

*Summary Plan Description*  
*Delta Dental*

for

*City of Appleton*

**96602-002**  
**TEAMSTER**



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## PLAN DESCRIPTION INFORMATION

1. Name of Plan: City of Appleton Group Dental Plan
2. Plan Sponsor: City of Appleton
3. Plan Administrator and Named Fiduciary:  
City of Appleton  
100 North Appleton Street  
Appleton, WI 54911  
(920) 832-6455
4. Employer Identification Number: 39-6005381
5. The Plan provides dental benefits for participating employees and their enrolled dependents. The Plan is a self-funded plan, and benefits are payable solely from the Plan Sponsor's general assets.
6. Plan benefits described in this booklet are effective July 1, 2002 (revised 01/01/2010).
7. Plan records are maintained as of a year ending on December 31.
8. Agent for service of legal process:  
  
City of Appleton  
100 North Appleton Street  
Appleton, WI 54911
9. The Plan Supervisor is responsible for performing certain delegated administrative duties, including the processing of claims. The Plan Supervisor is:  
Delta Dental of Wisconsin  
P O Box 828  
Stevens Point WI 54481-0828  
Telephone: 715-344-6087  
Toll Free: 1-800-236-3712
10. The Plan's contributions are shared by the employer and employee for part-time employees and by the employer for full-time employees.
11. Each employee of the employer who participates in the Plan receives a Summary Plan Description, which is this booklet. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.
12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated by the Plan Sponsor. Any changes to the Plan or termination of the Plan will be communicated to covered persons as required by applicable law.

### **Plan Description Information Continued**

13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets will be allocated and disposed of for the exclusive benefit of the participating employees and their dependents covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.
14. The Plan does not constitute a contract between the employer and any covered person or will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time. It is provided, however, that the foregoing will not modify the provisions of any collective bargaining agreement which may be made by the employer with the bargaining representative of any employees.
15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

NOTE: Throughout this booklet, Plan Supervisor means Delta Dental of Wisconsin, the Plan's Dental Claim Administrator.

**SCHEDULE OF DENTAL BENEFITS**

**Individual Maximum Benefit**

Preventive, Basic, Major,  
Prosthodontic, and Orthodontic Services .....\$5,000 per calendar year

**Preventive Services**

Covered expenses are payable at 80% of the maximum plan allowance

**Basic Services**

Covered expenses are payable at 80% of the maximum plan allowance

**Major Services**

Covered expenses are payable at 80% of the maximum plan allowance

**Prosthodontic Services**

Covered expenses are payable at 80% of the maximum plan allowance

**Orthodontic Services**

Individual Lifetime Maximum Benefit for Orthodontic Services.....\$2,000

Covered expenses are payable at 60% of the maximum plan allowance for covered employees and covered dependent children under age 19 at the time treatment commences.

## **HOW TO FILE A DENTAL CLAIM**

You will receive an identification (ID) card. It will show your name, group number and the effective date of your coverage.

Show your ID card to the dentist's office for dental services. The bills can be sent directly to the claims administrator, Plan Supervisor, on the dentist's own claim forms. Instructions are on the back of the card. Mail the bills to:

Delta Dental of Wisconsin  
Attention: Claims Department  
P O Box 828  
Stevens Point WI 54481-0828

## **DELTA DENTAL PPO DENTISTS**

Delta Dental PPO Dentists have signed a contract with Delta Dental, agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs, because you will be responsible only for applicable deductible amounts, copayments and coinsurance for benefits. These dentists agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

## **DELTA DENTAL PREMIER DENTISTS**

As a Delta Dental subscriber, you are free to see any dentist you choose on a treatment by treatment basis. If your dentist has signed a contract with Delta Dental, he or she has agreed to accept payment directly from Delta Dental on our Maximum Plan Allowance (MPA). The Delta Dental Premier or Dentist will charge you only for copayments, deductibles and services not covered by your group contract. After a claim for dental services is filed, you will receive an Explanation of Benefits form indicating the amount Delta Dental paid to the Delta Dental Premier Dentist and the amount, if any, you owe the dentist.

For information on Delta Dental Premier dentists, call 800-236-3712, or visit Delta's web site at [www.deltadentalwi.com](http://www.deltadentalwi.com).

## **NONCONTRACTING DENTISTS**

If your dentist has not signed a contract with Delta Dental, claim payments will still be calculated based on the MPA, but they will be sent directly to you rather than to the dentist. You will then need to reimburse your dentist through his or her usual billing procedure.

## **PAYMENT OF CLAIMS**

Plan Supervisor will make direct payment to the dentist's office if he/she is contracted with Delta Dental of Wisconsin, and you will receive a copy of the explanation of payment. If the dentist is not contracted with Delta, claim payments will be sent directly to you with the explanation of the benefit payment. Plan Supervisor reserves the right to request any information required to determine benefits

or process a claim. You or the provider of services will be contacted if additional information is needed to process your claim.

Payment of benefits under this plan will be made in accordance with an assignment of rights for you and your dependents as required under state Medicaid law.

Benefits accrued on behalf of you or your covered dependent upon death shall be paid, at the Plan's option, to any family member(s) or your estate.

Plan Supervisor will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by Plan Supervisor in good faith will fully discharge it to the extent of such payment.

### **PREDETERMINATION OF DENTAL BENEFITS**

If expense incurred in performing a dental service or one series of dental services can reasonably be expected to be \$200 or more, Plan Supervisor recommends you submit those charges for a Predetermination of Benefits. Plan Supervisor will advise you what expenses will be covered under the Plan. Plan Supervisor will take into account alternate procedures, services, or courses of treatment based upon professionally endorsed standards of dental care.

If treatment is to commence more than 90 days after the date treatment is authorized, Plan Supervisor will recommend that you submit another treatment plan.

### **OPTIONAL TREATMENT**

In all cases in which you select a more expensive service or supply than that which is dentally necessary, the Plan will pay only the portion of the fee for the service or benefit which is needed to restore the tooth or dental arch to contour and function. You will be responsible for the remainder of the dentist's fee.

### **DENTAL BENEFITS**

This section describes benefits for covered expenses. Covered expense means expense incurred by you for the services stated below. The expense must be incurred while you are covered for that benefit under the Plan. Covered expenses are payable on a maximum plan allowance at the coinsurance percentages and up to the Maximum Benefits shown on the Schedule of Benefits.

### **COINSURANCE**

Covered expenses are payable at the applicable percentage rates shown on the Schedule of Benefits, up to the Maximum Benefit.

## **COVERED DENTAL EXPENSES**

A temporary dental service, including study models, occlusal adjustments and local anesthesia will be considered an integral part of the final dental service rather than a separate service.

## **PREVENTIVE SERVICES**

Oral examinations.

Full mouth or panorex x-rays.

Bitewing x-rays.

Cleanings (prophylaxis).

Topical fluoride treatments. A prophylaxis performed in conjunction with a fluoride treatment is a separate dental service.

Space maintainers for covered dependent children to the age of 19. For fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.

Sealants on a permanent posterior tooth or teeth.

## **BASIC SERVICES**

Ancillary. Emergency oral examinations and palliative treatment for relief of dental pain.

Restorative. Fillings including composite restorations in anterior (front) teeth and stainless steel crowns, except as described elsewhere.

Endodontics. Procedures necessary for root canal treatments, root canal fillings and pulp vitality tests.

Routine extractions.

Periodontics. Procedures necessary for treatment of diseases of the tissues supporting the teeth including periodontal cleanings (prophylaxis), periodontal exams, periodontal scaling and periodontal splinting.

Prescription drugs and drug injections.

Dental implants, including the prosthesis placed over the implant and any adjustments to the prosthesis.

Analgesia.

General anesthesia. When administered by a dentist and when dentally necessary or necessary due to a medical condition that presents a high risk to the patient.

Actisite. When the covered person has had prior periodontal therapy performed and pocket depths are 5 mm or greater. Actisite must be performed a minimum of four weeks following active periodontal therapy. Actisite is limited to once per tooth per twelve months to a maximum of three tooth sites per quadrant.

Recementation of crowns and bridges.

## **MAJOR RESTORATIVE SERVICES**

Gold foil fillings and their maintenance.

Inlays or onlays and their maintenance.

Crowns and their maintenance.

Veneers.

### **Limitations for Major Restorative Services**

Expense incurred for Major Restorative Services performed on other than permanent teeth is not a covered expense.

## **PROSTHODONTIC SERVICES**

Installation and maintenance of removable or fixed bridgework.

Installation and maintenance of partial and complete dentures, including 6 months post-installation care.

Procedures to reline and rebase, but not within 6 months of the initial placement and not more than once in any 36 month period for any covered person.

### **Limitations for Prosthodontic Services**

Replacement of a complete upper or lower denture will be a covered expense only if the existing denture was installed at least 5 years prior to its replacement and cannot be made serviceable; unless:

1. Replacement is dentally necessary due to the placement of an initial opposing full denture or the extraction of natural teeth rendering the complete denture unserviceable; or
2. The complete denture, while in the oral cavity, is damaged beyond repair as a result of an injury received while you are covered under the Plan.

Expense incurred for Prosthodontic Services performed on other than permanent teeth is not a covered expense.

Expense incurred for Prosthodontic Services to replace at any time a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability is not a covered expense.

## **ORTHODONTIC SERVICES**

Benefits are subject to the coinsurance and lifetime maximums as shown on the Schedule of Benefits for Orthodontic Services. Orthodontic treatment means braces and necessary adjustments.

Expense incurred for:

1. Treatment and appliances for tooth guidance, interception and correction; including appliances and harmful habit appliances.
2. Services related to covered orthodontic treatment; including x-rays, extractions, exams, space regainers and/or study models.

Twenty five percent (25%) of the total case fee will be allowed for the initial downpayment. Benefit payments for orthodontic treatment are prorated by Plan Supervisor over the treatment period and payments are made monthly. If for any reason the treatment plan is terminated before completion of the treatment, no further benefits are payable.

### **Limitations for Orthodontic Services**

The Plan does not include charges for Orthodontic Services started prior to the effective date of your coverage under your employer's Plan.

Orthodontic Services are payable only for covered employees and covered dependent children under age 19 at the time treatment commences.

## LIMITATIONS AND EXCLUSIONS

The Plan does not provide benefits for:

1. Any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
  - a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or
  - b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;
2. Services and supplies:
  - a. for which no charge is made, or for which you would not be required to pay if you did not have coverage;
  - b. furnished by or payable under any plan or law through any government or any political subdivision, this does not include Medicare or Medicaid; or
  - c. furnished for a military service connected sickness or bodily injury by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
3. Any loss caused or contributed to by:
  - a. war or any act of war, whether declared or not; or
  - b. any act of international armed conflict, or any conflict involving armed forces of any international authority;
4. Completion of forms or failure to keep an appointment with the dentist;
5. Replacement of lost, broken or stolen appliances or duplicate appliances, except as specifically described;
6. Cosmetic dentistry, including personalization or characterization of dentures and facing on crowns or pontics posterior to the second bicuspid;
7. Preventive control programs including oral hygiene instruction, plaque control or dietary planning, lab tests, anaerobic culture, and sensitivity testing;
8. Appliances or restorations for: increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, correction of congenital or developmental malformations;

9. Fees for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards;
10. Any hospital charges or for services of any anesthesiologist;
11. General anesthesia unless administered by a dentist and dentally necessary or necessary due to a medical condition that presents a high risk to the patient;
12. Precision or semi-precision attachments;
13. Dental services which do not have uniform professional endorsement;
14. Orthodontic Services unless specified in the Schedule of Benefits;
15. The extent the expense exceeds the maximum plan allowance for the service, treatment or supply in the locality where furnished;
16. Expenses incurred by a late applicant as defined in this booklet;
17. Any expense incurred after the date your coverage under this Plan terminates;
18. Diagnosis and treatment of temporomandibular joint dysfunction (TMJ), including charges for: TMJ exams, x-rays and consultations; kinesiographic analysis; TMJ splints and appliances; splint equilibration and adjustments; physical therapy; or TMJ services performed to the teeth, unless the individual tooth warrants restoration on its own merit;
19. Services which are not considered to be dentally necessary;
20. Any dental expense unless specifically indicated;
21. Sterilization/infection control fees;
22. Oral surgical procedures;
23. Sickness or bodily injury for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverages under this Plan did not exist. Payments made under any other coverage will be credited toward any applicable calendar year deductible and coinsurance for the year the covered expenses were incurred;

24. Any covered expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

## DEFINITIONS

**Active status** means performing on a regular, full-time basis all customary occupational duties at the employer's business establishment for 37 ½ hours per week. Active status also means performing on a regular, permanent part-time basis all customary occupational duties at the employer's business establishment for at least 20 hours but less than 37 ½ hours per week. Each day of a regular paid vacation and any regular non-working holiday shall be deemed active status if you are not totally disabled on your effective date of coverage. You will be in an active status if you were in an active status on your last regular working day.

**Beneficiary** means you and your covered dependent(s), or legal representative of either, and anyone to whom the rights of you or your covered dependent(s) may pass.

**Bodily injury** means injury due, directly and independently of all other causes to an accident.

**Cosmetic dentistry** means those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic conditions exist.

**Covered person** means the employee or any of the employee's covered dependents.

**Dentally necessary** means the extent of care and treatment which is the generally accepted, proven and established practice by most dentists with similar experience and training where the service is provided.

**Dentist** means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and is operating within the scope of that license.

**Dependent** means the subscriber's legal spouse or an unmarried dependent child of the subscriber or the subscriber's spouse. The term child includes any of the following:

- A natural child.
- A stepchild
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the subscriber or the subscriber's spouse
- A child of an enrolled dependent child (until the enrolled dependent who is the parent turns 18)

The definition of dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child under 27 years of age who is not eligible for coverage under a group dental benefit plan offered by their employer and for which the amount of the Dependent's premium contribution is no greater than the premium amount for his or her coverage as a Dependent under the subscriber's plan.
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the child's 27<sup>th</sup> birthday.

The subscriber must reimburse us for any benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom dental care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A dependent does not include anyone who is also enrolled as a Subscriber.

A Dependent also includes an adult child who meets the following requirements:

- A full time student, regardless of age,
- Not married or eligible for coverage under a group dental benefit plan offered by their employer and for which the amount of the Dependent's premium contribution is no greater than the premium amount for his or her coverage as a dependent under the subscriber's plan.
- Under age 27 when called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the dependent was attending on a full-time basis, an institution of higher education.
- If the adult Dependent ceases to be a full-time student due to medically necessary leave of absence, then coverage must be continued in accordance with the existing law for continued coverage of students on medical leave, and age is not a factor that would affect when such continued coverage would end.

#### Extended Coverage for Full-time Students

Coverage for an enrolled dependent child who is a full-time student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- One year after the medically necessary leave of absence begins; or
- The date coverage would otherwise terminate under the Plan.

Coverage will be extended only when the enrolled Dependent is covered under the plan because of full-time student status at a post-secondary school immediately before the medically necessary leave of absence begins.

Coverage will be extended only when the enrolled Dependent's change in full-time student status meets all of the following requirements:

- The enrolled dependent is suffering from a serious sickness or injury;
- The leave of absence from the post-secondary school is medically necessary, as determined by the enrolled dependent's treating physician; and
- The medically necessary leave of absence causes the enrolled dependent to lose full-time student status for purposes of coverage under the plan.

A written certification by the treating physician is required. The certification must state that the enrolled dependent child is suffering from a serious sickness or injury and that the leave of absence is medically necessary.

For purposes of this extended provision, the term “leave of absence” shall include any change in enrollment at the post-secondary school that causes the loss of full-time student status.

#### Coverage for a Handicapped Child

Coverage for an unmarried enrolled dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the enrolled dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the participant for support.

Coverage will continue as long as the enrolled dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the plan.

We will ask you to furnish the claims administrator with proof of the child’s incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the claims administrator agrees to this extension of coverage for the child, the claims administrator may require that a physician chosen by us examine the child. We will pay for that examination.

The claims administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child’s incapacity and dependency within 31 days of the claims administrator’s request as described above, coverage for that child will end.

**Maximum Plan Allowance** means the total dollar amount allowed under the contract for a specific covered benefit including the amounts payable by Delta Dental and payable by the Covered Person.

**Plan Supervisor** means Delta Dental of Wisconsin, the claims administrator of your Plan.

**Employee** means you, as an employee, when you are permanently employed and paid a salary or earnings and are in an active status at your employer's place of business.

**Employer** means the sponsor of the Group Plan or any subsidiary(s).

**Expense incurred** means the maximum plan allowance made for dentally necessary services and supplies. The expense incurred date is the date the service is completed or the date which the teeth are prepared for fixed bridges, crowns, inlays, or onlays and the date the final impression is made for dentures or partials.

**Late applicant** means an employee and/or an employee's eligible dependent who enrolls or is enrolled for dental coverage more than 31 days after the eligibility date.

**Predetermination** means a review by us of a dentist's planned treatment and expected charges, including diagnostic charges, prior to the rendering of services.

**You and your** means you as the employee and any of your eligible covered dependents, unless otherwise indicated.

## **ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE**

These provisions apply to employees hired on or after the effective date of this Plan, and to dependents who are added on or after the effective date of this Plan.

### **EMPLOYEE ELIGIBILITY**

You are eligible for coverage if the following conditions are met:

1. You are an employee who meets the eligibility requirements of the employer;
2. You satisfy an eligibility period of 30 consecutive days of employment; and
3. You are in active status.

Your eligibility date is the date immediately following your completion of any eligibility period.

### **EMPLOYEE EFFECTIVE DATE OF COVERAGE**

You must enroll on forms furnished and accepted by Plan Supervisor.

1. If your completed enrollment forms are received by Plan Supervisor before your eligibility date, your coverage is effective on your eligibility date.
2. If your completed enrollment forms are received by Plan Supervisor after your eligibility date, but within 31 days from that date, your coverage is effective on your eligibility date.
3. If your completed enrollment forms are received by Plan Supervisor more than 31 days after your eligibility date, this is considered Late Enrollment. You must then provide evidence of insurability to Plan Supervisor. This form is available from your employer or Plan Supervisor. Plan Supervisor has the right to accept or decline coverage based upon the evidence of insurability. You will be covered on the date specified by Plan Supervisor once your evidence is approved.

### **EMPLOYEE DELAYED EFFECTIVE DATE**

If the employee is not in active status on the effective date of coverage, coverage will be effective the day the employee returns to active status. The employer must notify the Plan Supervisor in writing of the employee's return to active status.

### **DEPENDENT ELIGIBILITY**

Each dependent is eligible for coverage on:

1. The date the employee is eligible for coverage, if he or she has dependents who may be covered on that date; or

2. The date of the employee's marriage for any dependent acquired on that date; or
3. The date of birth of the employee's natural-born child; or
4. The date a child is placed in the employee's home for adoption.

The covered employee may cover dependents only if the employee is also covered. Check with your employer immediately on how to enroll for dependent coverage. Late enrollment may result in denial of dependent coverage by Plan Supervisor.

### **DEPENDENT EFFECTIVE DATE OF COVERAGE**

Each dependent must be enrolled on forms furnished and accepted by Plan Supervisor.

Each dependent's effective date of coverage is determined as follows:

1. If the completed enrollment forms are received by Plan Supervisor before the dependent's eligibility date, that dependent is covered on the date he/she is eligible.
2. If the completed enrollment forms are received by Plan Supervisor after the dependent's eligibility date, but within 31 days from that date, that dependent is covered on the date he/she is eligible.
3. If the completed enrollment forms are received by Plan Supervisor more than 31 days after the dependent's eligibility date, this is considered Late Enrollment. You must then provide evidence of insurability for your dependents to Plan Supervisor. This form is available from your employer or Plan Supervisor. Plan Supervisor has the right to accept or decline coverage based upon the evidence of insurability. The dependent will be covered on the date specified by Plan Supervisor once the evidence is approved.

However, no dependent's effective date will be prior to the employee's effective date of coverage.

If a dependent child becomes an eligible employee of the employer under this Plan, he/she is no longer eligible as a dependent and must make application as an employee.

### **Benefit Changes**

Additional or increased benefit coverage will become effective on the date of change if you are in active status. Otherwise, the change will be effective on the day next following the date you return to active status. A decrease in coverage will be effective immediately on the date of change. Also refer to the Dependent Delayed Effective Date provision for effective date of change in benefits for dependents.

Plan Supervisor must be notified of the change no more than 31 days following the date of change. If Plan Supervisor is not notified within 31 days, any additional or increased benefit coverage will become effective on the date Plan Supervisor receives written notification and approves the change.

## **SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS**

If the premium continues to be paid, your coverage will remain in force during:

1. A layoff;
2. A leave of absence; or
3. A period of total disability.

## **REINSTATEMENT OF COVERAGE FOLLOWING LAYOFF OR APPROVED UNPAID LEAVE OF ABSENCE**

If your coverage under the Plan was terminated after a period of layoff or leave of absence and you are now returning to work, you may reapply for coverage. If a written application for coverage is received by Plan Supervisor within 31 days of the date of re-employment, the effective date will be the date you returned to work. If a written application for coverage is received by Plan Supervisor more than 31 days after re-employment, you must then provide evidence of insurability for you and your dependents to Plan Supervisor. This form is available from your employer or Plan Supervisor. Plan Supervisor has the right to accept or decline coverage based upon the evidence of insurability.

## **TERMINATION OF COVERAGE**

Coverage terminates on the earliest of the following:

1. The date the group Plan terminates;
2. The end of the month for which any required contribution was due and not paid;
3. The date you enter full-time military, naval or air service;
4. The end of the month for which you fail to be in an eligible class of persons according to the eligibility requirements of the employer;
5. For your dependents, the date your coverage terminates;
6. For your dependents, the date the dependent enters full-time military, naval or air service;
7. For your dependents, the date the dependent marries;
8. For your dependents, the end of the month for which the dependent no longer meets the definition of a dependent;
9. For your dependents, the end of the calendar year for which a dependent reaches the limiting age;
10. The date you request termination of coverage to be effective for yourself and/or your dependents; or
11. For any benefit, the date the benefit is removed from the Plan.

## **CONTINUATION OF DENTAL BENEFITS**

### **THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)**

#### **CONTINUATION OF BENEFITS**

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with 20 or more employees. The law requires that employers offer employees and/or their dependents continuation of dental coverage at group rates in certain instances where there is a loss of group insurance coverage.

#### **ELIGIBILITY**

A qualified beneficiary under COBRA law means an employee, employee's spouse or dependent child covered by the Plan on the day before a qualifying event. A qualified beneficiary under COBRA law also includes a child born to the employee during the coverage period or a child placed for adoption with the employee during the coverage period.

**EMPLOYEE:** An employee covered by the employer's Plan has the right to elect continuation coverage if coverage is lost due to one of the following qualifying events:

- Termination (for reasons other than gross misconduct) of the employee's employment or reduction in the hours of employee's employment; or
- Termination of retiree coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

**SPOUSE:** A spouse covered by the employer's Plan has the right to elect continuation coverage if the group coverage is lost due to one of the following qualifying events:

- The death of the employee;
- Termination of the employee's employment (for reasons other than gross misconduct) or reduction of the employee's hours of employment with the employer;
- Divorce or legal separation from the employee;
- The employee becomes entitled to Medicare benefits; or
- Termination of a retiree spouse's coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

**DEPENDENT CHILD:** A dependent child covered by the employer's Plan has the right to continuation coverage if group coverage is lost due to one of the following qualifying events:

- The death of the employee parent;
- The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment with the employer;
- The employee parent's divorce or legal separation;
- Ceasing to be a "dependent child" under the Plan;

- The employee parent becomes entitled to Medicare benefits; or
- Termination of the retiree parent's coverage when the former employer discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

## **LOSS OF COVERAGE**

Coverage is lost in connection with the foregoing qualified events, when a covered employee, spouse or dependent child ceases to be covered under the same Plan terms and conditions as in effect immediately before the qualifying event (such as an increase in the premium or contribution that must be paid for employee, spouse or dependent child coverage).

If coverage is reduced or eliminated in anticipation of an event (for example, an employer's eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee's eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the maximum coverage period.

## **NOTICES AND ELECTION**

The Plan provides that coverage terminates, for a spouse due to legal separation or divorce or for a child when that child loses dependent status. Under the law, the employee or qualified beneficiary has the responsibility to inform the Plan Administrator (see Plan Description Information) if one of the above events has occurred. The employee or a family member must give this notice within 60 days after the event occurs. (For example, an ex-spouse should make sure that the Plan Administrator is notified of his or her divorce, whether or not his or her coverage was reduced or eliminated in anticipation of the event). When the Plan Administrator is notified that one of these events has happened, it is the Plan Administrator's responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

For an employee or family member who is determined under the Social Security Act to be disabled at any time during the first 60 days of COBRA coverage, the continuation coverage period may be extended 11 additional months. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the Plan Administrator within the initial 18 month coverage period and within 60 days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

For termination of employment, reduction in work hours, the death of the employee, the employee becoming covered by Medicare or loss of retiree benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

Under the law, continuation coverage must be elected within 60 days after Plan coverage ends, or if later, 60 days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the 60 day period, the right to elect coverage under the Plan will end.

A covered employee or the spouse of the covered employee may elect continuation coverage for all covered dependents, even if the covered employee or spouse of the covered employee or all covered dependents are covered under another group health plan (as an employee or otherwise) prior to the election. The covered employee, his or her spouse and dependent child, however, each have an independent right to elect continuation coverage. Thus a spouse or dependent child may elect continuation coverage even if the covered employee does not elect it.

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the 60 day election period and the waiver revoked before the end of the 60 day election period, coverage will be effective on the date the election of coverage is sent to the Plan Administrator.

## **MAXIMUM COVERAGE PERIOD**

Coverage may continue up to:

- 18 months for an employee and/or dependent whose group coverage ended due to termination of the employee's employment or reduction in hours of employment;
- 36 months for a spouse whose coverage ended due to the death of the employee or retiree, divorce, or the employee becoming entitled to Medicare at the time of the initial qualifying event;
- 36 months for a dependent child whose coverage ended due to the divorce of the employee parent, the employee becoming entitled to Medicare at the time of the initial qualifying event, the death of the employee, or the child ceasing to be a dependent under the Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the employer filed Chapter 11 bankruptcy;
- 29 months for all qualified beneficiaries if an employee or family member is determined to be disabled under the Social Security Act at any time during the first 60 days of continuation coverage (remaining from the date of termination of employment or reduction in hours). The qualified beneficiary must provide notice of such determination prior to the end of the initial 18 month continuation period to be entitled to the additional 11 months of coverage. For the purpose of COBRA, family member means the employee and any eligible dependent.

If a second qualifying event occurs (for example, the employee dies or becomes divorced) within the 18 month or 29 month coverage period, the maximum coverage period becomes 36 months from the date of the termination or reduction in hours.

The maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the Plan until some later date. However, if alternative coverage (i.e. state continuation) is provided after a qualifying event without regard to COBRA continuation and such coverage does not satisfy all the requirements of COBRA continuation, the employer must offer the covered qualified beneficiary the right to elect COBRA continuation. If COBRA coverage is rejected in favor of the alternative coverage, COBRA coverage need not be offered at the end of the alternative coverage period.

### **SPECIAL RULE INVOLVING EMPLOYEE'S ENTITLEMENT TO MEDICARE BENEFITS**

A special rule exists where the employee is entitled to Medicare at the time of an initial qualifying event due to termination or reduction of hours worked, or becomes entitled to Medicare within the initial 18 or 36 month continuation period following an initial qualifying event. If the employee is entitled to Medicare at the time of an initial qualifying event due to termination or reduction of hours worked, then the period of continuation for other qualified beneficiaries is the later of 36 months from the date of Medicare entitlement, or 18 months from the date of the qualifying event. If, on the other hand, the employee becomes entitled to Medicare during the initial continuation period of 18 months following the original qualifying event, then the other qualified beneficiaries will be entitled to continuation not to exceed 36 months from the date of the original qualifying event.

### **TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD**

Continuation coverage will terminate before the end of the maximum coverage period for any of the following reasons:

- The employer no longer provides group health coverage to any of its employees;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group dental plan (as an employee or otherwise); however, if the new plan coverage contains any exclusion or limitation with respect to any preexisting condition; then continuation coverage will end for this reason only after the exclusion or limitation no longer applies or prior creditable coverage satisfies the exclusion or limitation;
- NOTE: the federal Health Insurance Portability and Accountability Act of 1996 requires portability of health care coverage effective for plan years beginning after June 30, 1997, an exclusion or limitation under the other group health plan may not apply at all to the qualified beneficiary, depending on the length of his or her prior creditable coverage. Portability means once you obtain health insurance, you will be able to use evidence of that insurance to reduce or eliminate any pre-existing medical condition limitation period (under certain circumstances) when you move from one health plan to another.
- The individual on continuation becomes entitled to Medicare benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the Plan.

## **TYPE OF COVERAGE; PREMIUM PAYMENT**

If continuation coverage is elected, the coverage must be identical to the coverage provided under the employer's Plan to similarly situated non-COBRA beneficiaries. This means that if the coverage for similarly situated non-COBRA beneficiaries is modified, coverage for the individual on continuation will be modified.

The initial premium payment for continuation coverage is due by the 45th day after coverage is elected. The initial premium includes charges back to the date the continuation coverage began. All other premiums are due on the first of the month for which the premium is paid, subject to a 31 day grace period. The employer must provide the individual with a quote of the total monthly premium,

Premium for continuation coverage may be increased, however, the premium may not be increased more than once in any determination period. The determination period is a 12 month period which is established by the Plan.

The monthly premium payment to the Plan for continuing coverage must be submitted directly to the employer. This monthly premium may include the employee's share and any portion previously paid by the employer. The monthly premium must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. However, for qualified beneficiaries who are receiving up to 11 months additional coverage (beyond the first 18 months) due to disability extension (and not a second qualifying event), the premium for COBRA continuation coverage may be up 150% of the applicable premium for the additional months. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay the up to 102% premium cost.

## **OTHER INFORMATION**

Employees should contact the Plan Administrator for any question regarding continuation coverage and notify the employer of any changes in marital status, or a change of address.

## **THE UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)**

### **CONTINUATION OF BENEFITS**

Effective October 13, 1994 federal law requires that health plans must offer to continue coverage for employees who are absent due to service in the uniformed services and/or their dependents. Coverage may continue for up to 18 months after the date the employee is first absent due to uniformed service.

### **ELIGIBILITY**

An employee is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or the commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents who have coverage under the Plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

### **PREMIUM PAYMENT**

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 31 days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the employee's share and any portion previously paid by the employer.

### **DURATION OF COVERAGE**

Elected continuation coverage under USERRA will continue until the earlier of:

- 18 months beginning the first day of absence from employment due to service in the uniformed services; or
- the day after the employee fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependents.

### **OTHER INFORMATION**

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or a change of address.

## **COORDINATION OF BENEFITS**

### **Benefits Subject to this Provision**

Benefits described in this Plan are coordinated with benefits provided by other group plans for which you are also covered. This is to prevent the problem of overinsurance and a resulting increase in the cost of dental/medical coverage.

### **Effect on Benefits**

Benefits will be reduced under certain circumstances when you are covered both under the Plan, as described, and other plans defined below which provide similar benefits. Reimbursement will not exceed 100% of the total allowable expenses incurred under the Plan and any other plans included under this provision.

### **Definitions**

For this purpose a plan is one which covers medical or dental expenses and provides benefits or services by group or franchise insurance coverage, hospital or medical services. This includes group-type contracts not available to the general public obtained and maintained only because of the covered person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. The Plan also includes any coverage arranged through the following:

1. Employer trustee, union, employee benefit, or other association; or
2. Governmental program, mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution.

### **How Coordination of Benefits Works**

One of the plans involved will pay the benefits first. This is called the primary plan. The other plans will then make up the difference up to the total allowable expense. These plans are called secondary plans.

Allowable expense means any eligible expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. No plan will pay more than it would have paid without this provision.

## **Order of Benefit Determination**

In order to pay claims, this Plan must find out which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The Plan has no coordination of benefits provision.
2. The Plan covers the person as an employee.
3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the calendar year pays before the plan covering the other parent.
4. In the case of dependent children covered under the plans of divorced or separated parents, the following rules apply:
  - a. The plan of a male or female parent who has custody will pay the benefits first;
  - b. The plan of a male or female step-parent who has custody will pay benefits next;
  - c. The plan of a parent who does not have custody will pay benefits next;
  - d. The plan of a step-parent who does not have custody will pay benefits next.

There may be a court decree which gives one parent financial responsibility for the medical expenses of the dependent children. If there is a court decree, the rules stated above will not apply, if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

5. If the above four rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

If a person is laid-off or is retired or is a dependent of such person, that plan covers after the plan covering such person as an active employee or dependent of such employee. This item does not apply if either plan has no provision regarding laid-off or retired employees.

If a plan other than this plan does not include provisions 3. or 5., then this Plan will ignore those provisions in order to coordinate benefits with the other plan.

## **Right of Recovery**

Plan Supervisor reserves the right to recover benefit payments made for an allowable expense under the Plan in that amount which the payments exceed the maximum amount Plan Supervisor is required to pay under these provisions. This right of recovery applies to Plan Supervisor against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

Plan Supervisor alone shall determine against whom this right of recovery will be exercised.

## **REIMBURSEMENT/SUBROGATION**

The beneficiary agrees that by accepting and in return for the payment of covered expenses by the Plan in accordance with the terms of this Plan:

1. Except as provided below, the Plan shall be repaid the full amount of the covered expenses it pays from any amount received from others for the bodily injuries or losses which necessitated such covered expenses. If, and only if, the Plan, in its sole discretion, determines that the beneficiary cannot be made whole by the limits of all sources of recovery which are, were, or will be available to the beneficiary, the Plan shall be repaid the pro-rata portion of the amount of the covered expenses it pays from any amount received from others for the bodily injuries or losses which necessitated such covered expenses; the "pro-rata portion" shall be determined by the Plan in its sole discretion. "Amounts received from others" specifically includes, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "nofault" and automobile med-pay payments.
2. The Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the beneficiary.
3. The right to recover amounts from others for the injuries or losses which necessitate covered expenses is jointly owned by the Plan and the beneficiary. The Plan is subrogated to the beneficiary's rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the Plan as prescribed above; the Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the beneficiary.
4. The beneficiary will cooperate with the Plan in any effort to recover from others for the bodily injuries and losses which necessitate covered expense payments by the Plan. The beneficiary will notify the Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the Plan. Neither the Plan nor the beneficiary shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

## **GENERAL PROVISIONS**

The following provisions are to protect your legal rights and the legal rights of the Plan.

### **Disputes Over Charges**

Plan Supervisor shall, in accordance with the terms and provisions of the Plan, administer the maximum plan allowance level of benefits for professional services. Disputes as to charges for professional services shall be referred, on a timely basis, to Plan Supervisor who will be responsible for settlement. If no settlement is effected under such referral and suit is brought against a covered person or an attempt is made to collect the balance from a covered person by a collection agency, the covered person should notify Plan Supervisor immediately. If a settlement still cannot be reached and the matter cannot be resolved, Plan Supervisor shall pay the additional amount above the maximum plan allowance. No additional payment will be made or any other measure taken to protect the covered person if the covered person agrees to accept responsibility for any charges in excess of the maximum plan allowance determined by Plan Supervisor.

### **Notice of Claim**

Written notice of claim must be given to Plan Supervisor with out delay, or as soon thereafter as is reasonably possible. Notice may be given to Plan Supervisor at the address shown in the Plan Description Information section of the booklet. The notice should include your name, and the name of the person who received the services or treatment, along with the group number and insured employee identification number which is found on your ID card.

### **Proof of Loss**

You must give written proof of loss within 120 days after the date of loss. Your claim will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written notice must be given within one year after the date proof of loss is otherwise required, except if you were legally incapacitated.

### **Time of Payment of Claims**

Payments due under the Plan will be paid immediately upon receipt of written proof of loss.

### **Contestability**

The Plan has the right to contest the validity of your coverage under the Plan at any time.

### **Workers' Compensation Not Affected**

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

### **Physical Examination**

The Plan, at its own expense, has the right to have you examined as often as reasonably necessary while a claim is pending.

### **Legal Actions**

You cannot bring an action at law or equity to recover a claim until 60 days after the date written proof of loss is made. You cannot bring such action more than three years after such proof of loss is made.

### **Assignment of Benefits**

Assignment of benefits may be made only with Plan Supervisor's consent, except as may be required by applicable law. Plan Supervisor gives consent for assignment of benefits only with providers contracted with Plan Supervisor.

### **Workers' Compensation**

If benefits are paid by the Plan and the Plan determines you received Workers' Compensation for the same incident, the Plan has the right to recover as described under the Reimbursement/Subrogation provision. The Plan will exercise its right to recover against you even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that bodily injury or sickness was sustained in the course of or resulted from your employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier;
4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, you will notify the Plan Supervisor of any Workers' Compensation claim you make, and that you agree to reimburse the Plan as described above.

### **Medicaid**

This Plan will not take into account the fact that an employee or dependent is eligible for medical assistance Medicaid under State law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a State Medicaid plan for which payment would otherwise be due under this Plan, payment of benefits under this Plan will be made in

accordance with a state law which provides that the state has acquired the rights with respect to a covered employee to the benefits payment.

### **Construction Of Plan Terms**

The Plan Supervisor has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the Plan, including, without limitation, the benefits provided thereunder, the obligations of the beneficiary and the recovery rights of the Plan; such construction and prescription by the Plan Supervisor shall be final and uncontestable.

### **False Representation**

No benefits will be paid when the Plan Supervisor or your employer determines the claim or eligibility information was based on false, misleading, or incomplete statements by or on behalf of a covered person. Penalties for such negligence, abuse, or fraud may also include termination from the Plan and as an employee from the employer.

## **CLAIM APPEAL PROCEDURE**

Claim denials will be made within 90 days of receipt of the claim, or within 120 days in special circumstances when an extension of processing time is required.

If the Plan partially or fully denies a claim for benefits submitted by you and you disagree or do not understand the reasons for this denial, you may appeal this decision. You have the right to:

1. Request a review of the denial;
2. Review pertinent Plan documents; and
3. Submit in writing, any data, documents or comments which are relevant to the Plan's review of this denial.

Your appeal must be submitted in writing within 60 days of receiving written notice of denial. The Plan will review all information and send a written decision on the appeal within 60 days of the Plan's receipt of your request, or within 120 days in special circumstances when an extension of processing time is required.

You must exhaust all levels of the claims appeal procedure before you may file a legal action.

## APPENDIX A - HIPAA PRIVACY PLAN AMENDMENT

### HIPAA & PROTECTED HEALTH INFORMATION

#### 1. Purpose

This HIPAA & Protected Health Information section permits the Plan to disclose protected health information (“PHI”), as defined in HIPAA, to the City of Appleton (the “City”) to the extent that such PHI is necessary for the City to carry out its administrative functions related to the Plan. The City or its agent performs a variety of functions, such as collecting Plan enrollment information, deciding Plan eligibility and remitting payment for premiums and claims. The information collected by the City or its agent which is performing these functions is not PHI and is not protected by HIPAA. This Appendix reflects the requirements set forth in 45 C.F.R. § 164.504(f) of HIPAA and the related regulations promulgated by HHS.

#### 2. Disclosure To The City

The Plan may disclose the PHI to the City that is necessary for the City to carry out the following administrative functions related to the Plan.

The City needs access to PHI to:

- A. Determine the amount of benefits, if any, an individual and/or his dependent are entitled to from the Plan;
- B. Determine or investigate facts that are relevant to any claim for benefits;
- C. Determine whether a participant’s benefits should be terminated or suspended;
- D. Perform duties relating to the establishment, maintenance, administration and/or amendment of the Plan;
- E. Communicate with participants regarding the status of their claims;
- F. Recover any overpayment or mistaken payments made to claimants; and
- G. Handle participant issues with regard to subrogation and third party claims.

The City may use and disclose the PHI provided to it from the Plan only for the administrative purposes described in this paragraph.

#### 3. Limitations And Requirements Related To The Use And Disclosure Of PHI

The City agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:

- A. Use and Further Disclosure. The City shall not use or further disclose PHI other than as permitted or required by the Plan or as required by all applicable law, including but not limited to, HIPAA. When using or disclosing PHI or when requesting PHI from the Plan, the City shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.
- B. Agents and Subcontractors. The City shall require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the City with respect to such information.

- C. Employment-Related Actions and Decisions. Except as permitted by HIPAA and other applicable federal and state privacy laws, the City shall not use PHI from employment-related actions and decisions or in connection with any other employee benefit maintained by the City.
- D. Reporting of Improper Use or Disclosure. The City shall promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.
- E. Adequate Protection. The City shall provide adequate protection of PHI and separation between the Plan and the City by:
1. ensuring that only the following employees have access to the PHI provided by the Plan:
    - a. Privacy Officer; and
    - b. the following employees of the Human Resources Department:
      - Director of Human Resources
      - Deputy Director of Human Resources
      - Benefits Assistant
  2. restricting access to and use of PHI to only the City employees identified in Section 3.E.1.b. above and only for the administrative functions performed by the City on behalf of the Plan that are described in Section 2 above;
  3. requiring any agents of the Plan who receive PHI to follow the Plan's privacy rules; and
  4. using the following procedure to resolve issues of noncompliance by the City employees identified in Section 3.E.1. above:
    - a. Following an improper use or disclosure of PHI, the Plan Administrator shall be immediately notified, and the Plan Administrator and the City shall cooperate so as to remedy the situation and mitigate any harmful effect of such use or disclosure of PHI;
    - b. Following an investigation into the alleged improper use or disclosure, any City employee who has not followed the Appendix A or any applicable privacy rule shall be handled as the City and the HIPAA Privacy Officer deems appropriate; and
    - c. The Plan Administrator and the City will cooperate so as to create safeguards and procedures to prevent future noncompliance.
- F. Return or Destruction of PHI. If feasible, the City shall return or destroy all PHI received from the Plan that the City maintains in any form, and retain no copies of such PHI when it is no longer needed for the purpose for which disclosure was made. If the City determines that the return or destruction is not feasible, the City shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- G. Participant Rights. The City shall provide a participant with the following rights:
1. the right to access to his or her PHI in accordance with 45 C.F.R. § 164.524;

2. the right to amend his or her PHI upon request (or the City shall explain to the participant in writing why the requested amendment was denied) and incorporate any such amendment into a participant's PHI in accordance with 45 C.F.R. § 164.526; and
3. the right to an accounting of all disclosures of his or her PHI in accordance with 45 C.F.R. § 164.528.

H. Cooperation With HHS. The City shall make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to HHS for verification of the Plan's compliance with HIPAA.

#### 4. Certification

The Plan will disclose PHI to the City only upon receipt of a certification from the City that the Plan has been amended in accordance with 45 C.F.R. § 164.504(f), and that the City shall protect PHI as described in Section 3 herein.

#### 5. Security Standards Requirement

To comply with the Security Standards regulations that were published on February 21, 2003, the City must:

- A. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- B. ensure that the adequate separation required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- C. ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- D. report to the Plan any security incident of which it becomes aware. (**security incident shall be defined as the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.**)

#### 6. Genetic Information Nondiscrimination Act (GINA)

To comply with the (GINA) effective May 21, 2009 the city must:

- A. **not to use or disclose genetic information for underwriting purpose.**

#### 7. Health Information Technology for Economic and Clinical Health Act (HITECH)

To comply with the ARRA's (HITECH) act effective on February 17, 2010 the city must:

- A. **ensure that business associates comply directly with the HIPAA security rules.**

#### Effective Dates

Paragraphs 1-4 and Paragraph ~~6~~ 5 apply to the Plan no later than April 14, 2003, or such other date that the HIPAA Privacy Regulations apply to the Plan. Paragraph 5 applies to the Plan no later than April 20, 2005, or such other date that the HIPAA Security Regulations apply to the Plan. **Paragraph 6 applies to plan no later than May 21, 2010 and paragraph 7 no later than February 17, 2010.**

**APPENDIX B - CITY OF APPLETON**  
**NOTICE OF PRIVACY PRACTICES**

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**

The City of Appleton provides the following self-funded medical benefit plans that are subject to this notice: The City of Appleton Health Plan, The City of Appleton Dental Plan and the Employee Resource Center (collectively referred to as the “Plan”).

The Plan is required by law to take additional reasonable steps to ensure the privacy of your Protected Health Information referred to (PHI). The Plan is also required to provide all Plan participants with this notice to inform you about the following:

- The Plan’s uses and disclosures of PHI;
- Your privacy rights with respect to your PHI;
- The Plan’s duties with respect to your PHI;
- Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan’s privacy practices.

The term “*Protected Health Information*” (*PHI*) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

**USES AND DISCLOSURES**

The Plan may use and disclose your PHI for the following types of purposes:

***Uses and disclosure to carry out treatment, payment and health care operations***

The Plan and its business associates may use PHI without your authorization to carry out treatment or payment and health care operations. The Plan may disclose PHI to the Plan Sponsor (City of Appleton) for purposes related to administering benefits under the Plan. The Plan documents will be amended to protect your PHI as required by federal law.

*Business Associates* are individuals who help a covered entity with a function or activity involving the use or disclosure of PHI including claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management, practice management and re-pricing.

*Treatment* is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. (For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the

orthodontist may ask for your dental X-rays from the treating dentist).

*Payment* includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). (For example, the Plan or the Business Associate acting on the Plan's behalf may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan).

*Health care operations* include but are not limited to quality assessment and improvement, reviewing qualifications of health care professionals, underwriting, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, planning and general administrative activities. (For example, the Plan or Business Associate may use information about your claims to project future benefit costs or audit the accuracy of its claims processing functions.)

Genetic Information is about an individual's genetic tests; genetic tests of the individual's family members; or the "manifestation of a disease or disorder" in these family members that is family medical history.

Genetic tests are an analysis of human DNA, RNA, chromosomes, proteins or metabolites or chromosomal changes. (For example would be a test to determine whether an individual has a gene variant associated with breast cancer BRCA1 or BRCA2.)

The Plan will mail explanation of benefits forms and other mailings containing PHI for participants and enrolled dependents and family members to the address the Plan has on record for the employee who is enrolled in the Plan.

Disclosure of your PHI to family members, other relatives and your personal friends is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care and you have agreed to the disclosure or have been given an opportunity to object and have not objected.

#### ***Uses and disclosure with authorization***

Except as described in this notice, other uses or disclosures of your PHI will be made only with your written authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. This does not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

#### ***Other permitted or required uses and disclosures***

Use and disclosure of your PHI is allowed without your authorization under the following circumstances:

1. When required by law.
2. When needed by a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example to investigate complaints against

- providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
3. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain written notification conditions are met.
  4. When required for law enforcement purposes such as in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect; or to provide information about a victim of a crime.
  5. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that a person may be a victim of abuse, neglect or domestic violence.
  6. When required to give to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death or other duties as authorized by law. Disclosure is permitted to funeral directors, consistent with applicable law as necessary to carry out their duties with respect to the decedent.
  7. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to the health or safety of a person or the public.
  8. When needed by public health agencies for reasons such as preventing or controlling disease, injury or disability.
  9. When needed for research, subject to conditions.
  10. When authorized by and to the extent necessary to comply with worker's compensation or other similar programs established by law.
  11. When required by military authorities or to authorized federal officials for security and intelligence activities.

## **YOUR RIGHTS REGARDING PHI**

### ***Right to request restrictions***

You may request the Plan to restrict uses and disclosure of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will only agree to your request on a PHI disclosure to a health plan for payment or health care operations purposes (not treatment purposes), if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

### ***Right to request confidential communications***

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

If the Plan maintains PHI in an electronic record, you may make a request to receive the information in an electronic format. Any costs will be charged based on labor costs.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the City of Appleton Privacy Officer, Debra M. Shufelt; Deputy Director of Human Resources, 920-832-6427 or you may mail the request to 100 N. Appleton Street, Appleton, WI 54911-4799.

#### ***Right to inspect and copy PHI***

You have a right to inspect and obtain a copy of your PHI in the Plan's custody, contained in a designated record set for as long as the Plan maintains the PHI. The designated record set includes information such as medical records, billing records, enrollment, payment, claims adjudication and case or medical management maintained by the health plan. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the City of Appleton Privacy Officer as noted above. If you request a copy of the information we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

A form to request access to the PHI must be filled out and submitted to the City of Appleton Privacy Officer as noted above.

If access to this information is denied you will receive a written denial setting forth the basis for the denial and you may request that the denial be reviewed.

#### ***Right to amend PHI***

You have the right to request the Plan to amend PHI about you if it is incorrect or incomplete. You have a right to make this request for as long as the information is kept by or for the Plan.

Requests to amend PHI should be submitted to the City of Appleton Privacy Officer as noted above.

#### ***Right to accounting of PHI disclosures***

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting can not include PHI disclosures made: 1) to carry out treatment, payment or health care operations, 2) to individuals about their own PHI; 3) prior to April 14, 2003; or 4) based on your written authorization.

#### ***Right to notice of breach***

The Plan will notify you of any breach of unsecured PHI related to you.

#### ***Right to paper copy of this notice upon request***

To obtain a paper copy of this notice contact the Privacy Officer. You may also access this notice on the City of Appleton Website at [www.appleton.org](http://www.appleton.org).

#### ***Personal representative***

You may exercise your rights through a personal representative. The representative will be requested to produce evidence of authority to act on your behalf before that person will be given access to your PHI. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual;  
or
- An individual who is the parent of a minor child.

## PLAN DUTIES

### *Changes to this Notice*

The Plan reserves the right to change its privacy practice to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice has changed this notice will be revised and posted on the City of Appleton web site indicating the date last updated.

### *Minimum necessary standard*

When using or disclosing PHI or when requesting PHI from another covered entity, 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 taking into consideration practical and technological limitations.

### *De-identifiable information*

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and there is no reasonable basis to believe that the information can be used to identify an individual.

### *Summary health information*

The Plan may use or disclose summary health information to the Plan sponsor for obtaining premium bids or modifying, amending etc. the group plan. This could summarize the claims history, claims expenses or type of claims experienced by individuals for whom a Plan sponsor has provided benefits under a group health plan and from which identifying information has been deleted in accordance with HIPAA. **The Plan will not disclose or use genetic information for underwriting purposes.**

## COMPLAINTS

If you believe your privacy rights have been violated, you may contact:

City of Appleton Privacy Officer  
Debra M. Shufelt  
100 N. Appleton Street  
Appleton, WI 54911-4799  
920-832-6427

Additionally, the Privacy Officer may consult with the designated City of Appleton “Privacy Team” when necessary.

You can also contact the:

U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue S.W.  
Washington, D.C. 20201

The Plan and the City of Appleton will not retaliate against you for filing a complaint.

#### **NOTIFICATION**

A federal law known as HIPAA (the Health Insurance Portability and Accountability Act) regulates PHI use and disclosure by the Plan. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations. This notice is effective as of February 1, 2010.