

SCHOOL DISTRICT 27J
Brighton, Colorado



DENTAL PLAN BOOKLET
& SUMMARY PLAN DESCRIPTION

Effective January 1, 1990

Restated July 1, 2015

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SECTION I - INTRODUCTION

The School District 27J Dental Plan was originally adopted January 1, 1990. This is the Summary Plan Description of the dental benefits available to eligible employees as restated on July 1, 2015. This booklet describes the Plan's dental benefits and serves as the Plan Document.

While the plan sponsor expects and intends in good faith to continue this plan indefinitely, it reserves the right to amend, modify or terminate the plan at any time. Such amendment/termination of the plan shall be performed in writing and executed by an authorized individual of the School District 27J which action has either been pre-approved or later ratified (including by general ratification) by corporate resolution of the Board of Directors of School District 27J. Any oral statement by plan representatives that is contrary to the written terms of the plan is invalid and unenforceable.

In the event the plan is terminated, any covered expenses which have been incurred prior to the date of termination will be payable in accordance with the terms of the plan. Any plan assets will be allocated first to the payment of claims, with any shortfall paid from the general assets of the employer.

School District 27J has appointed Employee Benefit Management Services, Inc. as Claims Administrator for this Plan. As such, Employee Benefit Management Services, Inc has full discretion to determine initial plan benefits, to construe the terms of the Plan and to determine the answer to any questions arising under the Plan.

Wherever used in this booklet, masculine pronouns shall include both masculine and feminine gender unless the context indicates otherwise.

SECTION II - ELIGIBILITY, ENROLLMENT, CHANGES AND TERMINATION

EMPLOYEE ELIGIBILITY

1. Eligible Employees

Employees of School District 27J who are regularly scheduled to work a minimum of thirty (30) hours per week are eligible for coverage.

2. Ineligible Employees

The term "employee" shall in no event include an individual employed on a temporary or seasonal basis, or a leased or subcontract individual.

DEPENDENT ELIGIBILITY

1. Eligible Dependents

- a. The employee's legal spouse, including a same-sex spouse, legally married pursuant to the laws of the state in which they were married and including a Civil Union, domestic partner or common law spouse, as defined by applicable state courts, except if legally separated. The Plan Administrator may require documentation proving a Civil Union, legal marital relationship or an Affidavit of Domestic Partnership or an Affidavit of Common Law Marriage.
- b. Any child of the employee, related to the employee by blood or marriage, until the end of the month in which the child attains age twenty-six (26). Dependents such as grandchildren are not considered eligible unless the employee has legal custody. Written evidence, such as a court decree for legal custody, must be attached to the enrollment form.
- c. Any natural child, child in placement for adoption, or legally adopted child. The child is eligible for coverage until the end of the month in which he attains age twenty-six (26).
- d. Foster child(ren) residing with the employee as a result of court action who are dependent on the employee for at least one half of his or her support.

Placement must be made and supervised by a county or private agency. This Plan will be considered secondary to any other group health plan covering the foster child(ren) and will coordinate benefits with the primary carrier.

- e. Any individual covered by a Qualified Medical Child Support Order (QMCSO) is required to be covered under this Plan as of the date of the QMCSO or the effective date of coverage for the enrolled employee, whichever is later. If the employee does not carry dependent coverage, the Plan will enroll the child(ren) named in the QMCSO and the employee must pay any required contribution. If the coverage is for a stepchild and the parent named in the QMCSO is covered under the stepparent's health plan, the Plan must enroll that stepchild unless the parent and stepchild have access to coverage through the parent's employer. All Plan limitations and exclusions will apply.

- f. Any dependent child incapable of self-sustaining employment by reason of mental retardation or physical disability, and became so incapable prior to the end of the month in which the dependent child attained age twenty six (26), is eligible for coverage as long as the handicap remains in effect and the employee's coverage under the Plan continues. Coverage will continue regardless of age, but the Plan may require periodic documentation of the dependent's continued disability and/or dependent status.

The Plan may request verification of a child's dependent status at any time.

2. Ineligible Dependents

The term "dependent" shall in no event include:

- a. Any dependent who is covered under this Plan as an employee,
 - b. A person on active military duty for any country,
 - c. Any person serving on a church mission.
3. If both a husband and wife or domestic partner are eligible employees under the Plan, either parent may cover any dependent children, but not by both parents.

ENROLLMENT CATEGORIES

The employee may choose from four (4) enrollment categories:

1. Employee Only.
2. Employee and Spouse.
3. Employee and Child(ren).
4. Employee, Spouse and Child(ren).

The employee must report any Change in Status to the School District 27J Office for Human Resources within thirty-one (31) days of a change.

ENROLLMENT AND EFFECTIVE DATE

1. Timely Enrollment - New Hire:

At the time of initial eligibility, each employee will be given the opportunity to enroll himself and his eligible dependents in the Dental Plan.

Employees may also choose to waive dental coverage only if the employee has chosen to waive medical coverage as well. If coverage is waived, the employee cannot enroll in the Plan until the next Open Enrollment period.

For employees to be covered under the Plan, the necessary Enrollment forms must be completed and returned to the School District 27J Office for Human Resources within thirty-one (31) days of the date of active employment or status change.

Effective Date:

a. Employees

Employees who enroll in the Plan in a timely manner become covered under the Plan on the first of the month following their date of active employment.

b. Dependents

Dependents who are enrolled in the Plan when the employee enrolls become covered under the Plan on the same date as the employee.

2. Enrolling New Dependents:

New dependents must be enrolled within thirty-one (31) days of being acquired, such as through marriage, Affidavit of Domestic Partnership, birth, adoption, placement for adoption or court decree to be covered under the Plan and necessary contributions must be made.

If a dependent is not enrolled for coverage within thirty-one (31) days of being acquired, the dependent may be enrolled at the next Open Enrollment period.

Effective Date:

Dependents become covered under the Plan on the later of the employee's date of eligibility or the date such dependent is acquired, provided the dependent is enrolled for coverage within thirty-one (31) days of being acquired. In the case of a court decree including a QMCSO, the effective date of coverage will be the date of the court decree or QMCSO if submitted to the Plan Administrator within 31 days of the court decree. If submitted beyond 31 days of the court decree, it will be effective on the day the decree is received by the Plan Administrator.

3. Annual Open Enrollment:

During the annual Open Enrollment period, employees who previously waived coverage may elect to enroll in the Plan. If coverage was initially waived and the employee decides to enroll in the Plan during the next Open Enrollment period, the employee and his eligible dependents can enroll during the Open Enrollment period.

Also, during the Open Enrollment period, the employee may change the level of coverage selected (i.e., Single to Family or Family to Single).

Effective Date:

For employees and/or dependents that initially waive coverage and enroll in the Plan during the annual Open Enrollment period, coverage under the Plan begins on July 1 following this Open Enrollment period.

COST OF COVERAGE

Regular employees working 30 or more hours per week – Your amount of insurance is furnished up to the allowable School District 27J Contribution, as per the negotiated agreement; you contribute any amount above the School District 27J Contribution and toward the cost of your dependent's insurance.

For your convenience, any contributions required by you are made by payroll deduction.

A summary of costs is available from the School District 27J Office for Human Resources.

WHEN COVERAGE FOR EMPLOYEES ENDS

Coverage under this Plan will cease on the earliest of the following dates. (Refer to Section III for Continuation of Coverage provisions).

1. The last day of the month in which the employee completes his last full day of active employment.
2. The last day of the month in which the employee's employment status drops below thirty (30) hours per week. If the employee continues on COBRA and his employment status again equals or exceeds thirty (30) hours per week, the employee will be reinstated in the Plan and given full credit for prior service.
3. The last day of the month for which the employee has paid the required cost of coverage.
4. Under the Family and Medical Leave Act (FMLA) of 1993, coverage ends on the earlier of:
 - a. The date a Participant notifies the Employer that he is not returning to work from an approved FMLA leave; or
 - b. The date the approved FMLA leave ends.
5. The date the Employer terminates this Plan.
6. The date the employee enters the Armed Forces.

WHEN COVERAGE FOR DEPENDENTS ENDS

A dependent's coverage under this Plan will cease on the earliest of the following dates. (Refer to Section III for COBRA Continuation Coverage provisions).

1. The date the employee's coverage terminates.
2. For employees that are not enrolled in the Section 125 Flexible Spending Account, the end of the month in which the employee requests termination of the dependent's coverage.
3. For employees that are enrolled in the Section 125 Flexible Spending Account, dependent termination can only be elected during Open Enrollment or subsequent to a qualified change in status event.
4. For a spouse, the date of a final divorce decree or legal separation.
5. For a dependent child, the last day of the month during which the child attains age twenty-six (26), becomes self-supporting or marries.
6. The last day of the month in which the employee dies.
7. The date the dependent enters the armed forces.

ACTIVE MILITARY DUTY AND MILITARY RESERVISTS

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

LEAVE OF ABSENCE

A leave of absence approved by the School District 27J is not considered termination of employment with the School District 27J for purposes of this Plan. During an approved leave of absence, you may continue your coverage under this Plan by paying the entire premium for you and your covered dependents directly to the School District 27J. You must contact the School District 27J Office for Human Resources to arrange for continuation of coverage and premium payments, or coverage will not be continued.

WHAT HAPPENS WHEN YOU RETIRE

If you retire from the School District 27J, your group dental coverage may be continued for a period of time; refer to Section III –COBRA Continuation Coverage.

SECTION III - COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

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

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer's plan) are not considered for continuation under COBRA.

Domestic Partners and Children of a covered Employee's Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee’s hours of employment are reduced;
- The parent – covered Employee’s employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a “Dependent child.”

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee’s Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent child’s losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator

School District 27J Dental Plan
 18551 East 160th Avenue
 Brighton, CO 80601
 (303) 655-2900

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled to an extension of the 18 month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator as set forth herein, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator

School District 27J Dental Plan
18551 East 160th Avenue
Brighton, CO 80601
(303) 655-2900

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualifying Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator

School District 27J Dental Plan
18551 East 160th Avenue
Brighton, CO 80601

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator:

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SECTION IV - FAMILY AND MEDICAL LEAVE ACT (FMLA)

Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor if, in fact, FMLA is applicable to the Employer and all of its employees and locations.

If applicable, during any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the employee and his or her covered Dependents if the employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the employee and/or his or her Dependents when Plan coverage terminated.

SECTION V - HOW THE PLAN WORKS

The Plan reimburses Eligible Expenses incurred by Participants. All benefits are subject to the General Limitations and Exclusions in Section VIII.

CHOICE OF DENTIST

A Participant can obtain care from any licensed Dentist.

TYPES OF SERVICES

There are four (4) classifications under which benefits can be obtained:

1. Preventive/Diagnostic Services
2. Basic Services
3. Major Services
4. Orthodontic Services

PREDETERMINATION OF BENEFITS

If anticipated charges for any one course of treatment are expected to exceed \$300, the employee or dependent must submit a plan of treatment (prepared by the attending dentist on a Predetermination of Benefits form) to be approved by the Claims Administrator prior to such expense being incurred. A Predetermination of Benefits form is not necessary if emergency care is required.

Predetermination of Benefits permits the review of the proposed treatment in advance and allows for resolution of any questions before, rather than after, the work has been done. Additionally, the Participant and the Dentist will know in advance what is covered and the estimated benefits.

DETERMINATION OF INCURRED DATES

A charge will be considered to be incurred on the date the service is received, with the following exceptions:

1. For an appliance, or modification of an appliance - on the date the impression is taken.
2. For a crown, bridge or gold restoration - on the date the tooth is prepared.
3. For root canal therapy - on the date the pulp chamber is opened.

SECTION VI - SUMMARY OF BENEFITS

Following is a summary of how benefits are paid under this Plan. For more information, refer to the applicable section on Eligible Expenses.

Calendar Year Deductible

Per Person	\$25 per calendar year
Per Family	2 times the individual deductible

NOTE: When both the employee and spouse are employed by School District 27J and are enrolled individually in the Plan, the Family Deductible shall be considered to have been satisfied for both once two individual deductibles have been met under either's coverage.

Maximums

Orthodontic Services	\$2,000 per person per lifetime
All Other Dental Services	\$1,500 per person per calendar year

Percentage Payable

Preventive/Diagnostic Services	90%, deductible waived
Basic Services	80%, after the deductible
Major Services	50%, after the deductible
Orthodontic Services	50%, deductible waived

Limitations

Cleanings and/or Scalings	2 per calendar year*
Fluoride Treatments	1 per calendar year up to age 19
Oral Examinations (Routine)	2 per calendar year
X-rays	
- Full-mouth or Panorex x-rays	1 series per 3 consecutive calendar years
- Bitewing x-rays	2 pair of supplemental bitewings per calendar year

* 2 additional scalings per calendar year are eligible for payment under the Major Services benefit after 2 have been incurred under the Preventive Services benefit.

SECTION VII - ELIGIBLE EXPENSES What Services Are Covered Under This Plan?

PREVENTIVE/DIAGNOSTIC SERVICES

1. Examinations: Routine oral examinations, but not more than two exams in a calendar year.
2. Cleanings: Routine prophylaxis (cleaning and scaling of teeth) by a Dentist or dental hygienist, but not more than two times per calendar year.
3. Fluoride: Fluoride treatment by a Dentist or dental hygienist for dependent children up to age nineteen (19), but not more than once in a calendar year.
4. Dental X-rays, but not more than:
 - a. One full-mouth series or Panorex X-rays in any period of three consecutive calendar years; and,
 - b. 2 pair of supplemental bitewing x-rays in a calendar year.
5. Dental sealants applied to the first and second permanent molars, but:
 - a. Only for dependents who are age fifteen (15) or younger; and,
 - b. Only when the teeth have not been treated with sealants for at least four years.
6. Emergency treatment for the relief of dental pain.

BASIC SERVICES

1. Extractions.
2. Space Maintainers
3. Interproximal Discing
4. Fillings, other than gold.
5. Endodontic procedures (procedures, such as root canals, used for the treatment of the dental pulp).
6. Examinations and Visits
 - a. Professional visit after hours. (Payment will be made on the basis of services rendered or visit, whichever is greater.)
 - b. Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general Dentist.

BASIC SERVICES – Continued:

7. X-ray and Pathology
 - a. Additional films (up to 12).
 - b. Single film.
 - c. Biopsy and examination of oral tissue.
 - d. Microscopic examination.
8. Appliances such as occlusal guards or night guards or bite plates that change or alter the way the teeth meet or restore the bite.

MAJOR SERVICES

1. Periodontal procedures (procedures for treatment of the area around each tooth).
2. Oral Surgery.
3. Denture Repairs.
4. Bridgework, fixed and removable
 - a. Initial placement, including adjustments during the six-month period following placement. The placement must be needed as a result of an extraction, after the Participant is covered under this Plan, of one or more natural teeth that were not an abutment for a denture or fixed bridge. The Plan will not pay for replacement of third molars (wisdom teeth).
 - b. Replacement or addition of teeth to an existing bridge if:
 - (i) needed to replace one or more natural teeth which are extracted while the Participant is covered under the Plan; or
 - (ii) if the existing bridgework was placed at least five (5) years prior to its replacement and cannot be made serviceable.
 - c. Repair or recementing.
5. Crowns, Gold Fillings and Inlays
 - a. Inlays and onlays, including repair or recementing if necessary.
 - b. Gold Fillings.
 - c. Crowns
 - (i) Initial placement
 - (ii) Replacement, if the original was put in more than five (5) years prior to the replacement and cannot be made serviceable.

- (iii) Repair or recementing.

MAJOR SERVICES – Continued:

- 6. Dentures, full and partial
 - a. Initial placement, including adjustments during the six-month period following placement. The placement must be needed as a result of the extraction of one or more natural teeth that were not an abutment for a denture or fixed bridge after the Participant is covered under this Plan. The Plan will not pay for replacement of third molars (wisdom teeth).
 - b. Replacement
 - (i) Full denture if necessitated by:
 - (a) a structural change within the mouth and more than five (5) years have passed since the prior placement; or,
 - (b) the prior placement of an immediate or temporary denture when the replacement occurs within twelve (12) months of the placement of the immediate or temporary denture.
 - (ii) Partial denture, if the original was put in more than five (5) years prior to the replacement and cannot be made serviceable.
 - c. Laboratory or office relines
 - d. Denture duplication (jump case)
- 7. Anesthesia (general) for covered services when medically necessary for oral or dental surgery, and the anesthetic agent produces a state of unconsciousness with the absence of pain sensation over the whole body.

(Local anesthetic, analgesic and routine post-operative care for extractions and other oral surgery are part of the allowance for each service.)
- 8. Treatment of craniomandibular/temporomandibular (TMJ) disorders as approved by the American Academy of Craniomandibular Disorders, to include:
 - a. diagnosis and baseline records;
 - b. behavior modification modalities;
 - c. repair and regeneration; and
 - d. orthopedic stabilization.

MAJOR SERVICES – Continued:

9. Dental Implants and Transplants
 - a. Initial placement. The placement must be needed as a result of an extraction, after the Participant is covered under this Plan, of one or more natural teeth and the allowance is limited to the usual and customary allowance for a bridge or partial denture that would have been covered by the Plan to replace the tooth, or teeth. The Plan will not pay for replacement of third molars (wisdom teeth).
 - b. Replacement, if the original was put in more than five (5) years prior to the replacement and cannot be made serviceable.
 - c. Repair or recementing.
10. Scalings: Two (2) additional scalings per calendar year are eligible for payment under the Major Services benefit after two (2) have been incurred under the Preventive Services benefit.

ORTHODONTIC SERVICES

This coverage applies to orthodontic treatment (a program to straighten teeth).

Eligible charges are those made to the Participant for an Orthodontic procedure that (a) is in an "Orthodontic Treatment Plan" that has been determined to be necessary for proper function and is not cosmetic.

An "Orthodontic Treatment Plan" is a report on a form satisfactory to the Claims Administrator that among other things describes the recommended treatment, gives the estimated charge, and is accompanied by cephalometric X-rays, study models and other supporting evidence.

The claim will be paid in installments beginning when the orthodontic appliances are first inserted, and monthly or quarterly thereafter for the estimated duration of the treatment plan, as long as the patient remains covered. The initial payment will be an amount not greater than six (6) monthly or two (2) quarterly installments and subsequent installments will be in equal amounts, until the lifetime maximum amount is met.

Participants enrolling in the Plan who have had orthodontic services prior to enrollment in the Plan will not be covered for services performed prior to enrollment under this Plan. Monthly or quarterly orthodontic maintenance charges will be Eligible Expenses. If charges are overlapping from charges incurred prior to enrollment, the charges will be pro-rated.

SECTION VIII - GENERAL LIMITATIONS AND EXCLUSIONS
What Is Not Covered Under This Plan?

This is a partial list of services which are NOT Eligible Expenses. Be sure to refer to the specific coverage sections (e.g., "Preventive/Diagnostic Services") for information about limitations specific to each benefit.

DENTAL BENEFIT EXCLUSIONS:

ACCEPTED DENTAL PRACTICE

Charges for dental services which do not have uniform endorsement within the dental community.

ACTIVE MILITARY DUTY

Services or supplies incurred while the Participant is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; the governmental body or its agencies are liable.

ACUPUNCTURE

Services related to acupuncture, whether for medical, dental or anesthesia purposes.

ANESTHESIA

General anesthesia and intravenous sedation in the absence of medical need.

AUTO ACCIDENT EXPENSE

Expenses for treatment resulting from an automobile accident will not be covered to the extent of minimum coverage required by any applicable state law for injuries suffered by a Participant. For more information see the "Automobile Insurance Provisions" Section XII of this booklet.

BROKEN APPOINTMENTS

Charges for broken or missed appointments, or completion of claim or Treatment Plan Forms by the Dentist or other provider.

CLEFT PALATE

Treatment of cleft palate, anodontia, or mandibular prognathism.

COSMETIC SERVICES

Treatment of the teeth or gums for cosmetic purposes, including realignment of teeth.

DENTAL BENEFIT EXCLUSIONS CONTINUED:

CRIMINAL ACTIVITIES

Any charges incurred for services or supplies resulting directly or indirectly from participation in criminal, illegal or unlawful activities are not covered, including but not limited to charges resulting from the Participant's operating a motor vehicle with a level of alcohol or illegal drugs in the body in excess of the applicable state statutory limit defining driving while impaired or driving under the influence of alcohol or drugs.

DUPLICATE (DOUBLE) COVERAGE

If the Participant is covered by more than one dental plan, benefit payments will not be more than 100% of covered expenses.

DUPLICATE PROSTHETIC DEVICES

Charges for any duplicate prosthetic device or other appliance. Payment will not be made for a "spare" set of dentures or any other duplicate appliance such as, but not limited to, removable orthodontic retaining devices.

EXPERIMENTAL SERVICES

Procedures which are defined as experimental or investigative in nature, or which are not proven to be effective.

GOVERNMENT SERVICES

Treatment for which payment is made by any federal, state, county, municipal, or other governmental agency, including any foreign government; except that nothing shall deny or reduce benefits because the Participant is eligible for or receiving benefits under a state medical assistance program commonly referred to as Medicaid.

HYPNOSIS

Services related to hypnosis, whether for medical, dental or anesthesia purposes.

INELIGIBLE EXPENSE

Services or supplies related to, or arising from complications of, services that are not eligible (for example, cosmetic and experimental procedures).

INPATIENT HOSPITAL BENEFITS

Inpatient hospitalizations, regardless of the reasons such services are necessary.

LOST/MISLAID/STOLEN

Replacement of lost, mislaid or stolen prosthetics.

DENTAL BENEFIT EXCLUSIONS CONTINUED:

NECESSARY

Services and supplies that are not Necessary (as defined in "Definitions") are not covered. The fact that a provider may prescribe, order, recommend, or approve a service does not, of itself, make it Necessary or an allowable expense, even though it is not specifically listed as an exclusion.

NO-COST SERVICES

Benefits for services for which the Participant has no legal obligation to pay, or charges made only because benefits are available under this Plan. The Plan will not cover benefits for services for which the Participant has received a professional or courtesy discount, or for services provided to the Participant by a member of the Participant's Immediate Family.

OTHER NON-COVERED SERVICES include but are not limited to:

- a. Dietary instructions.
- b. Prescription drugs.
- c. Oral hygiene instructions.
- d. Caries susceptibility tests.
- e. Histopathological examinations.
- f. Bacteriological studies for determination of pathologic agents.
- g. Upgrading of serviceable dentistry.
- h. A fixed bridge is not a benefit when done in conjunction with a removable appliance in the same arch.
- i. Diagnostic photographs.
- j. Gold foil restorations.
- k. Metallic or porcelain inlays.
- l. Precision attachments for partials and/or dentures.
- m. Analgesics.
- n. Athletic mouth guards.
- o. Prosthetic devices to replace teeth lost, extracted or otherwise missing prior to the Participant's Plan effective date.
- p. Pulp vitality tests.
- q. Sedative fillings.

OTHER NON-COVERED SERVICES - Continued:

- r. Temporary crowns.
- s. Veneers.
- t. Bleaching of discolored teeth.
- u. Behavior Management.
- v. Services or supplies rendered or furnished to a covered individual by a Dentist or Dental Hygienist, which they are not licensed to render.

PRE-COVERAGE (SERVICES BEGUN BEFORE COVERAGE IS EFFECTIVE)

- 1. Prosthetics, including bridges and crowns, for which the tooth was prepared prior to the date the Participant became covered under this Plan.
- 2. Root canal therapy if the pulp chamber was opened prior to the effective date of coverage under this Plan.
- 3. Appliance or modification of appliance where an impression was made before the patient was covered under this Plan, except in the case of orthodontic maintenance services.

POST-TERMINATION (SERVICES COMPLETED AFTER COVERAGE CEASES)

Expenses incurred after coverage ends except prosthetics (artificial replacement of one or more natural teeth), including bridges and crowns, which were fitted and ordered prior to the date coverage ended. The Participant must receive the prosthetic device within thirty (30) days after coverage is terminated.

REASONABLE AND CUSTOMARY CHARGES

Any expense which is in excess of the Reasonable and Customary Charges determined by the Plan.

REBASING/RELINING

Rebasing or relining of a denture less than six (6) months after the first placement, and not more than one rebasing or relining in any two-year period.

REPLACEMENT DENTURE

A new denture or bridgework if the existing denture or bridgework can be made serviceable and if the existing denture or bridgework is less than five (5) years old.

REPORT PREPARATIONS

Charges for preparing insurance reports, itemized bills, or claim forms.

DENTAL BENEFIT EXCLUSIONS CONTINUED:

SERVICES NOT IDENTIFIED

Any service or supply not specifically identified as a benefit in the Plan.

SURGERY

Orthognathic surgery (surgical orthodontics).

THIRD PARTY LIABILITY (SUBROGATION)

Services or supplies resulting from a condition or injury for which someone else is legally responsible.

TMJ

Treatment of Temporomandibular Joint (TMJ) disorder or dysfunctions, except as stated under Eligible Expenses.

TRAVEL EXPENSES

Travel expenses for the Participant or the Dentist/Provider.

TREATMENT OPTIONS

When there are two or more methods of treating a condition, the benefit for a covered dental service will be based on the least expensive course of treatment. The dental profession must recognize the treatment to be adequate within widely accepted standards of dental practice and be appropriate in view of the patient's oral condition.

VERTICAL DIMENSION/OCCCLUSION

Procedures, restorations and appliances to change vertical dimension or to restore occlusion (proper contact between opposing teeth).

WAR

Services or supplies provided as a result of a disease contracted or bodily injury sustained due to war, whether declared or undeclared, civil war, insurrection, rebellion, or revolution, or to any act or condition incidental to any of the foregoing.

WORKERS' COMPENSATION

Services or supplies resulting from occupational accident or sickness recoverable under State or Federal statute such as Workers' Compensation, Occupational Disease laws, or public health law, even though the Participant waives or fails to assert his right under such law.

SECTION IX - CLAIMS REVIEW PROCEDURES

WHEN TO FILE CLAIMS

Each claim must be signed by the Participant and substantiated by an itemized statement for the expenses incurred. **Claims for benefits under this Plan must be filed with the Claims Administrator within ninety (90) days of the date on which the expense is incurred, or within ninety (90) days of the date of termination of eligibility of benefits hereunder, whichever occurs first. Any claims submitted after fifteen (15) months from the date of incurred service might be denied payment of benefits.** It is the Participant's responsibility to file claims on a timely basis.

CLAIMS REVIEW PROCEDURES

A Claim means a request for a Plan benefit, made by a Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims. A Claim for benefits is not a Claim that has been previously submitted, denied, appealed, and re-denied upon appeal.

A "Claim" is a Post-Service Claim under the terms of the Plan. A Post-Service Claim means a Claim for covered medical services that have already been received by the Plan Participant.

All questions regarding Claims should be directed to the Claims Administrator. All claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims involving specialized medical knowledge or judgment. The Plan Administrator shall have full responsibility to adjudicate all claims and to provide a full and fair review of the initial claim determination in accordance with the following Claims review procedure.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

For the purposes of this section, Claimant means the Plan Participant or the Plan Participant's authorized representative. A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives. A Claimant does not include a healthcare provider simply by virtue of an assignment of benefits.

An Adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and, therefore, cannot be appealed.

Initial Benefit Determination

The Initial Benefit Determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Claim. If the Claims Administrator requires an extension due to circumstances beyond the Plan's control, the Claims Administrator will notify the Claimant of the reason for the delay within the initial 30-day period. A benefit determination on the Claim will be made within 15 days of the date the notice of the delay was provided to the Claimant. If additional information is necessary to process the Claim, the Claims Administrator will request the additional information from the Claimant within the initial 30-day period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure

to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Determination

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant. If a Claim is denied in whole or in part, notice will include the following:

1. Specific reason(s) for the denial.
2. Reference to the specific Plan provisions on which the denial was based.
3. Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.
4. Description of the Plan's Claims review procedures and the time limits applicable to such procedures.
5. Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
6. If applicable:
 7. Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and that a copy will be provided free of charge to the Claimant upon request).
 8. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim, or a statement that such explanation will be provided free of charge, upon request.
 9. Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

Claims Review Procedure - General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by either an appropriate Plan representative or the Claims Administrator on the Plan's behalf, who is neither the individual who made the Initial Benefit Determination, nor a subordinate of that individual. The review will take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without

regard as to whether this information was submitted or considered in the Initial Benefit Determination.

If the Adverse Benefit Determination was based in whole or in part upon medical judgment, including determinations on whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary, the Plan Administrator or its designee will consult with a health care professional who has the appropriate training and experience in the applicable field of medicine; was not consulted in the Initial Benefit Determination; and is not the subordinate of the initial decision-maker. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

The Plan Administrator will provide free of charge upon request by the Claimant, reasonable access to and copies of, documents, records, and other information as described in Items 5 through 8 under "Notice of Adverse Benefit Determination".

First Level of Claims Review

The written request for review must be submitted within 180 days of the Claimant's receipt of notice of an Adverse Benefit Determination. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
% Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the initial Adverse Benefit Determination within the 180 day period will render that determination final.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal.

Second Level of Claims Review

If the Claimant does not agree with the Claims Administrator's determination from the first level review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the first level of review, along with any additional supporting information to:

Plan Administrator
% Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the determination from the first level of review within the 60 day period will render that determination final.

The second level of review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal. The determination by the Plan Administrator upon review will be final, binding, and conclusive and will be afforded the maximum deference permitted by law.

If upon review, the Adverse Benefit Determination remains the same and the Claimant still does not agree with the determination, the Claimant has the right to bring an action for benefits. Before filing a lawsuit, the Claimant must exhaust both levels of review as described in this section. A legal action to obtain benefits must be commenced within one (1) year of the date of the notice of the Plan Administrator's determination on the second level of review.

SECTION X - COORDINATION OF BENEFITS
How Benefits Are Determined If Expenses Are Covered By More Than One Plan

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan, or the couple's Covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or nongroup insurance contracts and subscriber contracts;
- (2) Uninsured arrangements of group or group-type coverage;
- (3) Group and nongroup coverage through closed panel plans;
- (4) Group-type contracts;
- (5) The medical components of long-term care contracts, such as skilled nursing care;
- (6) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;
- (7) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Reasonable and Customary Charge" in the Definitions section.)

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (B) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

- (1) The benefits of the plan which covers the person directly (that is, as a Member/Employee, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

- (2) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child's parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's spouse does, the plan of that parent's spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.
- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

- 1st The plan covering the custodial parent,
- 2nd The plan covering the spouse of the custodial parent,
- 3rd The plan covering the non-custodial parent, and
- 4th The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (5) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

- (3) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or as a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Member/Employee. This rule does not apply if Rule (1) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (4) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.
 - (5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (D) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

SECTION XI - AUTOMOBILE INSURANCE PROVISIONS

When Dental Expenses Are Covered By Auto Insurance

A "No-Fault Complying Policy" is an insurance policy approved by the applicable State Division of Insurance that provides at least the minimum coverage (\$50,000 medical/ \$50,000 rehabilitation in Colorado) required by law, and one that is subject to the Auto Accident Reparations Act. Any State or Federal law that provides similar benefits through legislation or "No-Fault" is also considered a complying policy.

Beginning July 1, 2003, Colorado automobile insurance policy renewals will no longer be issued on a "No-Fault" basis, but rather on a "Tort" basis. A "Tort Complying Policy" is one that will cover injuries sustained as a result of an accident caused by a specific party. The policy of the insured who is at fault for the accident will provide coverage for such injuries.

HOW THE PLAN COORDINATES WITH COMPLYING POLICIES

When an injury occurs involving an automobile and a complying policy exists, the Plan will coordinate its benefits with the complying automobile insurer for Eligible Expenses.

WHAT THE PLAN WILL PAY

The deductible of the complying automobile policy will be considered an Eligible Expense and paid in accordance with Plan provisions.

When the complying automobile insurer has paid its maximum benefits, the Plan will become liable for Eligible Expenses in excess of the maximum benefit not paid by the complying automobile insurer.

If a deductible is charged under the complying automobile policy for choosing a Non-Network Provider when a Network Provider could have been visited without the deductible being imposed, this Plan will not pay benefits for that deductible.

If more than one complying automobile insurer is responsible for providing benefits, the Plan will become liable after all complying automobile insurers have paid their maximum benefits.

LIMITATIONS AND EXCLUSIONS

1. This Plan will not provide benefits to the extent of minimum coverage required by any applicable state law for injuries suffered in an automobile accident, if:
 - a. Participant is the owner of the vehicle; and,
 - b. Participant is either operating or riding in the owned vehicle; and,
 - c. The vehicle is not covered by automobile Insurance as required by law.

The benefits of this Plan will be available if the injured Participant is a non-owner operator, passenger or a pedestrian not covered by Automobile Insurance.

2. If there is a Complying Policy in effect, and the individual covered by this Plan waives or fails to assert his rights to such benefits, this Plan will not pay benefits that could be available under a Complying Policy.

SECTION XII - THIRD PARTY LIABILITY: How Benefits Are Paid If Someone Else Is Liable For A Participant's Dental Expenses

ACTS OF THIRD PARTIES – CONDITIONAL BENEFIT PAYMENTS

If a Participant has dental expenses as a result of an injury or accident for which a third party is, or may be, held responsible, the Plan Administrator may authorize the Plan to make advance expense reimbursements to, or payments on behalf of, such Participant, subject to the Plan's rights to reimbursement and subrogation. However, before any such reimbursements or payments will be conditionally made, the Participant (or the Participant's legal guardian if the Participant is a minor) shall execute an agreement, if requested, that acknowledges and affirms (1) the conditional nature of the reimbursements or payments and (2) the Plan's rights of reimbursement and subrogation, as provided for below. The execution of such an agreement is not necessary to preserve the Plan's rights of reimbursement and subrogation.

RIGHT TO REIMBURSEMENT AND SUBROGATION

If a Participant receives any benefits arising out of an injury or illness for which the Participant (or the Participant's guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan will be reimbursed. Such reimbursement will be made by the Participant (or the Participant's guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the Participant (or the Participant's guardian or estate) from: (1) any policy or contract from any insurance company or carrier (including the Participant's insurer) and/or (2) any third party, plan or fund as a result of a judgment or settlement. The Participant on behalf of himself (or his guardian or estate) acknowledges and agrees that this Plan will be reimbursed in full before any amounts (including attorneys' fees incurred by the Participant or his guardian or estate) are deducted from the policy, proceeds, judgment or settlement. The plan's reimbursement and subrogation rights shall have priority over any other competing claims regardless of whether the total amount of the recovery of the covered person is less than the actual loss suffered, or less than the amount necessary to make the covered person whole.

The Plan will be entitled, not obligated, to proceed in the name of the covered person if the covered person fails to take the necessary action to recover such expenses. This Plan shall be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including the Participant's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under this Plan arising out of the Injury or Illness for which the Participant (or the Participant's guardian or estate) has, may have or asserts a cause of action. In addition, this Plan will be subrogated for attorneys' fees incurred in enforcing its subrogation rights under this Section.

If the Participant files litigation or makes a claim for third party liability expenses, then the amount of the Plan's reimbursement or subrogation claim must be included in such litigation or claim. The Participant on behalf of himself (or his guardian or estate) specifically agrees not to do anything to prejudice this Plan's rights to reimbursement or subrogation. No settlement may be made and no parties may be released with the prior written approval of the Plan Administrator. In addition, the Participant on behalf of himself (or his guardian or estate) agrees to cooperate fully with the Plan and Administrator in asserting and protecting the Plan's reimbursement and subrogation rights. The Participant on behalf of himself (or his guardian or estate) agrees to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect his Plan's subrogation rights.

Finally, the Participant on behalf of himself (or his guardian or estate) specifically agrees to notify the Administrator, in writing, whatever benefits are paid under this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation rights under this Section.

This clause is a condition of coverage under this Plan. Failure to comply with the requirements of this Section by the Participant (or his estate or guardian) may, at the Administrator's discretion, result in a forfeiture of benefits under this Plan.

SECTION XIII - DEFINITIONS

This section defines certain words used throughout the booklet. The first letter in each definition is capitalized throughout the document. Refer to this section to find out how, for the purposes of this booklet, a term is used.

CHANGE IN STATUS

“A Change in Status includes any item from the following list. Any change in election must be consistent with and required by the Change in Status.”

1. Change in employee’s marital status: Including marriage, divorce, annulment, legal separation or death of a spouse;
2. Change in number of tax-eligible dependents: Including birth, adoption, placement for adoption, change in legal custody status or Qualified Medical Child Support (QMCSO) or death of a dependent;
3. Change in employment status: Reduction or increase in hours by an employee, spouse or eligible dependent, including transition from full-time to part-time, part-time to full-time, strike or lockout;
4. Commencement of/or return from a Family and Medical Leave Act (FMLA) or other approved unpaid leave of absence by an employee, employee’s spouse or eligible dependent;
5. Commencement or termination of employment by an employee, employee’s spouse or eligible dependent;
6. Attainment or loss of dependent eligibility as defined by the Plan. For example, exceeding the Plan’s established age limitations, loss or attainment of full-time student status, marriage or eligibility for coverage under another health plan would all qualify as eligible change in status events;
7. Entitlement to/or loss of Medicaid or Medicare coverage by an employee, employee’s spouse or eligible dependent;
8. Residence and/or work site change: A required change in place or residence and/or work site of an employee, employee’s spouse or eligible dependent. For example, a move outside a health plan’s service area would qualify as a change in status event; however, a non-employment related change in residence would not qualify as an eligible event; or
9. Significant change in available benefits and/or their cost, when imposed by a third party. For example, if a fully insured health plan imposes a change in benefit coverage levels or increases premiums substantially (greater than 20%), this would qualify as a change in status event; however, an employer’s change in contribution amounts would not.

CLAIMS ADMINISTRATOR

The person or organization designated by School District 27J responsible for the administration and processing of claims in accordance with the Plan Document.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) enables certain Participants to continue dental coverage beyond the date it would otherwise terminate.

COINSURANCE

An arrangement where the Participant pays a percentage of the Eligible Expenses after the Deductible has been satisfied.

COORDINATION OF BENEFITS

If dental expenses are covered by more than one dental plan, the Coordination of Benefits rules determine the order in which two (2) or more dental plans will pay benefits and how much each plan will pay. If a Participant incurs dental expenses that are eligible under this Plan and another insurance plan, benefits from both plans will be coordinated so the total reimbursement does not exceed 100% of Eligible Expenses.

DEDUCTIBLE

A specified amount of Eligible Expenses a Participant must pay each calendar year before benefits are provided.

The Deductible per family is two (2) times the individual Deductible amount. The maximum that can be applied for one Participant is the individual Deductible.

When both the employee and spouse are employed by School District 27J and are enrolled individually in the Plan, the Family Deductible shall be considered to have been satisfied for both once two individual deductibles have been met under either's coverage.

DENTIST

A licensed provider who is legally entitled to practice dentistry in all its branches under the laws of the state or the jurisdiction where services are rendered.

ELIGIBLE EXPENSE

An expense incurred for a covered service or supply. The expense is considered incurred on the date the service or supply is received and does not include any charge:

1. For a service or supply that is not necessary;
2. Which is in excess of the Reasonable and Customary Charge and
3. Which is provided by a member of the Participant's Immediate Family.

EMERGENCY

The sudden onset of a condition characterized by serious symptoms (such as severe pain or extensive bleeding) of short duration (not chronic).

EMPLOYEE CONTRIBUTION

The specified cost determined by the School District 27J that must be paid by the employee for enrollment in the Plan.

EMPLOYER

The Employer is School District 27J.

ENROLLMENT

The process of completing an enrollment form, supplied by the School District 27J Office for Human Resources, to participate in this Plan.

EXCLUSIONS

Specific services or conditions that are not eligible for benefit regardless of medical necessity.

IMMEDIATE FAMILY

This includes the employee and his/her eligible dependents. It also includes parents, in-laws, sisters and brothers.

MAXIMUM BENEFIT

The maximum dollar amount payable under the terms of the Plan for any Participant while covered under the Plan.

MEDICARE

Federal insurance or assistance provided by the Health Insurance for the Aged Act (Title XVIII of the Federal Social Security Act), or as such Act may be amended.

NECESSARY

Those services and supplies provided for the diagnosis and treatment consistent with a dental-related illness, injury or condition requiring definitive dental treatment, and in accordance with prevailing dental practices in the community. These services must be ordered by the Dentist.

OPEN ENROLLMENT

A period each year during which employees have an opportunity to enroll in the Plan.

ORTHODONTIST

A Dentist duly certified to practice orthodontics.

PARTICIPANT

An eligible employee or dependent who is enrolled for benefits under the Plan.

PLACEMENT FOR ADOPTION

Assumption and retention by the employee of a legal obligation for primary support of a child in anticipation of adoption of that child.

PLAN

School District 27J Dental Care Plan.

PLAN ADMINISTRATOR

The persons having specified administrative duties and powers; in this case, School District 27J.

PLAN YEAR

Period of twelve (12) months, beginning July 1 and ending June 30 of each year. Benefits are payable on a Calendar Year basis (January 1 – December 31).

PREDETERMINATION OF BENEFITS

A report on the plan of treatment prepared by the attending Dentist/Orthodontist on a “Pre-determination of Benefits” form. The report is submitted to the Claims Administrator prior to any treatment expected to exceed \$300; it describes the recommended treatment, gives the estimated charge and is accompanied by cephalometric x-rays, study models and/or other supporting evidence. Its purpose is to determine the available benefits.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A judgment or decree by a court of “competent jurisdiction” that requires a group health plan to provide coverage to the children of a Plan Participant, pursuant to a state domestic relations law. The child is termed an “alternate recipient” and is entitled to coverage.

REASONABLE AND CUSTOMARY CHARGE

The eligible charge for each procedure covered under the Plan. A charge is considered Reasonable and Customary if it is made by an eligible provider and is as normally made in the community and surrounding communities in which services are rendered for similar services provided under similar conditions to persons of like circumstances. For purposes of this Plan, the basis for determination of Reasonable and Customary charges is the ninetieth (90th) percentile and will be reviewed periodically by the Employer.

SELF SUPPORTING

When a dependent obtains full-time employment and the employee is no longer able to claim the dependent on their income tax filing, the dependent is considered to be self supporting.

SUBROGATION

A right of the Plan to enforce a claim against a third party for reimbursement when Third Party Liability has been established for Eligible Expenses paid under this Plan. The recovery will not exceed the amount of the award.

THIRD PARTY LIABILITY

Liability of another entity or person who becomes legally responsible for a Participant's condition or injury.

SECTION XIV - STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUES PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been

delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - a. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - (i) All staff in the Benefits Office/Department
 - (ii) All staff in the Human Resources Office/Department
 - (iii) All staff in the Finance Office/Department
 - (iv) All staff in the Payroll Office/Department
 - b. The access to and use of PHI by the individuals described in subsection a above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE “PRIVACY STANDARDS”) ISSUES PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

DISCLOSURE OF ELECTRONIC PROTECTED HEALTH INFORMATION (“ELECTRONIC PHI”) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION FUNCTIONS

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. 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;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and
4. Report to the Plan any security incident of which it becomes aware.

SECTION XV - GENERAL PLAN INFORMATION

1. EMPLOYER AND NAME OF PLAN

School District 27J Dental Plan
18551 East 160th Avenue
Brighton, CO 80601
(303) 655-2900

2. PLAN SPONSOR

School District 27J
(Address and phone same as above)

3. PLAN ADMINISTRATOR

School District 27J
(Address and phone same as above)

4. CLAIMS ADMINISTRATOR

Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

5. COBRA ADMINISTRATOR

School District 27J
(Address and phone same as above)

6. NAME AND ADDRESS OF EMPLOYER WHOSE EMPLOYEES ARE COVERED BY THE PLAN

School District 27J Dental Plan
18551 East 160th Avenue
Brighton, CO 80601

7. THE EMPLOYER IDENTIFICATION NUMBER ASSIGNED BY THE INTERNAL REVENUE SERVICE

84 – 6012304

8. THE PLAN NUMBER ASSIGNED BY THE PLAN SPONSOR

501

9. TYPE OF PLAN

This is a welfare benefit plan maintained for the purpose of providing Dental coverage.

10. TYPE OF ADMINISTRATION

The Plan is administered by the Plan Administrator with benefits provided in accordance with the self-funding provisions established by the District.

11. AGENT FOR SERVICE OF LEGAL PROCESS

School District 27J Dental Plan
18551 East 160th Avenue
Brighton, CO 80601
(303) 655-2900

12. ELIGIBILITY PROVISIONS

All benefits under this Plan are subject to the eligibility provisions explained on earlier pages.

13. SOURCE OF CONTRIBUTIONS TO THE PLAN

The Plan is funded by contributions from the employer and employees.

14. FUNDING MECHANISM

Benefits under the Plan are provided through a self-funded arrangement. Self-funding means that the monthly rates are fixed at a level expected to cover the normal cost of providing benefits.

15. DATE OF THE END OF THE PLAN YEAR

The Plan year ends on each June 30.

16. HOW TO FILE CLAIMS AND APPEALS

The procedure for filing claims and appeals is explained on earlier pages.