Forest Hills School District

Dental Plan

Group #217

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Dental Plan

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The intent of this dental benefit plan is to provide benefits for eligible dental services that meet professionally acceptable standards for the treatment of the existing dental condition.

School Claims Service, LLC
P.O. Box 812
New Cumberland, PA 17070-0812
Phone # (866) 403-7700
Fax # (866) 403-7701
Please feel free to visit our website at:
www.schoolclaimsservice.com

To all full-time employees of Forest Hills School District:

Forest Hills School District asks that you read this booklet so you are aware of your benefits, understand your eligibility and obtain maximum benefit from this plan.

You will receive an explanation of benefits for each finalized claim. **Retain all explanations of benefits.** This is your record of services provided, date of each service and amount paid. An explanation of benefits is essential when coordinating benefits with other dental plans.

If you should need additional information, you may call School Claims Service, LLC, between the hours of 8 a.m. and 4:30 p.m. at (800) 362-2080.

This booklet is not a contract. It explains in nontechnical language the essential features of your employee fringe benefit plan. 4-09-15-W.O. 268

Schedule of Benefits

Diagnostic & Preventive 100%

- Exams
- X-rays
- Cleaning
- Fluoride
- Sealants
- Palliative treatment

Basic Services.....100%

- Basic restorative
- Endodontics
- Nonsurgical periodontics
- Repair
- Simple extractions
- Complex oral surgery
- Anesthesia

Major Restorative.....100%

- Inlays, onlays, crowns
- Surgical periodontics

Deductibles & Maximums

- No deductible
- $1,000 per fiscal year maximum per individual

Coinsurances and deductible are based on the maximum allowable charge.

Eligibility

Employees who satisfy the eligibility requirements and who enroll prior to the effective date will be covered on the effective date. If the age of the employee has been misstated, all benefits payable under this policy shall be such as the premium paid would have purchased at the correct age.

Employees who become eligible after the effective date of the policy and who complete an enrollment form within 30 days of initial eligibility shall be covered on the first day of the month following the date specified by the district on the enrollment form, except for a newborn or adopted child who will be covered from the moment of birth or placement.

A newborn child, adopted child or one placed for adoption within 31 days of birth shall be considered enrolled from the moment of birth for 31 days. For coverage to continue beyond the 31-day period, notification of birth, adoption or placement for adoption, and payment of the required premium shall be paid within the 31-day period.

Dependents are eligible upon enrollment of the employee, or within 30 days of their eligibility due to a change in status such as marriage. If the employee and/or their dependents are not enrolled within 30 days of eligibility, they cannot be enrolled until the open enrollment period conducted by the district. The restriction shall not apply to dependent children of an employee subject to a court or administrative order of support relating to the provision of health care coverage. Dependent coverage only may be terminated during open enrollment periods unless a change in status, such as divorce has occurred.

Dependent(s) – Unmarried son/daughter, or stepson/stepdaughter of a certificate holder or member of the certificate holder's household resulting from a court order or placement by an administrative agency, who is enrolled in the plan until: (a) the end of the month which he/she turns 19; or (b) the end of the month which he/she turns 23 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the certificate holder for maintenance and support; or (c) to any age if he/she is and continues to be both

incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the certificate holder for maintenance and support. For a dependent who falls into category (b), evidence of his/her student status and reliance on the certificate holder shall be furnished to the company in the form requested within 31 days after said dependent attains the age of 19 and, thereafter, not more frequently than semiannually. For a dependent who falls into category (c), evidence of his/her reliance on the certificate holder due to his/her condition shall be furnished to the company in the form requested within 31 days after said dependent attains the age of 19, or within 31 days after said dependent attains the age of 23 if he/she is a full-time student at an accredited educational institution. Newly born children of a member shall be considered dependents from the moment of birth. Adoptive children shall also be considered dependents from the date of adoption or placement, except for those adopted or placed within 31 days of birth who shall be considered dependents from the moment of birth.

Covered Services

Services provided under the plan will be in accordance to this certificate and/or the attached schedule of exclusions, limitations and schedule of benefits. Certain benefits may be subject to coinsurances, deductibles, maximums, limitations and waiting periods as listed.

A pretreatment estimate is recommended for extensive treatment and is used to determine the extent of covered services of members. Substantiating materials must be submitted to estimate benefits when requested by School Claims Service, LLC. If the requested data is not submitted, SCS, LLC, on behalf of the district reserves the right to determine benefits payable, taking into account alternative procedures, services or course of treatment, based upon accepted standards of dental practice.

Schedule of Exclusions and Limitations

Exclusions

Except as specifically provided in this booklet, no coverage will be provided for services, supplies or charges:

1. Not specifically listed as a covered benefit.
2. Which, in the opinion of the dentist, are not clinically necessary for the member's health.
3. Necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan.
4. Started by any dentist prior to the member's eligibility under SCS, LLC including, but not limited to endodontics, crowns, bridges, inlays, onlays and dentures. If the condition was treated within 90 days prior to eligibility under this plan, the condition may be covered when the member has been continuously eligible for 12 months under the plan.
5. Incurred prior to the member's effective date or after the termination date of coverage with the company, except those services as provided for in the extension and continuation of benefits sections of this booklet.
6. That do not meet accepted standards of dental treatment, which are experimental or investigational in nature or are considered enhancements to standard dental treatment as determined by SCS, LLC.
7. For hospitalization costs.
8. Determined by SCS, LLC to be the responsibility of workers' compensation or employer's liability, services for which benefits are covered under any federal government or state program, excluding medical assistance, or for services for treatment of any automobile related injury in which the member is entitled to payment under an automobile insurance policy. The school district's benefits would be in excess to the third-party benefits and therefore, the school district would have the right of recovery for any benefits paid in excess.
9. For prescription drugs.

10. Administration of nitrous oxide, general anesthesia and I.V. sedation, unless specifically described on the schedule of benefits.
11. Which are cosmetic in nature as determined by SCS, LLC.
12. Elective procedures including the prophylactic extraction of third molars within the first six months of enrollment.
13. For the following, which are not included as orthodontic benefits – retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect.
14. For any dental or medical services performed by a physician and/or services which benefits are otherwise provided under a medical-surgical plan of the member.
15. For congenital mouth malformations or skeletal imbalances, including, but not limited to treatment related to cleft palate therapy, treatment related to disharmony of facial bone, treatment related to or required as the result of orthognathic surgery including orthodontic treatment, dental implant services including placement and restoration of implants, and oral and maxillofacial and temporomandibular joint services including associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth, all treatment of temporomandibular disorders (TMD, TMJ, CMD, MFPD, etc.), both surgical and nonsurgical treatment, arthroscopy of the joint and orthognathic surgery, and treatment of any malocclusion involving joints or muscles by orthodontic repositioning of the teeth. This exclusion shall not apply to newly born children of members.
16. For dental treatment of fractures and dislocations of the jaw except as a result of accidental injury.
17. For treatment of malignancies or neoplasms.
18. Procedures requiring appliances or restorations (except when involving full or partial dentures or correction of a dental condition as a result of accidental injury) that are necessary for adult or pediatric full mouth rehabilitation,

including precision attachments or stress breakers, restoration of occlusion, to alter vertical dimension of occlusion, restorative equilibration and kinesiology.

19. For the cost to replace lost, stolen or damaged prosthetic or orthodontic appliances.
20. Deemed by SCS, LLC to be of questionable efficacy.
21. For broken appointments.
22. Which are not dentally necessary as determined by SCS, LLC.
23. Arising from any intentionally self-inflicted injury or contusion, or as a consequence of the member's commission of or attempt to commit a felony or engagement in an illegal occupation or of the member's being intoxicated or under the influence of illicit narcotics.
24. For house calls for dental services.
25. For prosthetic services.
26. For orthodontic services.
27. For any service for which the member failed to follow the guidelines of SCS, LLC.

Limitations

The following services will be subject to limitations as set forth below:

1. Full mouth X-rays – one every three years.
2. One set of bitewing X-rays per consecutive six months.
3. Periodic oral exam – one per six months.
4. Prophylaxis – one per six months.
5. Fluoride treatment – one per six months through age 18.
6. Space maintainers – only eligible for dependent children through age 18 when used to maintain space as a result of prematurely lost deciduous posterior teeth and permanent first molars, or deciduous posterior teeth and permanent first molars that have not, or will not develop.
7. Therapeutic drug injections.

8. Prefabricated stainless steel crowns – one per tooth per lifetime.
9. Crown lengthening – one per tooth per lifetime.
10. Periodontal maintenance following active periodontal therapy – four in any 12 consecutive months per member, reduced by the number of routine prophylaxis received during that 12-month period so that the total prophylaxis for the period does not exceed four.
11. Periodontal scaling and root planing – one per 24-month period per area of the mouth.
12. Placement or replacement of single crowns, single and abutment buildups and post and cores, bridges, full and partial dentures – one within five years of their placement.
13. Denture relining or rebasing – integral if provided within six months of insertion by the same dentist.
14. Subsequent denture relining or rebasing – limited to one every 36 months thereafter.
15. Surgical periodontal procedures – one per 24-month period per area of the mouth.
16. Sealants – one per tooth per three years through age 10 on permanent first molars and through age 15 on permanent second molars.
17. Pulpal therapy – through age five on primary anterior teeth and through age 10 on primary posterior teeth.
18. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed for the less costly treatment.
19. Inlays, onlays, crowns, dentures and bridges shall be considered completed on the date they are finally inserted.
20. One consultation per consultant during any one-year period.

Definitions

Certificate Holder(s) – An individual who has submitted an application for dental coverage for him/herself and his/her dependents for whom premium payments are due and payable by the policyholder.

Certificate of Insurance (Certificate) – This document, including riders and/or endorsements, if any, which describes the member's coverage purchased from SCS, LLC by the policyholder.

Coinsurances – Those percentages of the maximum allowable charge as set forth in the schedule of benefits that are the responsibility of either the employee or his/her enrolled dependents.

Company – School Claims Service, LLC

Coordination of Benefits (COB) – A method of integrating benefits for covered services under more than one plan to prevent duplication.

Cosmetic – Those procedures, which are not dentally necessary and are undertaken primarily, in the opinion of the company, to improve or otherwise modify the member's appearance, when the cause is not related to accidental injury.

Covered Service(s) – A service or supply specified in this booklet for which benefits will be covered when rendered by a dentist, or if specifically approved by SCS, LLC.

Deductible(s) – A specified amount of expenses set forth in the schedule of benefits for covered services that must be paid by the member before the district will assume liability.

Dentally Necessary – A dental service or procedure as determined by a dentist to either establish or maintain a patient's dental health. Such determinations are based on the professional diagnostic judgment of the dentist and the standards of care that prevail in the professional community. The determination as to when a dental service is necessary shall be made by the dentist in accordance with guidelines established by the

district. In the event of any conflict of opinion between the dentist, the district and SCS, LLC, as to when a dental service or procedure is dentally necessary, the opinion of the district and SCS, LLC shall be final.

Dependent(s) – Unmarried son/daughter, or stepson/stepdaughter of a certificate holder or member of the certificate holder's household resulting from a court order or placement by an administrative agency, who is enrolled in the plan until: (a) the end of the month which he/she turns 19; or (b) the end of the month which he/she turns 23 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the certificate holder for maintenance and support; or (c) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the certificate holder for maintenance and support. For a dependent who falls into category (b), evidence of his/her student status and reliance on the certificate holder shall be furnished to the company in the form requested within 31 days after said dependent attains the age of 19 and, thereafter, not more frequently than semiannually. For a dependent who falls into category (c), evidence of his/her reliance on the certificate holder due to his/her condition shall be furnished to the company in the form requested within 31 days after said dependent attains the age of 19, or within 31 days after said dependent attains the age of 23 if he/she is a full-time student at an accredited educational institution. Newly born children of a member shall be considered dependents from the moment of birth. Adoptive children shall also be considered dependents from the date of adoption or placement, except for those adopted or placed within 31 days of birth who shall be considered dependents from the moment of birth.

Effective Date – The date on which coverage for the policyholder and it's eligible members begin.

Enrollment/Change Form – A form provided by SCS, LLC that the certificate holder completes to enroll. Such information may be transmitted from the policyholder to SCS, LLC using any agreed-upon form of written or electronic media.

Experimental or Investigative – The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply that the company, relying on the advice of the general dental community including, but not limited to, dental consultants, dental journals and/or governmental regulations, determines are not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval for which approval has not been granted at the time the services were rendered.

Grace Period – A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which the policy shall continue in force subject to the right of the district to cancel in accordance with the cancellation provision hereof.

Group Policy – The agreement between SCS, LLC and the policyholder, under which the certificate holder is eligible to enroll.

Limitation(s) – The maximum frequency or age set forth in the schedule of exclusions and limitations incorporated by reference into this certificate.

Maximum(s) – The greatest amount the district is obligated to pay for covered services during a specified period.

Maximum Allowable Charge – The maximum amount the plan will allow for a covered service.

Member(s) – Certificate holder(s) and their dependent(s).

Nonparticipating Dentist – A dentist who has not signed a contract with SCS, LLC.

Participating Dentist – A dentist who has executed a participating dentist contract with SCS, LLC, under which he/she agrees to provide covered dental care services under this plan.

Plan – Dental benefits pursuant to this certificate and attached schedule of benefits.

Policyholder – Organization that executes the group policy.

Pretreatment Estimate – The review by the plan of a treatment plan to determine the eligibility of a member, the coverage for services in accordance with the schedule of benefits, the schedule of exclusions and limitations, and the plan allowance for such services.

Renewal Date – The date on which the group policy renews. Also known as anniversary date.

Schedule of Benefits – Attached list of covered services, coinsurance amounts, deductibles and maximums.

Termination Date – The date on which the dental benefits are no longer in effect.

Treatment Plan(s) – The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared for a member by a dentist as a result of an examination.

Waiting Period(s) – A period of time a member must be insured under this certificate before he/she is eligible for covered services. Any waiting periods applicable to dental benefits covered under this plan are shown in the attached schedule of benefits.

Coordination of Benefits

A. Applicability

1. This coordination of benefits (COB) provision applies to this plan when an employee or the employee's covered dependent has dental care coverage under more than one plan. "Plan" and "This Plan" are defined below.
2. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:
   a. Shall not be reduced when under the order of benefit determination rules. This plan determines its benefits before another plan.

b. Reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section D, "Effects on the Benefits of This Plan."

B. Definitions

1. **Plan** is any of these which provides benefits or services for, or because of, medical or dental care treatment:
   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
   b. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under a. or b. above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

2. **This Plan** is the part of the group contract that provides benefits for dental care expenses.
3. **Primary Plan/Secondary Plan.** The order of benefits determination rules state whether this plan is a primary plan or a secondary plan as to another plan covering the person.

When this plan is a primary plan, its benefits are determined before those of the other plan, and without considering the other plan's benefits.

When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

4. **Allowable Expense** means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans

covering the person for whom the claim is made.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

5. **Claim Determination Period** means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this COB provision or a similar provision takes effect.

C. Order of Benefit Determination Rules

1. **General.** When there is a basis for a claim under this plan and another plan, this plan is a secondary plan. This plan has its benefits determined after those of the other plan, unless:
   a. The other plan has rules coordinating its benefits with those of this plan.
   b. Both those rules and this plan's rules, in Subsection 2 below, require that this plan's benefits be determined before those of the other plan.
2. **Rules.** This plan determines its order of benefits using the first of the following rules which applies:
   a. Nondependent/Dependent. The benefits of the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan, which covers the person as a dependent.
   b. Dependent child/parents not separated or divorced. Except as stated in paragraph 2 below, when this plan and another plan cover the same child as a dependent of a different person, called "parents."
      1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.
      2) If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan covering the other parent for a shorter period of time.

However, if the other plan does not have the rule described in 1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

c. Dependent child/separated or divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   1) First, the plan of the parent with custody of the child.
   2) Then, the plan of the spouse of the parent with the custody of the child.
   3) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the dental care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Active/inactive employee. The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule 4) is ignored.

e. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, member or subscriber longer, are determined before those of the plan that covered that person for the shorter term.

D. Effect on the Benefits of This Plan

1. When this section applies. This section D applies when, in accordance with Section C. "Order of Benefit Determination Rules," this plan is a secondary plan as to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in 2. immediately below.
2. Reduction in this plan's benefits. The benefits of this plan will be reduced when the sum of:
   a. The benefits that would be payable for the allowable expense under this plan in the absence of this COB provision.
   b. The benefits that would be payable for the allowable expense under the other plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

E. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. SCS, LLC has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. SCS, LLC need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give SCS, LLC any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another plan may include an amount, which should have been paid under this plan. If it does, SCS, LLC may pay that amount to the organization, which made that payment. That amount will then be treated as though it

were a benefit paid under this plan. SCS, LLC will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payments made by SCS, LLC is more than it should have been paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid.
2. Insurance companies.
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

How to File a Claim

A dental claim form, available at your personnel office or provider's office, must be completed by you and the provider of services.

1. Complete Part I on the claim form.
2. Give the claim form to your dentist.
3. After treatment is completed, the dentist should complete Part II of the claim form, indicating the services performed, date of service and the charges.
4. Send the completed form to the address listed on the claim form.

A separate claim is needed for you and each of your dependents. To avoid delay in handling your claim, be sure to answer all questions on the form completely and correctly. Expenses cannot be processed without your signature in the appropriate areas of the form.

Appealing Claims if Denied

If your claim should be denied in whole or in part you will receive written notification.

A claim work sheet will be provided by SCS, LLC showing the calculation of the total amount payable, charges not payable and the reason.

If you receive a denial of your claim, you may request a review by filing a written application with School Claims Service, LLC. On receipt of a written request for review of a claim, SCS, LLC will review the claim and furnish copies of all documents and all reasons and facts relating to the decision.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you

should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. 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.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA 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 or reduction of hours of employment, death of the employee, {commencement of a proceeding in bankruptcy with respect to the employer,} or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (<u>divorce</u> or <u>legal separation</u> of the employee and spouse or a <u>dependent child's losing eligibility for coverage</u> as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA 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.

COBRA continuation coverage is temporary continuation of coverage. When the qualifying event is the death of the employee, the 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 lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, 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 continuation coverage.

Second qualifying event extension of 18-month period of 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 notice of the second qualifying event is properly given the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the 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, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Keeping Administrator Informed

It is imperative that you keep the administrator informed of any address changes for all participates or beneficiaries who are or may become qualified beneficiaries. Likewise it is your responsibility to advise the administrator of any qualifying events such as divorce.

If You Have Questions

Questions concerning your ***Summary*** Plan ***Description*** or your COBRA continuation coverage rights should be addressed to the Contact or contacts identified below.

School Claims Service, LLC
Employee Benefits Division
PO Box 812
New Cumberland, PA 17070-0812
(866) 403-7700

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