Summary Plan Description

Delta Dental Premier

for

ST. FRANCIS SCHOOL DISTRICT

93293
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Introduction

The District has selected Delta Dental to administer this Plan and you should contact Delta Dental directly at 1-800-236-3712 if you have any questions about your benefits under the Plan. You can also find more information about Delta Dental at the end of this booklet.

Delta Dental Premier Dentists

As a participant of this dental plan, you are free to see any dentist that you choose, but not all dentists, procedures or charges will be paid for under this Plan. If the dentist that you select has signed a contract with Delta Dental (a “Delta Dental Premier Dentist”), he or she has agreed to accept payment directly from Delta Dental, based on the Maximum Plan Allowance (MPA). The Delta Dental Premier Dentist will charge you only for co-payments, deductibles and procedures not covered by this Plan. After a claim for dental procedures is filed, you will receive an Explanation of Benefits form indicating the amount, if any, that Delta Dental paid and the amount, if any, that you owe the dentist.

Noncontracting Dentists

If the dentist that you have selected has not signed a contract with Delta Dental, claim payments will still be calculated 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.

Please note that if the fee charged by a noncontracted dentist is not allowed in full, Delta Dental is not implying that the dentist is overcharging. Dental fees vary and are based on each dentist’s overhead, skill and experience. Therefore, not every dentist will have fees that fall within Delta’s MPA.

For information on Delta Dental dentists, call 1-800-236-3712, or visit Delta’s web site at www.deltadentalwi.com.

Filing Claims

To file a claim with Delta Dental, simply present your ID card to the receptionist at the Delta Dental Premier Dentist’s office, or give your Social Security number. If you do not elect to work with a Delta Dental Premier Dentist, you should begin by using this same process, but it is your obligation to make sure that your dentist bills Delta Dental. Delta Dental will generally accept any standard claim form and will provide claim forms to your dentist on request.
**Predetermination of Benefits**

Predeterminations are not required, but Delta Dental encourages you to use this service to ensure that you have a better understanding of what services and charges will be covered under the Plan. After an examination, your dentist may recommend a treatment plan. If the services involve crowns, fixed bridgework, partial or complete dentures, or orthodontics, ask your dentist to send the treatment plan with radiographs to Delta Dental before he or she begins that course of treatment. The available coverage will be calculated and printed on a Predetermination of Benefits form. Copies of the form will be sent to you and your dentist.

The Predetermination of Benefits form is generally valid for 1 year from the date that it is issued.

Should you have any questions about a predetermination, just call Delta Dental at 1-800-236-3712.

**Optional Treatment**

If you select a more expensive service or benefit than is customarily provided, or for which Delta Dental does not believe a valid need is shown, Delta Dental will pay no more than the applicable percentage of the fee for the service that would be adequate to restore the tooth or dental arch to contour and function. You are then responsible for the remainder of the dentist’s fee. Before you schedule dental appointments, you should discuss with your dentist the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.
### I. Summary of Benefits

**Group Number:** 93293

**Effective Date of Program:** July 1, 2004

Dependents are covered through the end of the calendar year that they attain age 25.

**Benefit Maximums:**

- Per Person, per calendar year: $1,000.00
- Lifetime Orthodontic Maximum Benefit per Dependent: $1,500.00

**Benefits:**

Payment for procedures provided by dentists for treatment of dental disease or injury will be made on the basis of Delta Dental’s MPA. Delta Dental will pay the following percentage of its MPA for any covered service, up to the Benefit Maximum (listed above) for each eligible person:

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II. Covered Procedures

This section describes the services that are generally covered under the Plan. You should note, however, that all services are subject to: (1) the limits in the Summary of Benefits; (2) all of the limitations described within each coverage category below; (3) the Exclusions outlined later; and (4) any subsequent Plan amendments.

Diagnostic and Preventive Procedures

1. Examinations at 5-month intervals. Initial examinations at 24-month intervals.
2. Full mouth x-rays, which include bitewing x-rays, at 2-year intervals. Full mouth x-rays may be either individual films or panoramic film.
3. Bitewing x-rays at 5-month intervals, limited to a set of 4 films.
4. Dental prophylaxis (teeth cleaning) at 5-month intervals.
5. Topical fluoride applications at 5-month intervals, for dependent children to age 19.
6. Space maintainers for retaining space when a primary tooth is prematurely lost.

Basic Restorative Procedures

1. Emergency treatment to relieve pain.
2. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.
3. a. amalgam (silver) restorations;
   b. composite (tooth-colored) restorations in anterior (front) teeth;
   c. stainless steel prefabricated crowns — 1 per tooth in a 3-year period.
4. Topical application of sealants for dependents to age 14. Application is limited to the occlusal surface of permanent molars that are free of decay and restorations. Benefits are limited to 1 application per tooth per lifetime.
5. Local anesthetic as part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery.
6. Endodontics (root canal treatment and root canal fillings) — 1 per tooth in a 2-year period.
7. Periodontics (procedures needed to treat diseases of the gums and the bone supporting the teeth) — nonsurgical treatment once each 2 years; surgical treatment once each 3 years. Periodontal maintenance — either periodontal maintenance or adult prophylaxis at 6-month intervals.

Major Restorative Procedures

1. Crowns, inlays or onlays, when teeth are broken down by decay or accidental injury and may no longer be restored adequately with a filling.
2. Prosthetics (fixed bridgework, partial or complete dentures to replace missing permanent teeth);
   a. repairs and adjustments to prosthetic appliances;
   b. denture reline and rebase once in any 3-year period;
   c. porcelain veneers on crowns or pontics on the 6 front teeth, bicuspid and upper first molars;
d. replacement of a defective existing crown, inlay, onlay, fixed bridge or partial or complete denture only after 5 years from the date on which it was last supplied, regardless of who provided payment for the service;

e. fixed bridges and partial or complete dentures where chewing function is impaired due to missing teeth. Complete or partial dentures should be constructed when needed to replace missing teeth. Fixed bridges are a benefit only if the use of a removable prosthetic appliance is inadequate.

Orthodontic Procedures

Orthodontic services include orthodontic appliances and treatment, and related services for orthodontic purposes, including examinations, x-rays, extractions, photographs, study models, etc., for persons eligible as stated in the Summary of Benefits.

Your coverage includes orthodontic treatment in progress. Delta Dental’s payment for orthodontic treatment in progress extends only to the unearned portion of the treatment. Delta will determine the unearned amount eligible for coverage.

Repair or replacement of orthodontic appliances is not covered by this dental plan.

If orthodontic treatment is stopped for any reason before it is completed, Delta Dental will pay only for services and supplies actually received. No benefits are available for charges made after treatment stops.

Delta Dental calculates all orthodontic treatment schedules according to the following formula: One-fourth of the total case fee is considered the initial or down payment fee. The remainder of the allowed fee is divided by the total number of months of treatment. Monthly payments are made by Delta Dental at the coverage percent stated on the Summary of Benefits page.
III. Exclusions

This Plan does not provide any coverage for the following:

1. Services for injuries or conditions that can be compensated under Workers’ Compensation or Employer’s Liability Laws.
2. Services or appliances, including prosthetics (crowns, bridges or dentures), started prior to the date the patient became eligible under this dental plan.
3. Prescription drugs, premedications or relative analgesia; charges for anesthesia other than charges by a licensed dentist for administering general anesthesia in connection with covered oral surgery (cutting procedures); preventive control programs; charges for failure to keep a scheduled visit with a dentist; charges for completion of forms; charges for consultation.
4. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
5. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
6. Services that are determined to be partially or wholly cosmetic in nature.
7. Cast restorations placed on eligible patients under age 12; prosthetics placed on eligible patients under age 16.
8. Appliances or restorations for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function; for temporary dental procedures; for implantology techniques; or for splints, unless necessary as a result of accidental injury.
9. Treatment by other than a licensed dentist, his or her employees, or his or her agents.
10. Dental care injuries or diseases caused by war or act of war, riots or any form of civil disobedience; injuries sustained while committing a felony; injuries intentionally inflicted; injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.
11. Claims not submitted to Delta Dental of Wisconsin within 15 months from the date the procedure was provided.
12. Replacement of lost or stolen dentures or charges for duplicate dentures.
13. Procedures or benefits not specifically provided under this dental plan or excluded by Delta Dental rules and regulations, including Delta processing policies, which may change periodically and are printed on the Explanation of Benefits and Explanation of Payment forms.
IV. Coordination of Benefits

Benefits are coordinated when more than one plan provides dental coverage for you and your dependents. If you or your family members have dental benefits under other group plans, Delta Dental will coordinate allowable expenses from this Plan with them. An allowable expense is a necessary, reasonable and customary charge for an item covered at least partly by one or more plans covering the person making the claim.

When another plan is primary, Delta Dental is the secondary plan. Depending on the benefit you have already received and what your other plan covers, you may receive up to 100% benefit between the two plans, but not more than that.

As the secondary plan, Delta Dental calculates your benefit as if there were no other plan. Then we subtract what the other plan paid, taking deductibles and co-payment levels for the benefit into consideration. The difference between what we pay as the secondary plan and what we would have paid as the primary plan is available to pay for allowable expenses incurred but not paid in a calendar year for the person making the claim.

Determining Which Plan is Primary

When a husband and a wife work for different employers, they may have coverage under two group plans. The plan covering the patient as the employee has responsibility for providing benefits before the plan covering the patient as a dependent.

If the patient is a dependent child, the plan of the parent whose birth date is earlier in the calendar year (month and day only) is primary.

If the patient is a dependent child of separated or divorced parents and two or more plans cover the child, the plan of the parent with custody of the child is primary. The plan of a spouse of the parent with custody of the child is secondary, and lastly the plan of the parent not having custody.

If a court decree states that parents have joint custody of a child but does not say which parent is responsible for the child’s health care expenses, or if it says that both parents are responsible but gives physical custody to one parent, benefits for the child are determined by the rules just described. But if a court decree states that one parent is responsible for the child’s health care expenses, the benefits of that parent’s plan are determined first.

The benefits of a plan covering a person as an active employee (neither laid off nor retired) or as such an employee’s dependent are determined before those of a plan covering the person as inactive (laid off or retired) or as such an employee’s dependent. If another plan does not have this rule and this results in a disagreement on which plan is primary, this rule is ignored.
If you have *continuation coverage* under federal or state law and are also covered under another plan, the benefits of a plan covering you as an employee, member or subscriber or as a dependent of an employee, member or subscriber are determined first, then the continuation coverage next. If another plan does not have a continuation coverage rule and this results in a disagreement on which plan is primary, this rule is ignored.
V. Eligibility

Covered Employee

You are covered by this dental plan while you are an eligible employee of the group.

Covered Dependents

If you are enrolled for family coverage, the following persons are covered under this Plan as your dependents:

1. Your lawful spouse.
2. Your unmarried children (including any children of your unmarried child until your child is 18 years old), including step- and adopted children and children placed for adoption with you.
3. Unmarried dependent children who are full-time students at an accredited school, college or university until the end of the calendar year when they attain age 25.
4. Unmarried dependent children age 19 and over who are incapable of supporting themselves because of physical or mental incapacity that began prior to their 19th birthday or the date you became eligible for this dental plan.

Dependents in military service are not covered by this Plan.

Effective Dates of Coverage

You are covered by this Plan beginning on the first day this dental plan becomes effective or as determined by the group.

Your eligible dependents are covered beginning on the first day you become covered under the dental plan.

Changes in Coverage

You may change your enrollment in this Plan if there is a qualifying event. The enrollment change will be effective as determined by the group. Notification of the enrollment change must be received by us within 30 days of the change.

You may change your enrollment without a qualifying event during the open enrollment, if an open enrollment period is offered by your group.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the day you or your dependents are no longer eligible or the day this Plan is terminated.
If the agreement between Delta Dental of Wisconsin and the group terminates, this document no longer describes the benefits of your Plan.

All coverage ends on the day coverage terminates. Procedures must be fully completed prior to termination of the coverage to be considered for benefit.

You and/or your dependents may also be entitled to continuation coverage, as described in the Notice of Continuation Coverage that is included at the end of this booklet.
VI. Claims Procedures

Prior Approval of Benefits

This Plan does not require any prior approval of dental procedures. However, you or your dentist may request a Predetermination of Benefits to obtain advance information on the Plan’s possible coverage of dental procedures before they are rendered. Payment, however, is ultimately limited to the benefits that are covered under the Plan and is subject to all applicable deductibles, co-payments, coinsurance, waiting periods, and annual and lifetime benefit maximums.

How to Contest a Claim Denial

Denial of a Claim for Benefits

If you make a claim for benefits under this Plan and your claim is denied, in whole or in part, you and your dentist, will receive written notification called an “Explanation of Benefits,” from Delta Dental. Delta Dental will generally provide that notice within 30 days after your claim is received. If you do not receive a notice within 30 days, you should contact Delta Dental. If you or your dentist did not submit information necessary to make a benefits determination, you may receive a notice that describes the required information. You will have 45 days from receipt of the notice to provide the specified information.

Appealing a Claim Denial (Filing a Grievance)

If you have questions about the denial of your claim for benefits, please contact Delta Dental at 1-800-236-3712. Because most questions about benefits can be answered informally, Delta Dental encourages you first to try resolving any problem by talking with them. However, you do have the right to file an appeal requesting that Delta Dental formally review the benefits determination.

To file a grievance or appeal a benefits determination, contact Delta Dental’s Benefit Services Department at 1-800-236-3712, fax your request to 1-715-343-7616, or mail your request to Delta Dental, P.O. Box 828, Stevens Point, WI 54481. Provide the reasons why you disagree with the benefits determination and include any documentation that you believe supports your claim. Be sure to include the subscriber’s name, the covered dependent’s name if applicable, and the subscriber’s Social Security number on all supporting documents.

Upon making such a request, you will be provided access to and copies of all documents, records, and other information relevant to your claim for benefits.

You have the right to appear in person before Delta Dental’s Grievance Committee to present written and oral information and ask questions of the persons responsible for the determination that resulted in the grievance. We will provide you with written notice of the meeting place and time at least 7 days before the meeting.
Delta Dental will provide you or your authorized representative with written notice of the decision on the appeal. You should contact Delta Dental, in writing, if you do not receive this response within 30 days after you file your request.

If you do not exhaust the appeal procedures described above, and if you file a lawsuit seeking payment of benefits, the court may not permit you to go forward with your lawsuit because you failed to utilize Delta Dental’s grievance/claims appeal procedures. Also, no legal action can be brought against Delta Dental or the District later than 3 years after the date of the Grievance Committee’s final decision on the review of the benefits determination.

If you have any questions, please contact:
Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
1-800-236-3712 or 1-715-344-6087

Benefits under this Plan are provided by Delta Dental under an insurance contract that the District has purchased specifically for this Plan. All benefits under the Plan are controlled and governed by that insurance contract and the District shall have no obligation to ever pay for any benefits that are not otherwise paid for under that insurance contract. Because of this, Delta Dental has certain authority to interpret the contract and to review claims as set forth above. With respect to all other matters under this Plan, including some questions concerning eligibility and interpretation of other documents that might affect eligibility, the District shall serve as the Plan Administrator and shall have the sole and absolute right to resolve any questions or ambiguities concerning the administration of the Plan, including, but not limited to, the ability to resolve ambiguities in the underlying Plan document(s) and to determine questions with respect to benefit eligibility and coverage. Any decision made by the District, as Plan Administrator, with respect to such matters will not be overturned by a reviewing court, arbitrator, mediator or other similar personal entity unless that person or entity first determines that the District acted in an arbitrary and capricious manner with respect to its decision in this regard.
VII. General Information

1. **Plan Name:** The St. Francis School District Benefits Program
   Group Dental Plan

2. **Plan Sponsor:** St. Francis School District
   4225 S. Lake Dr.
   St. Francis, WI  53235

3. **Plan Administrator:** St. Francis School District
   4225 S. Lake Dr.
   St. Francis, WI  53235
   1-414-747-3900

4. The Plan provides dental benefits for participating employees, certain retirees (if applicable), and their enrolled dependents.

5. The Plan year and fiscal year are July 1 – June 30.

6. **Agent for service of legal process:**
   
   Dr. Ronda Ewald
   St. Francis School District
   4225 S. Lake Dr.
   St. Francis, WI  53235

7. The Claims Administrator is responsible for performing certain delegated administrative duties, including the processing of claims. The Claims Administrator is:

   Delta Dental of Wisconsin
   P.O. Box 828
   Stevens Point, WI 54481
   Telephone: 1-715-344-6087
   Toll Free: 1-800-236-3712

8. The Plan’s contributions are shared by the District and employees and retirees. The District contribution is subject to change each year. The District will pay approximately 100% of the total annual premium for employees. Retirees who participate in the Plan will pay 100% of the annual premium for their coverage under the Plan.

9. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to covered persons as required by applicable law.
10. Upon termination of the Plan, the rights of the covered persons to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the covered persons, except that any taxes and administration expenses may be made from the Plan assets.

11. The Plan does not constitute a contract between the District and any covered person and 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 District, or for the District to discharge any employee at any time.

12. This Plan is not in lieu of and does not affect any requirement for coverage by Workers’ Compensation insurance.

Notices

Notice to the group or Delta Dental will be considered sufficient if mailed to their regular office address. Notices to you, as a subscriber, will be considered sufficient if mailed to your last known address or the last known address of the group. It is the responsibility of the group to notify you regarding changes or termination of your coverage.
VIII. Health Care Continuation Notice

This notice contains important information about your right to purchase a temporary extension of coverage under the group health plans maintained by the District. Federal law requires that this Plan offer some individuals who would otherwise lose their coverage the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates. This federal law is known as the Consolidated Omnibus Reconciliation Act of 1985 (or “COBRA”).

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. You, your spouse and any dependents should take the time to read the entire notice carefully. You should call Delta Dental or contact the District if you would like to obtain more information about COBRA.

Eligible Individuals

Employees. If you are or were an employee of the District who is covered under the Plan, then you will have the right to elect continuation coverage for yourself (and your spouse and dependents to the extent that they would also lose coverage) if you lose this group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). You may also have some additional rights if you lose this group health coverage while you are on a leave of absence to serve in the military—but any separate right(s) that you may have to receive continuation coverage (e.g., under the Uniformed Services Employment and Re-employment Rights Act) will be run concurrently with any rights that you may have under COBRA.

Spouse. If you are or were the spouse of an employee and you are also covered by the Plan, you have a separate right to elect COBRA continuation coverage for yourself (and your dependents under age 18 to the extent that they would also lose coverage) if you lose group coverage for any of the following reasons:

1. your spouse’s death;
2. your spouse’s termination of employment (for reasons other than gross misconduct) or reduction in hours of employment;
3. divorce or legal separate from your spouse;
4. your spouse’s entitlement to Medicare (Part A, Part B or both) benefits; or
5. the bankruptcy of your spouse’s employer, if your spouse is retired and receiving coverage under the Plan.

Dependents. If you are or were the dependent child of an employee and you are also covered by the Plan, you have a separate right to elect COBRA continuation coverage for yourself if you lose group health coverage for any of the following reasons (if you are under age 18, your parent generally has the right to exercise this right for you):

1. your parent’s death;
2. your parent’s termination of employment (for reasons other than gross misconduct) or reduction in hours of employment;
3. your parent’s divorce or legal separation;
4. your parent’s entitlement in Medicare (Part A, Part B or both) benefits;
5. your ceasing to be a “dependent,” as defined in the Plan; or
6. the bankruptcy of your parent’s employer, if your parent is retired and receiving coverage under the Plan.

If you are an employee or a former employee and you have a child or adopt a child while on COBRA, then that child is also entitled to elect COBRA continuation coverage. In order to receive such coverage, you must apply for coverage for that child under the same rules that apply to active employees under the Plan. Such coverage will be treated as though it started on the same date as the former employee’s continuation coverage for purposes of determining the child’s maximum period of coverage.

Please note, if you lose group coverage in anticipation of one of the above events (for example, your spouse terminates your coverage in anticipation of a divorce, but before the divorce becomes final), you may have the right to elect COBRA continuation coverage, beginning on the date of the actual “qualifying event” even though you did not actually maintain coverage when that event occurred.

Required Notices

When to Notify Us. Under the law, you have the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan. These events cause spouses and dependents to lose coverage under the Plan. You must give this notice to the administrator (along with any other documentation required by the Plan Administrator, e.g., divorce papers, benefits determination letter from the Social Security Administration) within 60 days after the event or the date on which coverage would end under the Plan because of such event. Under the law, the District will notify the Plan Administrator of the employee’s death, termination of employment (for reasons other than gross misconduct), reduction in hours of employment, or Medicare entitlement so that the appropriate notices can be sent.

If you (the employee, spouse or dependent) are determined to be disabled by the Social Security Administration at any time within 60 days following the event which gave rise to the individual’s loss of coverage, you must notify the Plan Administrator and provide the Plan Administrator with a copy of the benefits determination letter within 60 days of the receipt of the determination (but not after the expiration of the 18 month maximum coverage period) in order to be eligible for the 11 month extension described below in the Maximum Period of Coverage section. Each family member who has elected COBRA coverage under the Plan will be entitled to this 11 month extension.

Failure to notify the Plan Administrator as described above will cause you (and any other covered individual) to lose COBRA continuation rights. Under the law, you must notify the Plan Administrator within 30 days of any final determination that you are no longer disabled (for Social Security disability purposes).

Your Election Rights. When the Plan Administrator is notified that one of the events described above in the Eligible Individuals section of this Notice has occurred, it will notify the covered individual(s) that his/her coverage will end, but that he/she has the right to choose COBRA
continuation coverage. Under the law, you have at least 60 days from the later of (1) the date you would lose coverage (because of one of the events described above) or (2) the date of notice to you (after one of the events described above) to inform the Organization that you want COBRA continuation coverage. **If you do not choose COBRA continuation coverage or do not respond within this time period, your Plan coverage will end.**

**Continuation Coverage**

**Coverage Rights.** If you choose COBRA continuation coverage, the Plan is required to give you coverage which is identical to the coverage provided under the Plan to similarly situated employees or family members. This means that, for example, you can add dependents or otherwise modify your Plan enrollment elections on the same basis as Plan participants that are active employees. You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage is provided subject to your eligibility for coverage; the health plan administrator reserves the right to terminate your continuation coverage retroactively if you are subsequently determined to be ineligible.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**Maximum Period of Coverage.** The law requires that you be afforded the opportunity to maintain COBRA continuation coverage as follows:

1. for up to 18 months if you lost coverage due to your (or your spouse or parent’s) termination of employment (other than for gross misconduct), a reduction in hours or for a leave of military service (if you are the spouse or a dependent of the covered employee and the employee became entitled to Medicare less than 18 months before the current qualifying event, then your coverage may extend to the later of: (a) 18 months from the current termination or reduction or (b) 36 months from the employee’s Medicare entitlement);

2. for up to 36 months if you lost coverage due to divorce or legal separation from your spouse, your spouse’s Medicare entitlement, or, for dependents, because you ceased to satisfy the Plan’s definition of “dependent child”; or

3. for up to 29 months if: (a) you (the employee, spouse or dependent) are determined to be disabled (for Social Security disability purposes) at the time of the termination of employment or the reduction in hours or at any time within the first 60 days after such an event; and (b) the Plan Administrator is notified by you of the determination of
The 18 month (and the 29 month) period may also be further extended to a maximum of 36 months from the date of termination of employment or the reduction in hours if another event (such as a death, divorce or legal separation) occurs during that 18 month (or 29 month) period and while the individual maintains COBRA continuation coverage.

Expiration of Coverage. COBRA continuation coverage will never last beyond 36 months from the date of the event that originally made someone eligible to elect coverage. However, the law does provide that your continuation coverage period may be cut short for any of the following reasons:

1. the District no longer provides group health coverage to any of its employees;
2. the premium for your continuation coverage is not paid on time;
3. you become covered under another group health plan that does not prohibit or limit your coverage due to a pre-existing condition (if you become covered under another group health plan that has a pre-existing condition limitation or restriction that does not apply to you or a qualified beneficiary or which is satisfied as the result of the waiving of such limitation or exclusion as a result of qualifying coverage under another group health plan which offsets such period under the portability and access provisions of the Health Insurance Portability and Accountability Act of 1996, that plan will be viewed as having no pre-existing condition limitation or exclusion);
4. you become entitled to receive Medicare (Part A, Part B or both) benefits; or
5. you extended your continuation coverage due to a disability and there has been a final determination that the individual is no longer disabled for purposes of Social Security disability benefits.

Health Insurance Premiums. Under the law, you may have to pay all or part of the premium for your COBRA continuation coverage and this premium can be adjusted from time to time. You may also be required to pay an additional administrative fee. The administrative fee is generally equal to 2% of the monthly premium and must be paid at the same time as that premium. The administrative fee will, however, increase to 50% of the monthly premium for every month after you utilize the 11 month extension for disability described above—the higher administrative fee will continue if you subsequently experience another event that allows you to extend continuation coverage from 29 months to 36 months. All premiums must be paid on or before the first day of the month to which the premium relates. The first premium is due within 45 days after you elect COBRA continuation coverage. Subsequent premiums will be due on the first day of the month to which coverage applies, but there is a 30 day grace period for those subsequent premiums. Your COBRA continuation coverage will be terminated and you will not be permitted to reenroll for coverage if you fail to pay any premium (including the appropriate administrative fee) in a timely manner. If you make a payment after the due date but before the expiration of the grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.