, there may be an error in a payment or on other matters which may be corrected upon an audit or review. **The Board of Trustees reserves the right to make corrections whenever any error is discovered**.

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may amend or otherwise change the Plan at any time, including the eligibility requirements and any other rules. Moreover, the Board of Trustees may require new or greater co-payments at any time.

NO GUARANTEE OF A PARTICULAR PROVIDER

The continued participation of any one physician, hospital, or other provider cannot be guaranteed. The fact that a physician or provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it medically necessary or guarantee that it is a covered service.

ONE YEAR TO FILE A LAWSUIT

If a claim has been denied and you filed an appeal which is also denied, or you have a different type of adverse determination, you have one year from the date of the denial of the appeal or the adverse determination to file a lawsuit seeking to overturn the appeal and/or adverse determination. Failure to do so means that you will not be able to file your lawsuit.

Quick Reference Chart – Where to Call for Information

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Administrative Office • Claim Forms • Dental Claims and Appeals • COBRA Administrator • Cost of COBRA Continuation Coverage • COBRA Premium payments • COBRA Second Qualifying Event and Disability Notification • Dental predeterminations	**Health Services & Benefit Administrators** 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756 Phone: (925) 833-7313 Email: OaklandFireDental@HSBA.com **For Claims involving Urgent Care,** please contact the Administrative Office.
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**Privacy & Security Officer** **Health Services & Benefit Administrators** 4160 Dublin Boulevard, Suite 400 Dublin, CA 94568-7756 Phone: (925) 833-7313

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I. Introduction

What This Document Tells You

This Summary Plan Description (SPD)/Plan Document describes the self-funded dental benefits that are part of the Oakland Firefighters Health and Welfare Fund (the "Fund"). The Plan described in this document is effective January 1, 2018, and replaces all other plan documents, summary plan descriptions and applicable amendments as to those documents previously provided to Plan participants. This document is both the Summary Plan Description and the Plan Document.

All provisions of this document contain important information. If You have any questions about Your coverage or Your obligations under the terms of the Plan, be sure to seek help or information.

IMPORTANT INFORMATION

The Fund is committed to maintaining dental coverage for Employees, Retirees and their eligible family members at an affordable cost, however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverage at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the important changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where You and Your family can find and refer to them.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

Questions You May Have

If You have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Administrative Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the Administrative Office staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Administrative Office and obtain a written response. In the event of any discrepancy between any information that you receive from the Administrative Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

Foreign Language Assistance

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Administracion en Phone: (925) 833-7313

This booklet is both the Plan Document and the Summary Plan Description (SPD)

IMPORTANT NOTICE – NOTIFY THE PLAN OF CERTAIN CHANGES

You or Your Dependents must promptly furnish to the Administrative Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in Domestic Partnership status, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give this Plan a timely notice (as noted above) may cause Your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are paid to an ineligible person.

Statement of the Fund's Rights

In order that the Trust may carry out its obligation to maintain, within the limit of its resources, a program dedicated to providing the maximum possible benefits for all Employees, Retirees and their Dependents, the Board of Trustees expressly reserves the right, in its sole discretion at any time, and from time to time, but upon a non-discriminatory basis to:

- Terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already occurred; and
- Alter or postpone the method of payment of any benefit; and
- Amend or rescind any other provisions of the Plan.

You are not entitled to rely upon oral statements of employees of the Administrative Office or a Trustee. If you wish an official interpretation of the Plan, you should make a written request to the Administrative Office.

II. ELIGIBILITY FOR BENEFITS

Who Is Eligible?

The dental benefits of the Health and Welfare Trust are available to the following eligible active and retired Employees as well as their eligible Dependents.

- An active employee is a person who is employed under a Memorandum of Understanding (MOU) between the City of Oakland and the IAFF, Local 55.
- Persons employed by the IAFF, Local 55.
- Retired Employees who meet the requirements outlined in this booklet.

ALERT: RETIREE BENEFITS ARE NOT VESTED.

INITIAL ELIGIBILITY AND CONTINUING ELIGIBILITY FOR RETIREE COVERAGE DEPENDS ON THE BOARD OF TRUSTEES CONTINUING THE RETIREE BENEFITS. THE BOARD OF TRUSTEES RESERVES THE RIGHT TO CHARGE FOR, MODIFY AND/OR TERMINATE THE RETIREE BENEFITS AT ANY TIME. RETIREE BENEFITS ARE NOT A VESTED RIGHT.

Employees

A full-time active employee (as determined by the City) is eligible for Plan benefits on the first day of the month following the month in which payment is made on his behalf to the Trust, provided he has filed a timely application for enrollment in the Plan in a form and manner established by the Trustees.

Eligible Dependents

Dependents of active Employees or Retirees become eligible for Plan benefits on the same date that the active employee's coverage becomes effective provided that a timely and complete application is filed with the Trust and the Employee enrolls such dependents on a timely basis.

An eligible Dependent is:

- the Employee's or Retiree's lawful spouse (including opposite-sex and same-sex spouses) who is not legally separated from the spouse in any form. A spouse becomes eligible as of the date of marriage, provided that you have submitted an updated Enrollment/Change Form adding your spouse along with a copy of your certified marriage certificate within 30 days of the date of marriage. If an updated Enrollment/Change Form and proper documentation is not received within 30 days of the date of marriage, enrollment in the Plan for your spouse will not be effective until the first of the month following receipt of the required documentation.

  A former spouse is NOT eligible for coverage as a Dependent under the Plan, and a Participant may not enroll a former or Separated Spouse, even if a court orders such coverage, **except as required by COBRA.**

- the Employee's or Retiree's domestic partner. A domestic partner is a person in a committed relationship with the Employee or Retiree, in which two cohabiting, unrelated people who are over the age of 18, share common responsibility for the necessities of life and have resided together for at least six months prior to registering for a Certificate of Domestic Partnership (with the City Clerk's Office). To enroll a domestic partner in the Plan, an Employee or Retiree must submit to the Administrative Office a Certificate of Domestic Partnership (or

similar certificate or form if enrolled in a jurisdiction other than the City of Oakland). In most situations, the Domestic Partner will not qualify as a tax dependent for Federal Tax purposes and as such, the employee will be taxed on the value of the benefit provided to him or her. This is called "imputed income" and the employee will have to pay tax on this amount. California Tax law extends benefits to domestic partner health coverage and treats registered domestic partners as a spouse of the taxpayer for certain medical tax benefits. Thus, California law provides for a specific deduction, on the state income tax return, for premiums paid for domestic partner coverage. This is only a change to state tax law, and does not change the taxability of domestic partners under federal tax law.

Employees and Retirees must enroll their domestic partner in the Plan within 60 days of registration, or wait until the next open enrollment. The Board of Trustees may establish a time period and procedure for current and future enrollments of domestic partners.

Within 30 days of termination of the domestic partnership, an Employee must file a Statement of Termination of a Domestic Partnership through the City Clerk's Office (or other appropriate office if from another jurisdiction), and send a copy of the Statement to the Administrative Office within that 30-day period.

- the Employee's or Retiree's children younger than age 26 if they are:
  - Natural or adopted children or children placed for adoption; or
  - Stepchildren; or
  - A child that is named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice; or
  - Children of a domestic partner.

A dependent who is in full-time military service is excluded from coverage unless otherwise required by applicable law.

Adult Disabled Child: If, upon reaching the limiting age, an Employee or Retiree's unmarried dependent child is incapable of self-support due to physical or mental disability, coverage with this Plan may be extended (subject to all other Plan provisions and limitations) provided proof of the child's disability and continued dependency is submitted to the Plan within 31 days of the child's limiting birthday. Thereafter, additional proof of continued disability and dependency must be submitted as requested from time to time.

Qualified Medical Child Support Orders (QMCSO)

According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. In addition, a properly completed National Medical Support Notice (Notice) must be treated as a QMCSO. A Notice is a standardized medical child support order used by a State child support enforcement agency to enforce medical child support obligations. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO

- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined; and
- States the period for which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type of benefit or any option that the Plan does not otherwise provide, or if it requires an Employee or Retiree who is not covered by the Plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. If the order names an Employee or Retiree who is not enrolled in the Plan, but is eligible to enroll, the Dependent Child must be covered. For instance, if as a condition for covering the Employee's Dependents, the Employee must be enrolled, the Plan must enroll both. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of the Employee's or Retiree's Dependent Children, the Administrative Office will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on the Employee or Retiree, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the Employee or Retiree is covered by the Plan, the Administrative Office will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent Child(ren).

If the Employee or Retiree is a participant in the Plan, the QMCSO may require the Plan to provide coverage for the Employee's or Retiree's Dependent Child(ren) and to accept enrollment for the Child(ren) from a parent who is not a Plan participant. The Plan will accept enrollment of the Dependent Child(ren) specified by the QMCSO from either the Employee/Retiree or the custodial parent. Coverage of the Dependent Child(ren) will become effective as of the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, as is permitted by applicable law.

Coverage of a Dependent Child under a QMCSO will terminate when coverage of the Employee-parent or Retiree-parent terminates for any reason, subject to the Dependent Child's right to elect COBRA Continuation Coverage if that right applies. No eligible Employee's or Retiree's child covered by a QMCSO will be denied coverage on the grounds the child is not claimed as a dependent on the Employee's or Retiree's federal income tax return or does not live with the Employee or Retiree.

If a National Medical Support Notice is received, the Administrative Office will notify the Employee or Retiree of the requirements for compliance.

Retired Employees and Their Dependents

A firefighter is considered a "Retiree" (retired Employee) if he is currently receiving a firefighter's pension from the City of Oakland or PERS and enrolls for retiree benefits within 60 days after he ceases to be eligible as an active Employee under the Health and Welfare Trust.

A retired Employee is eligible for Plan benefits on his retirement effective date from the City of Oakland or PERS, provided that he has filed a timely application and makes the necessary payments to the Trust.

Dependents of retired Employees become eligible for Plan benefits on the same date the retired Employee's coverage becomes effective provided that a timely application is filed and the required payments are made to the Trust.

Termination of Eligibility

An Employee's eligibility will terminate on the earliest of the following dates:

- the first day of the month for which timely payment has not been made to the Trust; or
- the first day of the month following the month for which the Employee no longer meets the eligibility rules of the Plan.
- The date the Plan is discontinued.

A Retiree's eligibility will terminate on the earliest of the following dates:

- the first day of the month following the month for which the Retiree no longer meets the eligibility rules of the Plan.
- The date the Plan is discontinued.

A dependent's eligibility will terminate on the earliest of the following dates:

- the date the Employee's eligibility terminates; or
- the date the dependent (including a spouse, domestic partner, or child) fails to meet the eligibility requirements for dependents.
- The date the Plan is discontinued.

Surviving Dependents of Deceased Employees/Retirees – The surviving spouse and eligible children who were enrolled in the Plan on the date of the Employee's/Retiree's death remain covered by the Plan until the earliest of:

- the date the surviving spouse remarries; or
- the date the child no longer qualifies as a Dependent; or
- the date the Plan is discontinued.

Important: It is the participant's responsibility to notify the Plan within 30 days of any change in eligibility status of his or her Dependents. The Plan shall have the right to recover any funds paid on behalf of any ineligible dependent. A participant is required to notify the Administrative Office immediately of a divorce.

The Plan's Continuation of Eligibility Provisions

The eligibility of an Employee and his dependents may continue under the following conditions:

- *Leave of Absence* – If an active Employee is granted a temporary leave of absence, he may continue to maintain eligibility for himself and his dependents by making the required continuous self-payments to his employer, which will be forwarded to the Trust.
- *Disability* – If an active Employee is disabled as a result of illness or injury and is unable to perform the duties of his regular occupation, he may continue eligibility for himself and his dependents by making continuous self-payments to his employer, which will be forwarded to the Trust.
- *Surviving Dependents of Employees* – The surviving spouse and eligible children who were enrolled in the Plan on the date of the Employee's death remain covered by the Plan until the earliest of:
    - the date the surviving spouse remarries; or
    - the date the child no longer qualifies as a Dependent; or
    - the Plan is discontinued.

Family Medical Leave Act

The Family Medical Leave Act (FMLA), provides that if you work for an employer covered by that Act you are entitled to coverage under the Plan for up to 12 weeks of unpaid FMLA leave per year if:

1. You worked for the Employer for at least 12 months and for a total of at least 1,250 hours during the12 months before you take leave;
2. You work at a location where the Employer has at least 50 or more employees within 75 miles of your jobsite; and
3. You require leave for one of the following reasons:
    a. Birth of a child and to care for the newborn child within one year of birth;
    b. Placement of a child for adoption of foster care and to care for the newly placed child within one year of placement;
    c. Care for your child, spouse or parent with a serious medical condition;
    d. Your own serious health condition that makes you unable to perform the essential functions of your job;
    e. **Military Caregiver Leave** for up to 26 weeks in a single 12-month period to care for your spouse, son, daughter, parent, or next of kin who is member of the Armed Forces (including the National Guard or Reserves), and undergoing medical treatment, recuperation, or therapy for a serious injury or illness; or
    f. **Military Qualifying Exigency Leave** for up to 12 weeks of leave because of any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent who is a member of the National Guard and Reserves (excluding a member of the Regular Armed Forces) is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. Qualifying exigencies for which an employee may take leave include: short-notice deployment, military events and related activities, child care and school activities (such as arranging for alternative child care), financial and legal arrangements, counseling, rest and recuperation, and post-deployment activities.

If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

Employees who Enter Active Military Service

A participant who enters military service (whether voluntarily or involuntarily) will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about Your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA?

USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because You have been called to active duty in the uniformed services. USERRA protects Employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the

commissioned corps of the Public Health Service and anyone else designated as covered by the President of the United States during time of war or national emergency.

Your coverage under this Plan will terminate when You enter active duty in the uniformed services. However, You and Your eligible Dependents have the right to USERRA continuation of health coverage under the Plan.

- If You elect USERRA temporary COBRA continuation coverage, you (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the date You stopped working.
- If You go into active military service for **fewer than 31 days**, you (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan at the same cost as before your less than 31 days of military service.
- If you go into active military service for more than 30 days, You and any eligible Dependents may elect to purchase COBRA-like coverage for up to 24 months. After the first 30 days you will be required to pay a premium which is 102% of the Plan's cost of the coverage. Please note that coverage under USERRA is not the same as COBRA. Typical rights under COBRA are for 18 months, rather than the longer 24-month period.

Duty to Notify the Plan

The Plan will offer You USERRA continuation coverage only after the Administrative Office has been notified by You in writing or verbally that You will be serving in the uniformed services. You are not required to get your Employer's permission before leaving for uniformed service. However, you must notify the Administrative Office (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which You will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage

Once the Administrative Office receives notice that You have been called to active duty, the Plan will offer the right to elect USERRA coverage for the You (and any eligible Dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if You do not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Additionally, you (and any eligible Dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. **Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively.** Contact the Administrative Office to obtain a copy of the COBRA or USERRA election forms. This Plan has elected to apply the same procedures as for notification and election of COBRA coverage to the 24-months of USERRA continuation coverage. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If You go into active military service for up to **31 days**, you (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan at the same cost as before your less than 31 days of military service leave.
- If You elect USERRA temporary continuation coverage, you (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the date You stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be

102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

In addition to USERRA or COBRA coverage, your eligible Dependents may be eligible for health care coverage under **TRICARE** (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

If You return to work or become available for work for a Contributing Employer when You are discharged from military service (not less than honorably), eligibility will be reinstated on the day You return to work provided You return to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days, you will be eligible for the balance of the calendar month in which You return to work and for the next calendar month, provided You give written notice to the Administrative Office within 10 days after Your return to work. After that You will be entitled to eligibility:
- 14 days from the date of discharge if the period of service was 30 days or more but less than 181 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours of rest period), if the period of service was less than 31 days.

If You are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

You must notify the Administrative Office in writing within the time periods listed above. Upon reinstatement, your coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding Your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Administrative Office.

Keeping the Administrative Office Informed of Any Changes

You must notify the Administrative Office when ANY change occurs in the information provided on the enrollment form – for example, marriage, birth of a child, death, divorce, termination of domestic partnership or any other change in Your family status. You must also notify the Administrative Office if You change Your address.

It is very important that You notify the Administrative Office if You and Your spouse divorce. Any claims paid for expenses incurred by ineligible Dependents after the date of the divorce or the date the Dependent is not eligible for coverage will become the responsibility of the participant. Also, if the Administrative Office is not notified of a divorce within 60 days, the former spouse will lose rights to COBRA continuation coverage.

III. COBRA CONTINUATION COVERAGE

Offset for Plan's Alternative Continuation Coverage Please note: The maximum duration of any available COBRA Continuation Coverage will be reduced on a month-to-month basis for each month that any other available Fund continuation coverage is received under the Plan.

Continuation of Coverage (COBRA)

In compliance with a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (commonly called COBRA), eligible Employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Retirees, please note: When you retired, you (the Employee) were offered a choice between electing a temporary continuation of your active group health coverage ("COBRA Continuation Coverage") or electing Retiree coverage. As you elected the Fund's Retiree health coverage, you have no further COBRA continuation rights. However, your covered Dependent(s) may experience a COBRA Qualifying Event as described in this section.

NOTE: Domestic Partners and children of Domestic Partners are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends; however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

Who is Entitled to COBRA Continuation Coverage, When and for How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and,** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered Employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals.

Qualified Beneficiary

Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an Employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A child of the covered Employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Employee's period of employment, is an eligible Dependent Child and is entitled to rights under COBRA.
- A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

Qualifying Event

Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* Employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries [1]		
	Employee	**Spouse**	**Dependent Child(ren)**
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for the health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

1: *When a covered Employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent Children who are Qualified Beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.*

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Medicare Entitlement

A person becomes entitled to Medicare on the first day of the month in which he or she attains age 65, but only if he or she submits the required application for Social Security retirement benefits within the time period prescribed by law. Generally, a person becomes entitled to Medicare on the first day of the 30th month after the date on which he or she was determined by the Social Security Administration to be totally and permanently disabled and entitled to Social Security disability income benefits.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "Dependent Child" under the Plan, **You and/or a family member must inform the Plan <u>in writing</u> of that event no later than <u>60 days after that Qualifying Event occurs</u>.**

That written notice should be sent to the Administrative Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include Your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

> **NOTE: If such a notice is <u>not</u> received by the Administrative Office within the 60-day period, the Qualified Beneficiary will <u>not</u> be entitled to choose COBRA Continuation Coverage.**

Officials of the Employee's own employer should notify the Administrative Office of an Employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **You or Your family should also promptly notify the Administrative Office in writing** if any such event occurs in order to avoid confusion over the status of Your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

a. **Your Contributing Employer notifies the Plan** that Your health care coverage has ended because Your employment terminated, your hours are reduced so that You are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or

b. **<u>You</u> notify the Administrative Office** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the Administrative Office will give You and/or Your covered Dependents notice of the date on which Your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. <u>Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage</u>. Under the law, You and/or Your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

> **NOTE: If You and/or any of Your covered Dependents do not choose COBRA coverage within 60 days after receiving notice, You and/or they will have no group health coverage from this Plan after the date coverage ends.**

The COBRA Continuation Coverage that will be Provided

If You elect COBRA Continuation Coverage, you will be entitled to the same dental benefits that You had when the event occurred that caused Your coverage under the Plan to end, but You must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost You and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active Employees and their families, that same change will apply to Your COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage (the Cost of COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active Employees and families (including both the Fund's and Employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

NOTE: You will not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage to the Administrative Office.

For Monthly Payments, What If the Full COBRA Premium Payment Is Not Made When Due?

If the Administrative Office receives a COBRA premium payment that is not for the full amount due, the Administrative Office will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the Administrative Office will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

Grace periods

The initial payment for the COBRA Continuation Coverage is due to the Administrative Office **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, all subsequent payments should be in the Administrative Office by the 20th of the month <u>prior to</u> the coverage month in order to accurately reflect Your eligibility. There will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage before Election or Payment of the Cost of COBRA Continuation Coverage

If a provider requests confirmation of coverage and You, Your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** You, Your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of newly acquired dependents

If, while You (the Employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with You for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if You do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount You must pay for COBRA Continuation Coverage. Contact the Administrative Office to add a Dependent.

Loss of other group health plan coverage

If, while You (the Employee) are enrolled for COBRA Continuation Coverage Your Spouse or Dependent loses coverage under another group health plan, you may enroll the Spouse or Dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or Dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA plan and declined, the Spouse or Dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or Dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount You must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Administrative Office an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA during an 18-month Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of Your termination of employment or reduction in hours, You die, become divorced or legally separated, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to 36 months measured from the date of Your termination of employment or reduction in hours (or the date You first became entitled to Medicare, if that is earlier, as described below).

NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for Spouses and Dependents who are Qualified Beneficiaries.

Notifying the Plan

To extend COBRA when a second Qualifying Event occurs, you must notify the Administrative Office in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include Your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is not available to anyone who became Your Spouse after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with You (the covered Employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Extended COBRA Coverage in Certain Cases of Disability

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that You or a covered Spouse or Dependent Child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

This extension is available only if:

- the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
- the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

Notifying the Plan

You or another family member should follow this procedure (to notify the Plan) by sending a written notification to the Administrative Office of the Social Security Administration determination within 60 days after that determination was received by You or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include Your name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the Administrative Office before the end of the 18-month COBRA Continuation period.

- The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.
- The Administrative Office must also be notified within 30 days of the determination by the Social Security Administration that You are no longer disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

- The date the Fund no longer provides group health coverage to any of its Employees;
- The date the amount due for COBRA coverage is not paid in full on time;
- The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
- During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
- The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).

Notice of Early Termination of COBRA Continuation Coverage

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Administrative Office determines that COBRA coverage will terminate early.

COBRA Questions or to Give Notice of Changes in Your Circumstances

If You have any questions about Your COBRA rights, please contact the Administrative Office. For more information about Your rights under COBRA 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 their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

IV. DENTAL COVERAGE

Please note that this dental plan is <u>not</u> subject to the requirements of Health Care Reform. Therefore, the calendar year and lifetime maximums will apply to <u>all</u> Plan Participants.

Covered Dental Expenses

Benefits are payable for Medically Necessary dental care and treatment recommended and provided by a licensed dentist or dental hygienist working under the supervision of a licensed dentist subject to the conditions and limitations of the Plan.

Generally, the Plan will not reimburse you for all Dental expenses. Usually, you will have to satisfy some Deductibles or pay some Coinsurance toward the amounts you incur. Additionally, the Dental Plan does not pay for services or supplies that are excluded from coverage, any amount over the fee schedule, services or supplies in excess of a maximum Plan benefit or for services considered to be Experimental/Investigational.

The following outlines the benefits available under the Dental Plan.

Dental Care Benefits	
Calendar Year Deductible	None
Examinations including any second opinion (limited to 2 exams in any 12-month period), Treatments, Procedures (exception orthodontia)	Payable up to amounts shown in Schedule of Dental benefits
Dental Implants	$1,200 per implant (for surgically placing the implant in the jawbone)
Maximum Calendar Year Benefit	$3,500 per individual
Pre-authorization for certain procedures which are estimated to cost $500 or more is required.	
Orthodontia Benefits	
Calendar Year Deductible	None
Examinations, Treatments, Procedures	Payable at 100% of allowable expenses
Maximum Lifetime Orthodontic Benefit	$5,000 per individual

Dental Implants

Replacing a tooth with an implant is a costly expense. The Fund offers an implant benefit of up to $1,200 per tooth, to help with the cost. Tooth replacement by implants can average $3,000 - $5,000 per tooth (and may increase in the future); however, there are other less expensive ways of replacing missing teeth including a removable partial, complete denture, or a fixed bridge. We recommend you consult with your dentist regarding your options.

Implant surgery is a three-step process performed by a dentist.

- The dentist surgically places an implant directly into the jawbone allowing three to six months for bone to develop around the implant to help hold it in place.

- Once the bone has developed, the dentist places an attachment, referred to as a post or abutment. Several more months may be needed for the gum tissue to heal around the post.
- Once healing is complete, the implant serves as the replacement tooth's foundation an implant can be crowned.

The $1,200 implant benefit applies specifically to the charge for surgically placing the implant in the jawbone. This implant benefit accumulates towards the Plan's $3,500 annual maximum.

The Fund, additionally, provides an allowance for necessary bone grafting in preparation of implants (also subject to the Plan's $3,500 calendar year maximum).

Careful planning by extending implant services over the course of two calendar years may be useful in maximizing your annual Plan benefits.

Your dentist should submit a claim for a pre-authorization as outlined in the section below. This will allow you to know in advance how much the Plan will cover and how much you will be responsible for.

Replacement implants on the same tooth are limited to once every 5 years.

Pre-Authorization of Dental Benefits

The cost of dental care, like health care, has risen very rapidly. The Trustees recognize the need to contain costs without compromising the quality of dental care.

As a result, if a dentist prescribes a procedure listed in the Schedule of Dental Procedures under Crowns and Inlays/onlays, Prosthodontics, Endodontics, Oral & Maxillofacial Surgery and Periodontics which is estimated to cost more than $500. In addition, always have your dentist submit a pre-authorization for dental implants. Your plan of treatment must be submitted to the Plan for advance approval. This will provide You with the confidence that the prescribed dental work is necessary for the maintenance or improvement of Your dental health and the advance knowledge of the amount payable by the Plan.

Failure to obtain pre-authorization from the Plan will result in the reduction or denial of benefits.

No Dental Network

There is no dental network. This means that you are able to see any licensed provider. Charges will be subject to the fee schedule as outlined below.

Schedule of Dental Benefits

Payment for covered benefits is made at 100% of the following Scheduled Amounts for general dental services and 80% for covered orthodontia services.

Please note: If the procedure performed is not listed below, and is considered a covered service, the Fund will determine the maximum allowance for the procedure. A dental procedure of an equivalent gravity and severity listed above will be used as a basis for the Fund's determination.

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D0140	Limited oral evaluation - problem focused	$95
D0145	Oral evaluation - patient under 3 years of age - consult with primary caregiver	$85
D0150	Comprehensive oral evaluation - new/established patient	$109

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D0160	Detailed and extensive oral evaluation - problem focused report	$197
D0170	Re-evaluation - limited problem focused	$93
D0180	Comprehensive periodontal evaluation - new/established patient	$120
D0210	Intraoral-complete series	$165
D0220	Intraoral-periapical-first film	$38
D0230	Intraoral-periapical-each additional film	$32
D0240	Intraoral - occlusal film	$51
D0270	Bitewing - single film	$36
D0272	Bitewings - two films	$57
D0273	Bitewings - three films	$69
D0274	Bitewings - four films	$82
D0277	Vertical bitewings - 7 to 8 films	$118
D0290	Posterior-anterior or lateral skull and facial bone survey film	$166
D0321	Other temporomandibular joint films by report	$255
D0330	Panoramic film	$142
D0340	Cephalometric film	$151
D0350	Oral/facial photographic images	$91
D0365	Cone beam CT - capture and interpretation	$461
D0366	Cone beam capture and interpretation	$438
D0367	Cone beam CT capture and interpretation with field view of both jaws, with or without cranium	$465
D0368	Cone beam capture and interpretation	$458
D0380	Cone beam capture	$407
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	$455
D0382	Cone beam capture	$458
D0383	Cone beam capture	$443
D0384	Cone beam capture	$427
D0415	Collection microorganisms culture & sensitivity	$236
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	$252
D0418	Analysis of saliva sample	$197
D0421	Genetic test for susceptibility to oral diseases	$199
D0460	Pulp vitality tests	$72
D0470	Diagnostic casts	$148
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$223
D0475	Decalcification procedure	$252
D0476	Special stains fogr microorganisms	$361
D0477	Special stains not for microorganisms	$351

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D0478	Immunohistochemical stains	$208
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$214
D0481	Electron microscopy diagnostic	$284
D0482	Direct immunofluorescence	$131
D0483	Indirect immunofluorescence	$155
D0484	Consultation on slides prepared elsewhere	$208
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	$234
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	$197
D1110	Prophylaxis – adult (twice in a 12-month period)	$115
D1120	Prophylaxis – child (twice in a 12-month period)	$86
D1208	Topical application of fluoride (twice in any 12-month period)	$48
D1330	Oral hygiene instructions	$69
D1351	Sealant - per tooth	$70
D1510	Space maintainer - fixed-unilateral	$393
D1515	Space maintainer - fixed-bilateral	$521
D1520	Space maintainer - removable-unilateral	$480
D1525	Space maintainer - removable-bilateral	$591
D1550	Recementation of space maintainer	$106
D2140	Amalgam-one surface primary or permanent	$185
D2150	Amalgam-two surfaces primary or permanent	$231
D2160	Amalgam-three surfaces primary or permanent	$281
D2161	Amalgam-four/more surfaces primary/permanent	$338
D2330	Resin-one surface anterior	$213
D2331	Resin-two surfaces anterior	$257
D2332	Resin-three surfaces anterior	$316
D2335	Resin-four or more surfaces involving incisal angle	$394
D2390	Resin-based composite crown anterior	$591
D2391	Resin-based composite - one surface posterior	$229
D2392	Resin-based composite - two surfaces posterior	$293
D2393	Resin-based composite - three surfaces posterior	$361
D2394	Resin compos - four or more surfaces posterior	$431
D2410	Gold foil - one surface	$832
D2420	Gold foil - two surfaces	$954
D2430	Gold foil - three surfaces	$1,057
D2510	Inlay - metallic - one surface	$1,089
D2520	Inlay - metallic - two surfaces	$1,177
D2530	Inlay - metallic - three or more surfaces	$1,228
D2542	Onlay - metallic - two surfaces	$1,253

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D2543	Onlay metallic three surfaces	$1,301
D2544	Onlay metallic four or more surfaces	$1,340
D2610	Inlay - porcelain/ceramic - one surface	$1,220
D2620	Inlay - porcelain/ceramic - two surfaces	$1,222
D2630	Inlay - porcelain/ceramic - three/more surfaces	$1,283
D2642	Onlay - porcelain/ceramic - two surfaces	$1,299
D2643	Onlay - porcelain/ceramic - three surfaces	$1,340
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$1,390
D2650	Inlay resin based composite one surface	$1,194
D2651	Inlay resin based composite two surfaces	$1,185
D2652	Inlay resin based composite 3 or more surfaces	$1,213
D2662	Onlay resin based composite two surfaces	$1,236
D2663	Onlay resin based composite three surfaces	$1,262
D2664	Onlay resin based composite four or more surfaces	$1,304
D2710	Crown resin based composite indirect	$1,198
D2712	Crown 3/4 resin based composite indirect	$1,256
D2720	Crown - resin with high noble metal	$1,352
D2721	Crown - resin with predominantly base metal	$1,254
D2722	Crown - resin with noble metal	$1,298
D2740	Crown - porcelain/ceramic substrate	$1,422
D2750	Crown - porcelain fused to high noble metal	$1,424
D2751	Crown - porcelain fused predominantly base metal	$1,333
D2752	Crown - porcelain fused to noble metal	$1,368
D2780	Crown - 3/4 cast high noble metal	$1,374
D2781	Crown - 3/4 cast predominately base metal	$1,290
D2782	Crown - 3/4 cast noble metal	$1,341
D2783	Crown - 3/4 porcelain/ceramic	$1,372
D2790	Crown - full cast high noble metal	$1,484
D2791	Crown - full cast predominantly base metal	$1,286
D2792	Crown - full cast noble metal	$1,375
D2794	Crown titanium	$1,320
D2799	Provisional crown	$557
D2910	Recement inlay onlay/part coverage restoration	$147
D2915	Recement cast or prefabricated post and core	$148
D2920	Recement crown	$143
D2929	Prefab porcelain ceramic crown - primary tooth	$464
D2930	Prefabricated stainless steel crown - primary tooth	$330
D2931	Prefabricated stainless steel crown - permanent tooth	$398
D2932	Prefabricated resin crown	$438
D2933	Prefabricated stainless steel crown w/resin window	$449

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D2940	Sedative filling	$159
D2950	Core buildup including any pins	$339
D2951	Pin retention - per tooth addition restoration	$100
D2952	Post and core addition to crown indirectly fab	$521
D2953	Each additional indirectly fab post same tooth	$405
D2954	Prefabricated post and core in addition to crown	$429
D2955	Post removal	$369
D2957	Each additional prefabricated post - same tooth	$254
D2960	Labial veneer – chairside	$876
D2961	Labial veneer – laboratory	$1,248
D2962	Labial veneer – laboratory	$1,461
D2970	Temporary crown fractured tooth	$510
D2975	Coping	$756
D2980	Crown repair by report	$376
D2981	Inlay repair by report	$349
D2982	Onlay repair by report	$364
D2983	Veneer repair by report	$386
D2990	Resin infiltration of incipient smooth surface lesions	$232
D3110	Pulp cap – direct	$106
D3120	Pulp cap – indirect	$105
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$257
D3221	Pulpal debridement primary and permanent teeth	$288
D3310	Endodontic therapy anterior tooth	$937
D3320	Endodontic therapy bicuspid tooth	$1,067
D3330	Endodontic therapy molar	$1,313
D3331	Treatment root canal obstruction; non-surgical access	$793
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$558
D3333	Internal root repair of perforation defects	$448
D3346	Retreatment previous root canal therapy - anterior	$1,066
D3347	Retreatment previous root canal therapy - bicuspid	$1,207
D3348	Retreatment previous root canal therapy – molar	$1,432
D3351	Apexification/recalcification - initial visit	$462
D3352	Apexification/recalcification - interim visit	$328
D3410	Apicoectomy/periradicular surgery – anterior	$876
D3421	Apicoectomy/periradicular surgery – bicuspid	$983
D3425	Apicoectomy/periradicular surgery – molar	$1,090
D3426	Apicoectomy/periradicular surgery	$547

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D3430	Retrograde filling - per root	$368
D3450	Root amputation - per root	$627
D3460	Endodontic endosseous implant	$1,836
D3470	Intentional replantation w/necessary splinting	$998
D3920	Hemisection not including root canal therapy	$599
D3950	Canal preparation and fitting preformed dowel/post	$330
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$793
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$413
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per to	$367
D4230	Anatomical crown exposure for four or fewer contiguous teeth per quad	$939
D4231	Anatomical crown exposure 1-3 teeth per quadrant	$731
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$931
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$776
D4245	Apically positioned flap	$985
D4249	Clinical crown lengthening - hard tissue	$963
D4260	Osseous surgery for four or fewer contingent/tooth bound spaces-quad	$1,369
D4261	Osseous surgery 1-3 contingent/tooth bound spaces-quad	$1,088
D4264	Bone replacement graft - each add site quadrant	$701
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$711
D4268	Surgical revision procedure per tooth	$985
D4270	Pedicle soft tissue graft procedure	$1,044
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	$1,359
D4274	Distal or proximal wedge procedure	$837
D4275	Soft tissue allograft	$1,212
D4276	Combined connective tissue and double pedicle graft per tooth	$1,340
D4277	Soft tissue graft procedure first tooth	$1,186
D4278	Soft tissue graft procedure add tooth	$985
D4320	Provisional splinting – intracoronal	$657
D4321	Provisional splinting – extracoronal	$599
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$322
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$236

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$224
D4910	Periodontal maintenance	$172
D4920	Unscheduled dressing change	$133
D5110	Complete denture – maxillary	$2,212
D5120	Complete denture – mandibular	$2,216
D5130	Immediate denture – maxillary	$2,353
D5140	Immediate denture – mandibular	$2,379
D5211	Upper partial denture - resin base	$1,786
D5212	Lower partial denture - resin base	$1,723
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$2,267
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$2,275
D5225	Maxillary partial denture flexible base	$1,983
D5226	Mandibular partial denture flexible base	$1,970
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$1,313
D5410	Adjust complete denture – maxillary	$115
D5411	Adjust complete denture – mandibular	$113
D5421	Adjust partial denture – maxillary	$112
D5422	Adjust partial denture – mandibular	$112
D5510	Repair broken complete denture base	$277
D5520	Replace missing/broken teeth - complete denture	$241
D5610	Repair resin denture base	$268
D5620	Repair cast framework	$371
D5630	Repair or replace broken clasp	$340
D5640	Replace broken teeth - per tooth	$247
D5650	Add tooth to existing partial denture	$291
D5660	Add clasp to existing partial denture	$339
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$924
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$934
D5710	Rebase complete maxillary denture	$737
D5711	Rebase complete mandibular denture	$736
D5720	Rebase maxillary partial denture	$711
D5721	Rebase mandibular partial denture	$710
D5730	Reline complete maxillary denture chairside	$483
D5731	Reline lower complete mandibular denture	$478
D5740	Reline maxillary partial denture chairside	$465
D5741	Reline mandibular partial denture chairside	$468

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D5750	Reline complete maxillary denture laboratory	$596
D5751	Reline complete mandibular denture laboratory	$601
D5760	Reline maxillary partial denture laboratory	$591
D5761	Reline mandibular partial denture laboratory	$589
D5810	Interim complete denture maxillary	$1,105
D5811	Interim complete denture mandibular	$1,124
D5820	Interim partial denture maxillary	$930
D5821	Interim partial denture mandibular	$924
D5850	Tissue conditioning maxillary	$271
D5851	Tissue conditioning mandibular	$263
D5863	Overdenture complete maxillary	$2,725
D5864	Overdenture partial maxillary	$2,736
D5865	Overdenture complete mandibular	$2,736
D5866	Overdenture partial mandibular	$2,874
D5875	Modification removal prosthetic follow implant surgery	$548
D6010	Surgical placement implant body: endosteal implant	$1,200
D6011	Second stage implant surgery	$810
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$2,067
D6013	Surgical placement of mini implant	$1,200
D6040	Surgical placement: eposteal implant	$1,200
D6050	Surgical placement: transosteal implant	$1,200
D6053	Implant/abut supported removal denture complete edentulous arch	$3,611
D6054	Implant/abutment supported removable denture for partially edentulous arch	$3,505
D6055	Dental implant supported connecting bar	$3,775
D6056	Prefabricated abutment includes placement	$971
D6057	Custom abutment includes placement	$1,149
D6058	Abutment supported porcelain/ceramic crown	$1,762
D6059	Abutment supported porcelain to metal crown hi noble metal	$1,796
D6060	Abutment supported porcelain to metal crown predominately base metal	$1,751
D6061	Abutment supported porcelain to metal crown noble metal	$1,750
D6062	Abutment supported cast metal crown high noble metal	$1,751
D6063	Abutment supported cast metal crown predominately base metal	$1,751
D6064	Abutment supported cast metal crown noble metal	$1,703
D6065	Implant supported porcelain/ceramic crown	$1,906
D6066	Implant supported porcelain fused to metal crown	$1,915
D6067	Implant supported metal crown	$1,910
D6068	Abutment supported retainer porcelain/ceramic fixed partial denture	$1,805

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D6069	Abutment retainer porcelain to metal fixed partial denture hi noble metal	$1,805
D6070	Abutment retainer for porcelain to metal fixed partial denture predominantly base metal	$1,707
D6071	Abutment supported retainer porcelain fused metal fixed partial denture	$1,708
D6072	Abutment supported retainer for cast metal fixed partial denture	$1,780
D6073	Abutment retainer cast metal fixed partial denture predominantly base metal	$1,734
D6074	Abutment retainer cast metal fixed partial denture noble metal	$1,646
D6075	Implant supported retainer for ceramic fixed partial denture	$1,860
D6076	Implant supported retain porcelain fused metal fixed partial denture	$1,860
D6077	Implant supported retainer for cast metal fixed partial denture	$1,870
D6078	Implant/abutment supported fixed denture for completely edentulous arch	$9,634
D6080	Implant-Maintenance Procedures, Including Removal of Prosthesis, Cleansing of Prosthesis, and Abutments and Reinsertion of Prosthesis	$383
D6090	Repair implant supported prosthesis by report	$902
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$739
D6092	Recement implant/abutment supported crown	$196
D6093	Recement implant/abutment supported fix part denture	$230
D6094	Abutment supported crown titanium	$1,677
D6095	Repair implant abutment by report	$875
D6103	Bone graft repair of peri-implant	$938
D6190	Radiographic/surgical implant index by report	$547
D6194	Abutment supported retainer crown for fixed partial denture	$1,814
D6205	Pontic indirect resin based composite	$1,204
D6210	Pontic - cast high noble metal	$1,422
D6211	Pontic - cast predominantly base metal	$1,313
D6212	Pontic - cast noble metal	$1,357
D6214	Pontic titanium	$1,351
D6240	Pontic - porcelain fused to high noble metal	$1,431
D6241	Pontic - porcelain fused predominantly base metal	$1,335
D6242	Pontic - porcelain fused to noble metal	$1,368
D6245	Pontic - porcelain/ceramic	$1,417
D6250	Pontic - resin with high noble metal	$1,379
D6251	Pontic - resin with predominantly base metal	$1,345
D6252	Pontic - resin with noble metal	$1,350
D6253	Provisional Pontic	$957

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D6545	retainer - cast metal for resin bonded fixed prosthesis	$1,092
D6600	Inlay-porcelain/ceramic two surfaces	$1,229
D6601	Inlay - porcelain/ceramic three or more surfaces	$1,286
D6602	Inlay - cast high noble metal two surfaces	$1,253
D6604	Inlay - cast predominantly base metal 2 surfaces	$1,217
D6606	Inlay - cast noble metal two surfaces	$1,220
D6607	Inlay - cast noble metal three or more surfaces	$1,262
D6612	Onlay - cast predominantly base metal 2 surfaces	$1,266
D6710	Crown indirect resin based composite	$1,258
D6720	Crown - resin with high noble metal	$1,383
D6721	Crown resin w/predominantly base metal-denture	$1,292
D6722	Crown - resin with noble metal	$1,348
D6740	Crown - porcelain/ceramic	$1,422
D6750	Crown porcelain fused to hi noble metal-denture	$1,460
D6751	Crown - porcelain fused predominantly base metal	$1,320
D6752	Crown - porcelain fused to noble metal	$1,368
D6780	Crown - 3/4 cast high noble metal	$1,368
D6781	Crown - 3/4 cast predominately based metal	$1,310
D6782	Crown 3/4 cast noble metal-denture	$1,334
D6783	Crown 3/4 porcelain/ceramic-denture	$1,366
D6790	Crown full cast high noble metal-denture	$1,422
D6791	Crown full cast predominantly base metal-denture	$1,309
D6792	Crown full cast noble metal-denture	$1,363
D6794	Crown titanium	$1,312
D6920	Connector bar	$1,279
D6930	Recement bridge	$218
D6940	Stress breaker	$542
D6950	Precision attachment	$834
D6980	Bridge repair by report	$489
D7111	Extraction coronal remnants deciduous tooth	$170
D7140	Extraction erupted tooth or exposed root	$224
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$350
D7220	Removal of impacted tooth - soft tissue	$390
D7230	Removal of impacted tooth - partially bony	$488
D7240	Removal of impacted tooth - completely bony	$599
D7241	Removal impacted tooth - complete bony w/unusual surgical complications	$697
D7250	Surgical removal of residual tooth roots	$387

CDT-4 CODE	DESCRIPTION	SCHEDULED AMOUNT
D7251	Coronectomy - intentional partial tooth removal	$545
D7261	Primary closure of a sinus perforation	$945
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth Includes splinting and/or stabilization.	$0
D7280	Surgical access of an unerupted tooth	$601
D7285	Biopsy of oral tissue hard	$602
D7286	Biopsy of oral tissue soft	$414
D7287	Exfoliative cytological sample collection	$244
D7288	Brush biopsy transepithelial sample collection	$246
D7310	Alveoloplasty in conjunction with extractions 4 or more teeth/spaces per quadrant	$377
D7311	Alveoloplasty in conjunction with extractions 1-3 teeth/spaces quadrant	$374
D7412	Excision of benign lesion complicated	$1,091
D7440	Excision malignant tumor-lesion diameter up to 1.25 cm	$991
D7450	Removal benign odontogenic cyst/tumor- up t0 1.25 cm	$774
D7451	Removal benign odontogenic cyst/tumor- > 1.25 cm	$1,057
D7460	Removal benign nonodontogenic cyst/tumor- up 1.25 cm	$732
D7461	Removal benign nonodontogenic cyst/tumor > 1.25 cm	$1,183
D7471	Removal of lateral exostosis	$917
D7472	Removal of torus palatinus	$1,119
D7473	Removal of torus mandibularis	$1,036
D7485	Surgical reduction of osseous tuberosity	$950
D7490	Radical resection of maxilla or mandible	$9,269
D7510	Incision & drainage abscess-intraoral soft tissue	$305
D7951	Sinus augmentation with bone or bone substitutes	$3,830
D7960	Frenulectomy separate procedure	$565
D7963	Frenuloplasty	$602
D7970	Excision of hyperplastic tissue-per arch	$657
D7971	Excision of pericoronal gingiva	$341
D9110	Palliative treatment dental pain - minor procedure	$163
D9220	Deep sedation/general anesthesia-1st 30 minutes	$486
D9221	Deep sedation/general anesthesia-each additional 15 min	$208
D9223	Deep sedation/general anesthesia- 15 minute increments.	$202
D9230	Anxiolysis, Inhalation of Nitrous Oxide	$98
D9241	Iv conscious sedation/analgesia - 1st 30 minutes	$492
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$175
D9430	Office visit observation no other service performed	$98
D9440	Office visit-after regularly scheduled hours	$219

Please note: If the procedure performed is not listed above, and is considered a covered service, the Fund will determine the maximum allowance for the procedure. A dental procedure of an equivalent gravity and severity listed above will be used as a basis for the Fund's determination.

Exclusions

Dental benefits are not payable for:

1. any dental procedure (other than covered Orthodontia) performed for cosmetic purposes, or for correction of congenital abnormalities;
2. replacement of an existing partial or full removable denture or fixed bridgework by a new denture or fixed bridgework, or the addition of teeth to an existing partial removable denture, or to bridgework unless satisfactory evidence is presented that:
    - the replacement or addition of teeth is required to replace one or more additional teeth extracted after the existing denture or bridgework was installed;
    - the existing denture or bridgework was installed at least five years prior to its replacement and the existing denture or bridgework cannot be made serviceable; or
    - the existing denture is an immediate temporary and the replacement by a permanent denture is required and takes place within twelve months from the installation date of the temporary.
3. Replacement of an existing crown unless satisfactory evidence is presented that the existing crown cannot be made serviceable and was installed at least 5 years prior to the replacement date
4. Replacement of an implant on the same tooth that was placed less than 5 years prior to the replacement date.
5. Charges for personalization or characterization of dentures;
6. prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered prior to the time the individual became covered by the Plan; or which were ordered while covered by this Plan, but are installed or delivered more than 30 days after the termination date of coverage;
7. replacement of lost, misplaced or stolen dental appliances;
8. services and supplies which are not recommended and approved by the attending dentist;
9. charges for missed appointments or the completion of claim forms;
10. any intentionally self-inflicted illness or injury, whether committed while sane or insane;
11. any illness or injury arising out of, or in the course of, any work for wage or profit, any charges for which benefits are, or could be available if proper claim were made, through Workers' Compensation, Occupational Disease law or similar legislation;
12. conditions resulting from war or act of war, declared or undeclared, or service in the armed forces of any country;
13. conditions resulting from the commission of, or the attempt to commit, an assault or felony;
14. services and supplies provided by or covered under any governmental plan or law, or provided by any hospital or institution which does not require payment;
15. any charge the plan member is not legally obligated to pay and any charge not customarily made in the absence of this coverage;

16. experimental procedures.
17. Services provided outside the United States except for treatment for a dental emergency.

V. COORDINATION OF BENEFITS

Members of a family are often covered by more than one group health insurance plan. To avoid duplication of payments for the same covered dental charges, the benefits provided under this Plan will be coordinated with benefits provided under other group programs, service or prepayment programs.

This provision, known as a "coordination of benefits" provision, applies whenever the amounts payable under this Plan and any other Plans under which You have coverage would exceed allowable expenses incurred by You or Your Dependent during a calendar year.

Allowable expenses are any necessary and reasonable expenses for benefits, treatment or supplies covered by one of the plans under which You or Your Dependents are insured or covered.

Other plans to which this provision applies include, but are not limited to, group insurance plans, group hospital or medical service plans and other group prepayment plans, labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, and governmental programs or programs required or provided by any statute.

The rules for determining which program or plan of benefits will pay Your benefits are:

- A plan that covers You as an Employee will pay before a plan that covers You as a dependent. Thus, this plan will be primary and will pay its normal benefits first. The other plan involved will then pay the remaining expenses up to the maximum it provides;
- A plan that covers You as an active Employee will pay before a plan that covers You as a retired or laid-off Employee;
- For a child covered under both parents' plans, the primary plan is determined by using the "birthday rule." That is, the plan covering the parent whose birthday falls earlier in the year is primary. If the other plan does not have this provision, then the rules set forth in that plan will determine the order of benefits;
- If a child's parents are divorced or separated, benefits are paid first by the plan covering the parent who has custody; then, by the plan covering the stepparent – the spouse of the parent with custody; and finally, by the plan covering the parent without custody. If a court decree which meets the requirements of a qualified medical child support order specifies otherwise, however, the court decree will govern, unless it violates applicable law.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined by the longer/shorter length of coverage, and if length of coverage is the same, then the birthday rule applies between the dependent child's parent's coverage and the dependent spouse's coverage.
- A plan without a coordination of benefits provision will pay benefits before a plan with such a provision.
- If none of the above rules applies, then the plan that has covered the claimant the longest will pay benefits first.

At no time are combined benefits to pay more than 100% of the expenses actually incurred by an eligible individual. Thus, if this plan is the secondary plan, plan benefits may be reduced so the total payments do not exceed total covered expenses.

Before or at the time You submit a claim, you must provide the plan with written authorization to obtain the information it needs to complete Your claim. You are required to provide the Administrative Office with such information as is necessary to coordinate benefits between such plans.

The plan reserves the right to recover benefits from any person to whom or for whom payments were made or from any insurance company or organization which owes benefits when an overpayment has been made by this Plan under this provision.

Subrogation (Third Party Liability)

If a participant or dependent is injured or becomes ill, or receives treatment through due to the act or omission of another person, and if any full or partial payment of benefits are made paid under the Plan due to the injury, treatment, or illness, then to the extent the participant or dependent person received similar dental payments for the same injury, treatment, or illness from the third party, or any its insurer, the Plan will be entitled to a refund of such benefits.

The participant and/or dependent will be required to pay to the Plan immediately any proceeds received by way of suit, judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorist's coverage or other insurance) arising out of any claims for damages by the individual or his heirs, parents or legal guardians, to the extent of the payments made or to be made by the plan for which the third party may be responsible. Any participant and/or dependent who accepts payments from the Plan agrees that by doing so he is making a present assignment of his rights against such third party to the extent of the payments made by the Plan. These rules are automatic, but the Plan may require that any participant and/or dependent sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. **Any participant and/or dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved and benefit payments will be withheld until the individual has signed the required Agreement to Reimburse and/or Assignment of Recovery.** Any participant or dependent who receives benefits and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the participant and/or dependent has failed to reimburse, including reasonable interest in such unpaid funds.

By accepting payments from the Plan, any participant and/or dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company. A lien shall exist in favor of the Plan upon all sums of money recovered by the participant and/or dependent against the third party. The lien may be filed with the third party, the third party's agents, or the court. The participant and/or dependent shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.

If the participant and/or dependent settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the participant and/or dependent shall receive no further benefits from the Trust in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust.

VI. NOTICE OF PRIVACY PRACTICES

Oakland Firefighters Health and Welfare Plan as of December, 2017

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review It Carefully and Contact the Plan Office If You Have Any Questions.

We are required by state and federal law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information, known as Protected Health Information ("PHI") that identifies you is kept private and secure to the extent required by law. We are also required to give you this Notice regarding the uses and disclosures of medical information that may be made by the Plan, and your rights and the Plan's legal duties with respect to such information. The Plan must also follow the duties and privacy practices described in this Notice. This Notice and its contents are intended to conform to the requirements of HIPAA, and it applies to all records containing your PHI that are created, transmitted or retained by the Plan or Business Associates (including their subcontractors) that help administer the Plan. **(Although the primary purpose of the Privacy Notice requirement is to address concerns raised in health care plans, a dental plan, such as this Plan, must also comply with applicable privacy laws.)**

- **PHI Defined.** The term "PHI" or "medical information" in this Notice means individually identifiable medical and genetic information that relates to your physical or mental health condition, the provision of health care to you, or payment of such health care.
- **De-Identified PHI.** This Notice does not apply to information that has been de-identified. De-identified information neither identifies nor provides a reasonable basis to identify you.
- **Minimum Necessary.** When using or disclosing PHI, the Plan will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological factors and limitations and any applicable law requiring greater disclosure.

The Plan will inform you promptly if a breach occurs that may have compromised the privacy or security of your information. The Plan will not use or share your information other than as permitted by HIPAA and unless you tell the Plan Office it can in writing. If you tell the Plan office it can, you may change your mind at any time, but let the Plan know in writing. The rights in this Notice apply to you, your Spouse, and your eligible Dependents.

For more information please see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Our Uses and Disclosures: How do we typically use or share your medical information?

The following categories describe different ways that we use and disclose medical information. For each category of uses and disclosures, the Plan will explain what it means and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information may fall within one of the categories.

Treatment.	The Plan can use your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you, including but not limited to consultations and referrals between your providers. ***Example:*** *Doctor sends us information about your diagnosis and treatment plan, so we can arrange additional services.*
For Payment.	We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. ***Example:*** *We share information about you with the dental plan to coordinate payment for your dental work.*
For Health Care Operations/Appeals.	The Plan can use and disclose health information about you for Plan operations that are necessary to run the Plan. The Plan may also release your PHI to the Board of Trustees or an Appeals Committee if it is needed to make a decision regarding an appeal. *Example: We use health information in reviewing & responding to appeals, medical reviews, legal services, audit services, Plan administrative activities, premium rating, or conducting quality assessment and improvement activities.*
As Required by Law.	The Plan can use and disclose your health information if required by state, federal or local laws. ***Example:*** *The Plan might share information with the Department of Health & Human Services for compliance with federal privacy laws.*
To Avert a Serious Threat to Health or Safety/Assist Public Health Issues.	The Plan can use and disclose your health information when it believes, in good faith, that such disclosure is necessary to prevent a serious threat to the safety and health of you, another individual, or the public. This includes disclosing medical information for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability. ***Example:*** *We share health information to report suspected abuse, neglect or domestic violence if we have a reasonable belief, or to prevent disease, or to help with product recalls, or to prevent/reduce a serious threat to anyone's health or safety.*
To Inform You About Treatment Alternatives or Other Health Related Benefits.	The Plan may use PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. ***Example:*** *We may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.*
Disclosure to Health Plan Sponsor	Medical information may be disclosed to the Plan Sponsor (IAFF Local 55) and/or Plan Trustees) solely for purposes of administering benefits under the Plan.
Respond to Lawsuits and Disputes.	The Plan can use and disclose your health information to respond to a court order, administrative proceeding, arbitration, subpoena, other lawful process or similar proceeding. ***Example****: We receive a discovery request in which you are a party involved in a lawsuit.*

Government or Law Enforcement Requests.	To the extent permitted or required by local/state/federal law, the Plan may release your health information to law enforcement official or for law enforcement purposes, to authorized government agencies, to health oversight agencies, or to comply with laws related to workers' compensation claims.
Research.	The Plan can use and share your health information for health research subject to certain conditions.
Decedent's Health Information.	The Plan may disclose your PHI to your family members and others who were involved in your care or payment of your care, unless doing so is inconsistent with your prior written expressed wishes that was given to the Plan. However, PHI of persons who are deceased for more than 50 years is not protected under the HIPAA privacy and security rules. ***Example***: *We disclose health information to a coroner or medical examiner necessary to identify a deceased person or determine the cause of death.*
Business Associates & Subcontractors.	The Plan may also share your PHI with business associates, including its subcontractors or agents that perform certain administrative services for the Plan. The Plan has a written contract with each of its business associates that contains provisions requiring them to protect the confidentiality of your PHI.

Your Choices: For certain information, you can tell us your choices about what we share.

Except as provided for in this Notice or as permitted by law, the Plan will not release your PHI without your written authorization. If you have a clear preference for how the plan shares your information in the situations described below, contact the Plan office and tell the Plan what you want the Plan to do. The Plan Office has an Authorization Form that you may sign to authorize release of all or part of your PHI.

You have both the right and choice to tell the Plan to:

- ✓ Share information with your family, close friends, or others involved in your health care or payment for your case, as long as you do not object.
- ✓ Share information in a disaster relief situation.

If you are not able to tell the Plan your preference, for instance if you are unconscious or not around, the Plan may share your health information if the Plan believes it is in your best interest. The Plan may also share your health information when needed to lessen a serious and imminent threat to health or safety.

Your Rights: When it comes to your health information, you have certain rights.

This section explains your rights and some of your responsibilities to help you.

- ✓ **Right to Get a copy of your Medical records.** You have the right to see or get a copy of your health and claims records and other medical information about you. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. This includes the right to request a copy of your PHI in hard copy or electronic form contained in a designated record set for so long as the Plan maintains the PHI. The electronic form you request may be in the form of MS Word, Excel, text, or text-based PDF, among other formats. If the format you request is not readily producible, the Plan will provide you

with a copy of your PHI in a readable format as agreed to by you and the Plan. Your requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Pursuant to government regulations, you do not have a right to copies of psychotherapy notes.

- ✓ **Right to Correct Your Medical Information.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to correct the information. You have the right to request a correction for as long as the information is kept by or for the Plan. To request a correction, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information.

  We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to correct information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity -that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) is accurate and complete.

- ✓ **Right to an Accounting of Disclosures.** You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures other than disclosures made to carry out treatment, payment or health care operations, to individuals about their own medical information, incident to an otherwise permitted use or disclosure, pursuant to an authorization, for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, as part of a limited data set, and for other national security or to correctional institutions or law enforcement officials.

  To request an accounting of disclosures, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. Your request must specify a period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- ✓ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- ✓ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan must say "yes" if you tell us you would be in danger if the Plan office does not honor your request. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.
- ✓ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
- ✓ **Right to Provide an Authorization**. As noted above, the Plan may request your written authorization for uses and disclosures that are not identified by this Notice or permitted by law. Any authorization you provide regarding the use and disclosure of your PHI may be revoked at any time in writing.
- ✓ **Right to a File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with the Plan Office by contacting the Privacy Officer listed on the last page or with the U.S. Department of Health and Human Services, Office for Civil Rights by sending a letter to **200 Independence Avenue S.W., Washington, D.C. 20201**, calling **(877) 696-6775**, or visiting ***www.hhs.gov/ocr/privacy/hipaa/complaints/.*** You must file a complaint within 180 days after the occurrence of the event or violation. You may also contact the Privacy Officer if you have any questions or concerns regarding your Privacy rights or regarding the specifics of filing a complaint. All complaints must be submitted in writing. You will not be penalized for filing a complaint and the Plan will not retaliate against you for filing a complaint.
- ✓ **Right to Notice in Event of Breach of Unauthorized Disclosure (Breach Notice)**. You have the right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments.
- ✓ **Right to Restrict Disclosure of PHI If Paying Out-of-pocket.** If you paid for services out-of-pocket, in full, for a specific item or service, you have the right to ask your Health Care Provider to not disclose your PHI related to that item or service to the Plan for purposes of payment of health care operations. The Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure.
- ✓ **Right to Choose Someone to Act for You (Personal Representative).** You may exercise your rights through a Personal Representative, who will be required to produce evidence of his/her authority to act on your behalf before he/she will be given access to your health information or be allowed to take any action for you. The Plan office will verify that the person has this authority and can act for you before it takes any action. Proof of such authority may take one of the following forms: (a) notarized power of attorney for health care purposes or (b) court order of appointment of the individual as your conservator or guardian.

Changes to This Notice

The effective date of this Notice is **November 21, 2017.** **We can change this Notice, and the changes will apply to all information we have about you.** Any changes that may occur, we will mail the revised Notice to you. The New Notice will be available upon request (at any time), on our website, and we will mail a copy to you. The Plan will comply with the terms of any such Notice currently in effect.

Requests for Information:

Questions regarding this information should be addressed to **Coleen Christophersen, Privacy Officer** at:

Oakland Firefighters Health and Welfare Trust Fund
c/o HS&BA
4160 Dublin Blvd, Suite 400
Dublin, CA 94568
Telephone: (800) 267-3232/ Fax: (925) 833-7301
Website: http://www.iaff55.org/index.cfm?Section=1&pagenum=205&titles=0

CLAIMS AND APPEALS PROCEDURES

Claims Procedures

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures, which are described in this section. These procedures cover the Plan's self-funded dental claims. This notice also describes the procedure for you to follow if your claim is denied, in whole or in part, and you wish to appeal the decision. The Board of Trustees has the discretionary authority to decide benefit claims and appeals and to interpret the terms of the Plan.

How to File a Claim for Services That Have Already Been Received

A claim form may be obtained from the Administration Office. The following information must be completed in order for your request for benefits to be a claim, and for the Administration Office to be able to process your claim.

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant
- Date of Service
- Most current CDT service code
- Billed charges (bills must be itemized with all dates of Physician visits shown)
- Federal taxpayer identification number (TIN) of the provider
- Provider's billing name, address, phone number and professional degree or license
- Provider's signature
- Information on other insurance coverage, if any, including coverage that may be available to your spouse through his or her employer.

Claims for dental services that have already been provided will be considered to have been filed as soon as they are received at the Administration Office. All dental claims should be filed at the following address:

Oakland Firefighters
Health and Welfare Trust
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756

When Claims Must Be Filed

Claims for services that have been received should be filed within six months after the charges were incurred or as soon as reasonably possible but in no event later than one year after the date the charges were incurred.

Claims involving Urgent Care (defined below) must be submitted to the Administration Office by fax or phone. **(510) 451-8564.**

All other Claims should be submitted in writing to the address above.

Dental Claims

The claims procedures for dental benefits will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, or a Post-Service Claim. Read each section carefully to determine which procedure is applicable to your request for benefits:

Pre-Service Claims

A **Pre-Service Claim** is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before care is obtained in order to receive the maximum benefits provided by the Plan. Under terms of this Plan, prior approval of services by the Fund is required if a dentist prescribes a procedure listed in the Schedule of Dental Procedures under Crowns, Bridges, Prosthodontics or Periodontics which is estimated to cost more than $500. Failure to obtain pre-authorization from the Plan may result in a reduction or denial of benefits.

If your dentist improperly files a Pre-Service Claim, the Administration Office will notify you and/or your dentist as soon as possible but not later than five days after receipt of the claim, of the proper procedures to be followed in filing a claim. Notice of an improperly filed Pre-Service Claim will only be sent if the claim includes (i) your name, (ii) your specific dental condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

For properly filed Pre-Service Claims, you and/or your provider will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Administration Office. If an extension is necessary, you will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Administration Office needs additional information from you, the extension notice will specify the information needed. In that case you and/or your provider will have 45 days from receipt of the notification to support the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to support additional information, the normal period for making a decision on the claim will be the suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Administration Office then has *15 days* to make a decision on a **Pre-Service Claim** and notify you of the determination.

Urgent Care Claims

An **Urgent Care Claim** is any claim for dental care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations: (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) in the opinion of a dentist with knowledge of the claimant's dental condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an **Urgent Care Claim** is determined by the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a dentist with knowledge of your dental condition determines is an **Urgent Care Claim** within the meaning described above shall be treated as an **Urgent Care Claim**.

If your dentist improperly files an **Urgent Care Claim**, the Administration Office will notify you and/or your dentist as soon as possible and will make a good faith effort to notify the dentist not

later than *72 hours* after receipt of the claim of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a claim.

Generally, the Administration Office will respond to you and your dentist with a determination as soon as possible taking into account the urgency of your situation, but not later than *72 hours* after receipt of the claim. The determination will also be confirmed in writing.

However, if an **Urgent Care Claim** is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Administration Office will notify you or your dentist as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your dentist must provide the specified information not later than *2 business days* after receiving the request for the information. If the information is not provided within that time, your claim will be denied. Notice of the decision will be provided no later than *48 hours* after the Administration Office receives the specified information, but only if the information is received within the required time frame.

Post-Service Claims

Post-Service Claims are all claims that are not described in sections 1 through 3 above. Usually these will be claims submitted for payment after health services and treatment have been obtained. The procedure to follow for filing **Post-Service Claims** is described on page 21. Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days from the Plan's receipt of the claim. The Plan may extend the period once for up to *15 days* if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If the Plan needs additional information from you, your claim will be denied and the Plan will notify you of the denial, state the reason for the denial and specify the additional information needed. However, if you submit the necessary information within 45 days after receipt of the notification of the denial, there is no need to file a new claim. Once the Plan receives this information, it then has *15 days* to make a decision on a Post-Service Claim and notify you of the determination.

Notice of Decision

You will be provided with written notice of a denial of a claim, whether denied in whole or in part. Notice will be sent by the Administration Office. The notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of any further rights;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon written request at no charge;
- If the determination was based on the absence of dental necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms

of the Plan to your claim, or a statement that it is available upon written request at no charge.

For **Urgent Care Claims**, the notice will describe the expedited review process applicable to Urgent Care Claims. The notice of determination for Urgent Care Claims will be made in writing or orally and followed with written notification within 3 days thereafter.

Request for Review of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must meet the following criteria:

- made in writing;
- state the reason(s) for disputing the denial;
- accompanied by any pertinent material not already furnished to the Plan; and
- submitted within 180 days after you receive notice of denial.

Appeals involving an adverse determination of an **Urgent Care** or **Concurrent Care Claim** may be made by calling the Administration Office at **(510) 451-8564**. Appeals involving an adverse determination of a **Pre-Service** or **Post Service** claims must be submitted to the Trust Administration Office at the following address:

Oakland Firefighters Dental Claims
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756

Failure to file an appeal that meets all of these criteria will constitute a waiver of your right to a review of the denial of your Claim.

What is NOT a "Claim"

The following are not considered claims and are thus not subject to the requirements and timelines described in this section:

- Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim.
- A request for an advance determination regarding the Plan's coverage of a treatment or service that does not require prior authorization.

  NOTE: You may request a written determination from the Administrative Office regarding the Plan's coverage of the treatment or service. However, getting an advance determination (like getting prior authorization) does not guarantee payment of Plan benefits. For example, benefits would not be payable if Your eligibility for coverage ended before the services were rendered or the maximum benefit had already been paid.

Review Process

You have the right to submit comments, documents, records and other information in support of your claim for benefits. Upon written request and free of charge you will be provided with reasonable access to and copies of all documents, records and other information relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated in connection with the Claim (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of dental experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

Urgent Care Claim appeals will be reviewed by a different person at the Administration Office than the one who made the original decision and who is not a subordinate of the person who denied your claim. If your claim was denied on the basis of a dental judgment (such as a determination that the treatment or service was not a dental necessity, or was investigational or experimental), an independent dental professional who has appropriate training and experience in the relevant field of dentistry will be consulted. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you relating to the Claim.

Pre-Service Claim appeals should be filed with the Administration Office. If your claim was denied on the basis of a dental judgment, an independent health care professional who has appropriate training and experience in the relevant field of dentistry will be consulted. The Board of Trustees will then review all relevant information and make a determination on your appeal within *30 days* of receipt of the appeal by the Administration Office.

Post-Service Claim appeals will be reviewed by the Board of Trustees at their next regularly scheduled meeting as described below. The appeal must be submitted in writing to the Board of Trustees and must include the patient's name, participant's name, a statement that this is an appeal of the Adverse Benefit Determination, the date of the Adverse Benefit Determination and the basis of the appeal. If your claim was denied on the basis of a dental judgment (such as a determination that the treatment or service was not a dental necessity, or was investigational or experimental), an independent health care professional who has appropriate training and experience in the relevant field of dentistry will be consulted.

Timing of Notice of Decision on Appeal

Urgent Care Claim Appeals: You will be sent a notice of a decision on review by the Administration Office as soon as possible but no later than *72 hours* of receipt of the appeal by the Administration Office. If the Administration Office denies your appeal, you may request a review directly by the Board of Trustees as described above.

Pre-Service Claim Appeals: You will be sent a notice of decision on review by the Administration Office within *30 days* of receipt of the appeal by the Administration Office.

Post-Service Claim Appeals: Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received in the Administration Office within *30 days* of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of

your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified by the Administration Office of the decision as soon as possible, but no later than *5 days* after the decision has been reached.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon written request and free of charge;
- A statement of any further rights of appeal;
- If an internal rule, guideline, protocol or similar criteria was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon written request at no charge;
- If the determination was based on dental necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge;

The denial of a claim to which the right to review has been waived, or the decision of the Board or its designated Appeals Committee with respect to a petition for review, is final and binding upon all parties including the claimant or the petitioner. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you have previously designated the individual to act on your behalf. A form can be obtained from the Administrative Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

Using an Authorized Representative

An authorized representative may submit a claim (or later an appeal) for You if You are unable to complete it Yourself and have previously designated the individual to act on Your behalf. A form can be obtained from the Administrative Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on Your behalf.

In the case of an urgent claim, a health care professional with knowledge of Your medical condition may act as an authorized representative without Your having to complete the special authorization form.

When Claims Must Be Filed

Your claim will be considered to have been filed as soon as it is received by the Administrative Office. Pre-service and urgent claims must be filed before services are obtained.

You must submit all post-service claims no later than one year after the date charges were incurred.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until after You have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since You filed a request for review and You have not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be started more than one year after the end of the year in which services were provided.

The denial of a claim to which the right to review has been waived, or the decision of the Board or its designated Appeals Committee with respect to a petition for review, is final and binding upon all parties, including the claimant or the petitioner. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board.

Special exclusion for fraud

No benefits shall be paid for fraudulent claims of services or supplies by a covered Employee, eligible dependent, or any other person. If a fraudulent claim has been paid on behalf of any person, both the Employee and any person on whose behalf a fraudulent claim was submitted as a dependent of the Employee shall be liable to the Plan for repayment of any benefits paid on behalf of the Employee or any eligible dependent of the Employee against the amount which was fraudulently paid on behalf of the Employee or the other person.

If an Employee or an eligible dependent of the Employee has any outstanding liability for fraudulently paid claims, neither the Employee nor the Employee's eligible dependents may assign any rights to benefits to a provider of services or supplies until all fraudulently paid benefits are repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by an Employee or eligible dependent may be disregarded by the Plan, and payments of benefits by the Plan under a purported assignment is not a waiver of the right of the Plan to refuse to acknowledge other purported assignments. If any fraudulent claims have not been repaid, when an Employee or eligible dependent incur covered charges, the Employee or eligible dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims has been credited.

VI. GENERAL PROVISIONS AND INFORMATION

Name of the Plan

Oakland Firefighters Health and Welfare Trust

Name, address and telephone number of the plan sponsor

Board of Trustees

Oakland Firefighters Health and Welfare Trust
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756
Phone: (925) 833-7313

Plan Administrator

The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan Participants and Beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974.

The Board of Trustees has engaged the following Trust Fund Manager named below to provide day-to-day administrative services to the Plan:

Health Services & Benefit Administrators
4160 Dublin Boulevard, Suite 400
Dublin, CA 94568-7756
Phone: (925) 833-7313

The Internal Revenue Service has assigned to the Board of Trustees the (EIN) number

94-2918245

Plan number

01

Type of Plan

This is a Welfare Plan that provides dental benefits to eligible active and retired Employees and dependents.

Name and address of the person designated as agent for the service of Legal Process.

Richard Grosboll
Neyhart, Anderson, Flynn & Grosboll
369 Pine Street, Suite 800
San Francisco, CA 94104-3323

The service of legal process may also be made upon a Plan Trustee, or the Board of Trustees at HS&BA's address shown above.

Name and Business Address of each Trustee:

Board of Trustees

Charles Garcia, Co-Chairman
Local 55
369 15th street
Oakland, CA 94612

Larence Hom
Local 55
369 15th street
Oakland, CA 94612

Tom Marshall
Local 55
369 15th street
Oakland, CA 94612

Dan Robertson
Local 55
369 15th street
Oakland, CA 94612

Steve Splendorio
Retiree Representative
Local 55
369 15th street
Oakland, CA 94612

Zac Unger
Local 55
369 15th street
Oakland, CA 94612

Jim Whitty, Chairman
Local 55
369 15th street
Oakland, CA 94612

Availability of Collective Bargaining Agreements

The Plan is maintained pursuant to a Memorandum of Understanding (MOU). A copy of the MOU is available for examination and may be obtained upon written request to the Fund administrator.

Source of Contributions

Contributions to provide Plan benefits are paid by the employer in accordance with MOU, at fixed amounts per month. Retired Employees make self-payments to the Trust at rates established by the Trustees.

The Administrative Office will provide You upon written request, with information as to whether a particular employer is contributing to this Plan on behalf of participants working under the collective bargaining agreement and if the particular employer is contributing to the Plan and a list of organizations that provide benefits provided:

Plan Year

The Fund's fiscal Plan year-end date is June 30.

Claims and Appeals Procedures

The procedures to follow for filing a claim for self-funded benefits are set forth in the sections of this booklet titled *Claims and Appeals Procedures*.

Any denial of a claim for benefits will be explained in writing and the explanation will include the specific reason for the denial, reference to the Plan provisions upon which the denial was based, a description of any additional information You might be required to provide and an explanation of why it is needed, and an explanation of the Plan's claim review procedure.

You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a review to the Board of Trustees or to the insurance carrier. In connection with such a request, documents pertaining to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the review procedure.

Plan Amendments or Termination of Plan

The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments will be made in writing and become effective on the date the Amendment is signed by the Chairman and Co-Chairman or on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverage may be added by the Board of Trustees.

Discretionary Authority of Board of Trustees

In carrying out their responsibilities under the Plan, the Board of Trustee or its delegate, other Plan fiduciaries, and the insurers or administrators of each Benefit Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Non-Assignment

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no

way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

Facility of Payment

If the Board of Trustees or its designee determines that You cannot submit a claim or prove that You or Your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because You are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the provider(s) who provided the health care services or supported, or to any other individual who is providing for Your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, the Administrative Office nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Authority

The Board of Trustees of the Oakland Firefighters Health and Welfare Trust Reserves the right, in its sole discretion at any time and from time to time, but on a non-discriminatory basis to:

1. terminate or amend the amount or condition with respect to any benefits even though such action(s) may affect claims which have already occurred; and
2. alter or postpone the method of payment of any payment of any benefit: and
3. change the amount of required premiums; and
4. amend the eligibility; and
5. amend or rescind any other provision of the rules and regulations of the plan.

None of the benefits provided by the Plan are insured by any contract of insurance and there is no liability on the Board of Trustees of the Trust or any other individual or entity to provide payment over and beyond the amounts in the Trust collected and available for such purpose.

VII. DEFINITIONS

Allowed Charge/Allowed Amount/Allowable Charge means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. The allowed charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

- the amount payable for each covered dental procedure as outlined in the "Schedule of Dental Procedures" as amended from time to time; or
- The provider's/facility's actual billed charge.

The Plan uses 80% of the 2017 National Dental Advisory Services (NDAS) to determine the Allowed Charge. The Plan will not always pay benefits equal to or based on the provider's actual charge for health care services or supplies, even after You have paid any applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "allowed charge" amount for services or supplies.

Balance Billing: A bill from a provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan.

Contributing Employer means any employer who is required by any of the collective bargaining agreements to make contributions to the Fund, or who does in fact make one or more contributions to the Fund.

Dependent means Your legal Spouse and Your eligible children, under age 26, are eligible for dental benefits coverage. Eligible children are Your:

- natural children;
- legally adopted children or children placed for adoption;
- stepchildren; or
- a child that is named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice.

The following individuals are not eligible under the Plan: *a spouse of a Dependent Child (e.g. Employee's son-in-law or daughter-in-law) or a child of a Dependent Child (e.g. Employee's grandchild).*

Adult Disabled Child: If, upon reaching the limiting age, an Employee's unmarried dependent child is incapable of self-support due to physical or mental disability, coverage with this Plan may be extended (subject to all other Plan provisions and limitations) provided proof of the child's disability and continued dependency is submitted to the Plan within 31 days of the child's limiting birthday. Thereafter, additional proof of continued disability and dependency must be submitted as requested from time to time.

A dependent who is in full-time military service is excluded from coverage unless otherwise required by applicable law.

Dentist means an individual (who is licensed and acting within the scope of that license) trained and skilled to provide care of the teeth. This includes preventive, diagnostic and restorative care as well as the treatment of diseases, injuries or malformations of the teeth, jaws and gums.

Dental Hygienist means a person who is currently licensed to practice dental hygiene by the government authority having jurisdiction over the licensing and practice of oral hygiene.

Domestic Partner: See the Eligibility chapter in this document.

Employee means any person employed by a Contributing Employer in a job classification covered by a collective bargaining agreement with the Union and who meets the eligibility requirements of the Fund. The term "Employee" may include the Employees of the Fund, the Union, or the Administrative Office, non-bargaining unit Employees of Employers, and self-employed Employees and partners, if the inclusion of such Employees does not jeopardize the tax-exempt status of the Trust.

Experimental or Investigational Treatment means any course of treatment whether or not prescribed by a physician, for which charges incurred are not the direct result of injury or illness, and any other procedure not recognized to have medical significance or therapeutic value; or any course of treatment making use of drugs or devices not yet approved by the Federal Drug Administration. This includes treatments, procedures, drugs, devices, or care, and all related services or supplies that are experimental or investigational as determined by the Board of Trustees or its designee. A treatment, procedure, drug, device or care is experimental or investigative if:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished (unless the off-label use is approved by the Plan), or
2. the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. Reliable Evidence* shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is for the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence* shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

∗ Reliable Evidence shall mean only published reports and articles in authoritative medical, dental and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical or dental treatment or procedure.

Fund means the Oakland Firefighters Health and Welfare Trust.

Local Union means the International Association of Firefighters, Local 55 ("IAFF Local 55").

Medically Necessary means a dental treatment, service or supply that meets all of the following criteria as determined by the Board of Trustees or its designee:

- Appropriate and necessary for the symptoms, diagnosis, and direct care or treatment of Your illness or injury;
- Consistent with professionally recognized standards of health care in the United States, and given at the right time and in the right setting;

- Not primarily for Your convenience or the convenience of Your provider; and
- The most appropriate support or level of service that can be safely provided.

The fact that a physician, dentist or other provider may prescribe, order, recommend, or approve a service or supply does not in and of itself mean that it is Medically Necessary

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Orthodontia means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth, including cephalographic film, but not including extractions.

Plan Administrator means the Board of Trustees of the Oakland Firefighters Health and Welfare Trust Fund.

Plan Year means the 12-month period starting July 1 and ending June 30.

Retiree means a firefighter that is currently receiving a firefighter's pension from the City of Oakland or PERS and enrolls for retiree benefits within 60 days after he ceases to be eligible as an active employee under the Health and Welfare Trust.

Schedule of Dental Procedures means the description of dental procedures and the different amounts payable for each as outlined in this booklet and amended from time to time.

Spouse includes the Participant's lawful spouse (including opposite-sex and same-sex spouses) who is not legally separated from the spouse in any form. A spouse becomes eligible as of the date of marriage, provided that you have submitted an updated Enrollment/Change Form adding your spouse along with a copy of your certified marriage certificate within 30 days of the date of marriage. If an updated Enrollment/Change Form and proper documentation is not received within 30 days of the date of marriage, enrollment in the Plan for your spouse will not be effective until the first of the month following receipt of the required documentation.

A former spouse is NOT eligible for coverage as a Dependent under the Plan, and a Participant may not enroll a former or Separated Spouse, even if a court orders such coverage, **except as required by COBRA.**

Trust Agreement means the Trust Agreement establishing the Oakland Firefighters Health and Welfare Trust Fund and any modification, amendment, extension or renewal.

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