

Dakota County United Educators

Dental Reimbursement Fund

The Direct Reimbursement Dental Fund

Provided by DCUE for

Independent School District 196 Employees

Covered Under the Collective Bargaining Agreement

Between ISD 196 and DCUE

Effective September 1, 2020

Previous Printings:

September 1, 2019

September 1, 2018

September 2, 2014

September 1, 2011

September 1, 2010

October 1, 2006,

August 15, 2003,

August 15, 1998 and

September 1, 1996

6950 146th Street W Ste 114

Apple Valley MN 55124

952-432-4033

Dakota County United Educators
Dental Reimbursement Fund

Table of Contents

Declaration ii

DCUE Dental Reimbursement Fund 1-9

 Article I – Purpose of Fund 1

 Article II – Definitions 1-2

 Article III – Eligibility 2-3

 Article IV – Benefits 3-5

 Article V – Funding..... 5-6

 Article VI – Fund Administrator 6

 Article VII – Claims Procedures 6-8

 Article VIII – Miscellaneous..... 8

 Signatures 9

Appendix A – Benefit Program 11-18

 1.0 Overview 12-15

 2.0 Samples of Claim Form Supporting Documentation 16-18

Appendix B – Forms 19-27

 Sample Online Enrollment Form 20

 Sample Claim Form 21-22

 Sample DCUE Dental Explanation of Benefits 23

 Sample Claim Denial Letter..... 24

 Sample Request for Review of Claim Reimbursement Form..... 25

 Sample Notice of Right to Continue Dental Benefits Letter:

 COBRA 18 Months of Coverage 26

 Sample Expiration of Coverage Letter:..... 27

Appendix C – COBRA Benefits & HIPPA Regulations..... 29-38

 Continuation of Dental Coverage under COBRA..... 29-33

 Medical Data Privacy..... 34-38

Dakota County United Educators

DECLARATION made as of the 1st day of September 1996.

WHEREAS, the Dakota County United Educators Dental Reimbursement Fund (the Fund) was adopted effective the 1st day of September 1996, amended the 15th day of August 1998, amended the 15th day of August 2003, amended the 1st day of October 2006, amended the 1st day of September 2010, amended the 1st day of September 2011, amended the 1st day of September 2014, amended the 1st day of September 2016, amended the 1st day of September 2018, amended the 1st day of September 2019 and amended the 1st day of September 2020;

THEREFORE, the Fund is stated in its entirety as follows:

Dakota County United Educators
Dental Reimbursement Fund

ARTICLE I
Purpose of Fund

- 1.01 The purpose of this Fund is to reimburse the eligible employees of Independent School District 196 for certain dental care expenses that are not covered by said employee’s Medical or other Dental Insurance Plan. It is the intention of Dakota County United Educators that the Fund qualify as a health plan within the meaning of the S105(e) of the Internal Revenue Code of 1986, or as amended, and that the benefits payable under the Fund be eligible for exclusion under S105(b) of the Internal Revenue Code of 1986, or as amended.

ARTICLE II
Definitions

- 2.01 “Code” means the Internal Revenue Code of 1986, as amended, or as it may be amended from time to time.
- 2.02 “DCUE” means the Dakota County United Educators organization, an affiliate of Education Minnesota.
- 2.03 “DCUE Dental Reimbursement Board of Trustees” means the president, six (6) members of DCUE, and a Fund Administrator who could be one of the above.
- 2.04 “Effective Date” means September 1 or any mid-year hire date.
- 2.05 “Employee” means any individual employed by ISD 196 who is covered by that certain Collective Bargaining Agreement between ISD 196 and DCUE, in effect September 1, 1996, and successor agreements thereto.
- 2.06 “Expenses paid for dental care” or “expenses” means amount paid for dental costs (including most accepted dental procedures, endodontic, periodontal and orthodontic costs, but not whitening, medications or take home dental products) that are not covered under the eligible Participant’s health plan or other primary dental insurance.
- 2.07 “ISD 196” means Independent School District 196.
- 2.08 “Orthodontic costs” means related to the dental orthopedic correction of abnormal dental relationships including related abnormalities in facial structure, to the lifetime limited amount of benefits.

- 2.09 “Participant” means the eligible and enrolled employee of ISD 196 DCUE Dental Reimbursement Fund.
- 2.10 “Fund” means DCUE Dental Reimbursement Fund.
- 2.11 “Fund Administrator” means the person designated by the president of DCUE pursuant to Section 6.01 hereof.
- 2.12 “ Plan Year” means the twelve month period commencing September 1 and ending August 31.
- 2.12 “Change of Employment” status means your employment status has changed to termination, resignation, leave of absence, separated or divorced, disability, or death.

ARTICLE III
Eligibility

- 3.01 Each full-time employee who is covered in the Agreement between ISD 196 and DCUE, and enrolled in the Fund, is eligible to participate effective September 1 or any mid-year hire date, according to the Collective Bargaining Agreement between ISD 196 and DCUE.
- 3.02 Dependent and Retirement Coverage
 - A. Spouses are covered, if enrolled.
 - B. Dependent children will be covered to age 26.
 - C. Foster children: Anyone who is a foster child but who is not covered by a federal, state, or county insurance program is eligible for coverage by the DCUE Dental Reimbursement Fund.
 - D. District Employees who retire and/or their retired dependents are eligible for coverage at their own expense until the former employee is entitled to Medicare. (See Appendix C – COBRA Benefits & HIPPA Regulations)
 - E. If continuation of coverage is elected as Retiree with Dependents there are two times which you are able to switch to Single Coverage.
 - 1. A Qualifying Event occurs. (see Appendix C-Continuation of Rights under COBRA)
 - 2. A new plan year begins. There cannot be a lapse in payment between current plan year and new plan year.

- 3.03 Special Coverage Situations (where applicable, see Appendix C - COBRA Benefits & HIPPA Regulations).
- A. Job Share employees are eligible for coverage according to the language in the Collective Bargaining Agreement that states that eligible members are covered but must pay 1/2 of the premiums of dental insurance as set by ISD 196, and the Collective Bargaining Unit. Payments are due the first of the month.
 - B. Part-time district employees: Employees who work less than .75 FTE are NOT eligible for this Fund unless an exception is addressed in the Collective Bargaining Agreement.
 - C. District employees who experience a change in status may continue coverage via COBRA.
 - D. Enrolled dependents who have reached age 26 may continue coverage via COBRA.
 - E. Leave of Absence employees may continue coverage, by paying the full premium, until they return to work or have a change in status.
 - F. Leave of Absence employees who did not continue coverage at the time of election may be allowed back into the plan by Board of Trustee approval. If approved by the Board the member may rejoin at the start of a new plan year (September 1) if they have completed their online enrollment, continuation of coverage election notice and paid for September's premium by August 31st.
- 3.04 Participation in the Fund may thereafter be renewed upon satisfaction of the requirements contained in Section 3.01 hereof.

ARTICLE IV

Benefits

- 4.01 An enrolled Participant shall be entitled to benefits under this Fund.
- 4.02 Benefits under the Fund shall take the form of reimbursement by the DCUE Dental Reimbursement Fund for certain expenses for dental care incurred by a Participant for himself/herself, in accordance with Appendix A - Benefit Program.
- 4.03 A Participant desiring to receive benefits under the Fund shall submit a written request for reimbursement on the DCUE Dental Reimbursement Fund Claim Form (see Appendix B - Forms). The request must be received at the DCUE Dental Office (located within the DCUE office), either through U.S. Mail/District mail, or drop-off, within sixty (60) days of the date the expense

was incurred (the Treatment Date) and within thirty (30) additional days after payment by a Primary Insurance. The Claim Form must include the following:

- A. Employee name, employee number, and address. If both spouses work in the district both names, employee numbers, and birth dates must be included. Mark notification of new address;
- B. Name of patient and relationship to employee, using given names and middle initials to avoid confusion;
- C. Affirmation that the Participant has not been reimbursed and is not entitled to reimbursement for the expense by other dental or medical coverage. Be sure to check with medical coverage on claims for Oral Surgery and impacted wisdom teeth. The claim should not be filed until after the primary has paid. An Explanation of Benefits from the primary must be included;
- D. The actual paid amount of the expense for which reimbursement is required (the charges, minus discounts, write-offs, and primary insurance payments);
- E. The specific treatment received (orthodontic costs must be specifically identified as such, along with month(s) covered by the payment, or other items such as records, down payments, and retainers);
- F. The treatment date, or the date of payment for Orthodontics;
- G. The name of the person, organization or entity to whom the expense was paid (i.e. the dental office), address, and telephone number;
- H. Indication that Patient IS or IS NOT covered under another dental or medical program; along with attaching proper supporting documentation (see Appendix A-2.0);
- I. Participant's signature and the date on the Claim Form as affirmation that the payment has been made, and has not been claimed under any other insurance plan.

Providing fraudulent information will result in immediate termination from this Fund.

4.04 It is necessary that the Participant actually pay an expense prior to being reimbursed for it under the Fund. If a Participant requests reimbursement for an expense, he/she shall submit a reimbursement Claim Form and a copy

of an itemized statement/ledger. The Claim Form must be completely filled out and signed by the Participant. This must be submitted along with the statement/ledger showing the patient name and relationship to employee, the treatment date, the charges, the discounts, the primary insurance payments and write-offs, if applicable, and the payment of the actual amount incurred. The DCUE Dental Reimbursement Fund will make reimbursements solely to the Participant.

- 4.05 No expenses will be reimbursed from this Fund if the Participant incurring the expense has been reimbursed for it under another insurance policy or otherwise. If a Participant received benefits under this Fund for a claim then receives benefits from any other source at any time, s/he shall remit such benefits to the DCUE Dental Reimbursement Fund that exceed 100% of the actual covered charges.
- 4.06 Participants and their dependents covered under another insurance plan must file under that plan first. In such instances as both plans are direct reimbursement, the spouse whose birthday falls first in the calendar year will have their coverage considered the primary dental coverage. Any portions NOT covered under one plan may be submitted for reimbursement under the other plan.
- 4.07 Except as may otherwise be determined by the DCUE Dental Reimbursement Board of Trustees, benefits paid to or for a Participants for expenses incurred during any one plan year shall not exceed the ANNUAL maximum.
- 4.08 If participant in the Fund has for any reason terminated and is not covered under COBRA:
 - A. No benefits shall be paid for expenses incurred after the date of such termination;
 - B. Unless the former Participant was discharged from employment for cause, requests for reimbursement may be made after the date of such termination for expenses incurred prior to such date.

ARTICLE V

Funding

- 5.01 The DCUE Dental Reimbursement Fund shall be funded by contributions as determined by the Collective Bargaining Agreement between DCUE and ISD 196. The DCUE Dental Reimbursement Board of Trustees shall hold such contributions in a segregated account that shall be used solely to satisfy claims submitted by Participants and pay expenses for the operation of the Fund.

Benefits shall be paid to a Participant upon the submission and approval of a claim for benefits pursuant to the claim procedures set forth in Article VII.

- 5.02 For participants on COBRA or not otherwise employed in ISD 196, the cost does include a 2% minimum administrative fee, which is authorized by law and subject to change if the premium cost to the school district should change.

ARTICLE VI

Fund Administrator

- 6.01 The Fund Administrator is hereby designated by the president of DCUE to serve until resignation or removal by the president of DCUE and appointment of a successor by duly adopted resolution of the DCUE Dental Reimbursement Fund Board of Trustees. The Fund Administrator shall have the authority to control and manage the operation and administration of the Fund.
- 6.02 The Fund Administrator shall provide, upon request to each Participant receiving benefits under the Fund for each plan year, copies of all documents required under the Code to be furnished to such persons.

ARTICLE VII

Claims Procedures

- 7.01 A Participant shall make a claim for benefits by submitting a Dental Reimbursement Fund Claim Form in accordance with section 4.03.
- 7.02 If a claim is wholly or partially denied, notice of decision, in accordance with section 7.03 shall be furnished to the claimant within a reasonable period of time, not to exceed sixty (60) days after receipt of the claim by the DCUE Dental Reimbursement Fund office, unless special circumstances require an extension of time for processing the claim. If such an extension of time is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date on which the Fund Administrator and the DCUE Dental Board of Trustees expect to render a decision.
- 7.03 The Fund Administrator shall provide every claimant who is denied claims for benefits written notice setting forth, in a manner to be understood by the claimant, the following:
- A. A specific reason or reasons for denial;
 - B. Specific reference to pertinent Fund provisions upon which the denial is based;

- C. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- D. An explanation of the Fund's claims review procedures, as set forth in sections 7.04 and 7.05 below.

7.04 The purpose of the review procedure set forth in this section and in section 7.05 is to provide a procedure by which a claimant under the Fund may have reasonable opportunity to appeal a denial of a claim to the DCUE Dental Reimbursement Board of Trustees for a full and fair review. To accomplish that purpose, the claimant, or his/her duly authorized representative, may:

- A. Request review upon written application to the Fund Administrator using the Request for Review of Claim Reimbursement form (see sample in Appendix B - Forms);
- B. Review pertinent Fund documents, and
- C. Submit issues and comments in writing.
- D. A claimant, or his/her duly authorized representative, shall request a review by filing the above mentioned form for review with the Fund Administrator at any time within ten (10) working days after receipt by the claimant of written notice of the denial of his/her claim.

7.05 Decision on review of a denied claim shall be made in the following manner:

- A. The decision on review shall be made by the DCUE Dental Reimbursement Board of Trustees who may, at their discretion, hold a hearing on the denied claim. The DCUE Dental Reimbursement Fund Board of Trustees shall make their decision to 1) assess a late fee of 20% of the claimed amount, or 2) pay the claim amount in full as per schedule, or 3) deny the claim in full. If special circumstances require extension of time for processing in which case a decision shall be rendered as soon as possible, but not later than one hundred and twenty (120) days after receipt of the request for review. If such an extension of time for review is required, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.
- B. The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, and specific reference to the pertinent Fund provisions.

- 7.06 If a dispute arises with respect to any matter under this Fund, the Fund Administrator may refrain from taking any other or further action in connection with the matter involved in the controversy until the dispute has been resolved.

ARTICLE VIII

Miscellaneous

- 8.01 The Trustees have the authority to determine eligibility for benefits and construe the terms of the Plan, all Plan documents, rules, and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the Trustees that the decision will be upheld unless it is determined to be arbitrary or capricious.

The Trustees have the authority to change the eligibility rules and other provisions of the Plan; to amend, increase, decrease or eliminate benefits; and to terminate the Plan, in whole or in part. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them.

- 8.02 This Fund shall be effective as of September 1, 1996, amended August 15, 1998, amended August 15, 2003, amended the October 1, 2006, amended September 1, 2010, amended September 1, 2011, amended September 1, 2014, amended September 1, 2018, and amended September 1, 2019.
- 8.03 This Fund shall not be deemed to constitute a contract between ISD 196 and DCUE and any Participant or to be a consideration or inducement for the employment of any Participant or employee. Nothing contained in this Fund shall give any Participant or employee the right to be retained in the service of ISD 196 or to interfere with the right of ISD 196 to discharge any Participant or employee at any time, regardless of the effect that such discharge shall have upon him/her as a Participant of this Fund. However, the foregoing shall not be deemed to modify the provision of any collective bargaining agreements that may be made by ISD 196 with DCUE.
- 8.04 This Fund shall be construed and enforced according to the laws of the state of Minnesota to the extent not preempted by any federal law.

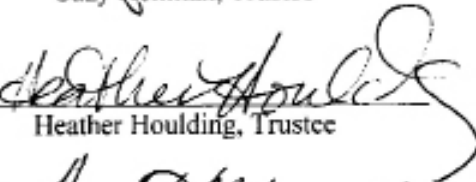
Dated this 1st day of September, 1996, and amended the 15th day of August, 1998, amended the 15th day of August, 2003, amended the 1st day of October 2006, amended the 1st day of September, 2010, amended the 1st day of September 2011, amended the 1st day of September 2014, amended the 1st day of September 2015, and amended the 1st day of September 2018, and amended the 1st day of September 2019.

**Dakota County United Educators
Dental Reimbursement Board of Trustees**

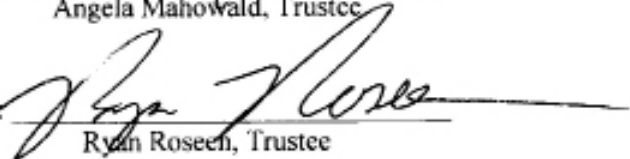
By: 
Kate Schmidt, DCUE President

By: 
Justine Kolb, Fund Administrator

By: 
Suzy Neilman, Trustee

By: 
Heather Houlding, Trustee

By: 
Angela Mahowald, Trustee

By: 
Ryan Rosech, Trustee

By: 
Peggy Ringgenberg, Trustee

By: 
Emma Ryan, Trustee

This side intentionally blank.

DCUE Dental Reimbursement Fund

Appendix A Benefit Program

Benefit Program

1.0 Overview

The DCUE Dental Reimbursement Fund (the Fund) is a direct reimbursement program for teachers and nurses, managed by the Dakota County United Educators (DCUE) as stated in the Collective Bargaining Agreement between ISD 196 and DCUE. The Fund is financially supported by ISD 196 through its monthly premium payments per full time employee. The monthly premium covers the employee and any eligible dependents enrolled in the program. There are no out-of-pocket premiums paid by the employee. Job Share employees pay one-half the premium if they elect to carry dental coverage. Employees working less than .75 FTE (other than Job Share) are not eligible to participate in the Fund.

1.01 With the DCUE Dental Reimbursement Fund:

- A. Participants are free to go to the dentist/orthodontist of their choice.
- B. All Dental treatment is covered, except for certain cosmetic procedures including but not limited to, bleaching, take-home dental products, and medications. Typically, there are no restrictions on pre-existing conditions.
- C. Participants are reimbursed AFTER submitting an itemized statement showing proof of payment and any documentation from primary insurance, along with the completed DCUE Dental Reimbursement Fund Claim Form. This eliminates excessive paperwork and long waiting periods for reimbursement.
- D. Participants know what their reimbursement will be before going to the dentist, based on the Annual Benefits per Individual payout structure (see next page).
- E. Funds budgeted to pay claims earn interest until claims are paid rather than going into the bank account of an insurance company.
- F. There are no preauthorization requests from insurance companies.
- G. A greater portion of dental care dollars goes to actual treatment.

1.02 Using the DCUE Dental Reimbursement Fund

- A. When you visit your dentist make sure you receive a complete itemized statement. See filing information on the back of the Claim Form or under the Dental tab on the website.

- B. If you have other dental coverage as your Primary Dental Insurance, your dental provider should file through them first. When the Primary has paid their portion of the claim, you must pay any remaining balance due (within 30 days) and then submit this balance to the Fund for payment according to the filing instructions.

1.03 Annual Benefits Per Individual

The maximum yearly payable benefit for dental claims per individual is \$1,325. There is a maximum lifetime orthodontic benefit of \$2,000 per individual under age 26. The Lifetime Maximum amount represents benefit received in reimbursement.

Your annual *dental claim* reimbursements are calculated based on dental claims incurred with treatment dates of September 1 through August 31, according to Figure 1:

	Claim Amount	Percentage Covered	Reimbursement
First \$500	\$0 to \$500	100%	\$500
Next \$300	\$501 to \$800	75%	\$225
Last \$1200	\$801 to \$2,000	50%	\$600
Total Claimed: \$2,000.00		Total Reimbursed: \$1,325	

Figure 1: Annual Dental Claim Benefit Reimbursement Scale

Your lifetime *orthodontic claim* reimbursements are calculated based on orthodontic payments, according to Figure 2:

	Claim Amount	Percentage Covered	Reimbursement
First \$2,000	\$0 to \$2,000	100%	\$2,000
Total Claimed: \$2,000.00		Total Reimbursed: \$2,000	

Figure 2: Lifetime Orthodontic Benefit Reimbursement Scale

Individuals are eligible for orthodontic reimbursement until the last day of the month in which they turn 26 years old.

Orthodontic payments must be submitted within the appropriate plan year to be reimbursed.

All medically necessary dental and orthodontic procedures are considered covered dental expenses when provided by or under the direction of a dentist or other specialized dental provider who is licensed by the state in which s/he practices.

The DCUE Dental Reimbursement Fund reimburses you for charges that are not paid by another insurance program. If you have coverage through any other dental plan or form of insurance, you must first submit your expenses to those plans before submitting any remaining expenses to this Plan for reimbursement.

1.04 Claim Form Filing Information

- A. Submit a separate Claim Form for each individual, filling in all appropriate spaces. Omitting information will delay reimbursement.
- B. Submit a separate Claim Form for each date of treatment.
- C. Provide BOTH a completed Claim Form and a statement from the provider showing date of treatment, patient, specific work done, charges, and payment(s) made, as required by our auditors. If primary insurance is involved, include the EOB that they provide to you.
- D. Claims MUST be filed within sixty (60) days of the treatment date, or MUST be filed within an additional thirty (30) days from the date of treatment, if your primary insurance provider is other than the DCUE Dental Reimbursement Fund. Late claims are processed on 80% of amount claimed. Claims filed after sixty (60) days past the end of the plan year (August 31) will be denied. Absolute deadline is October 31st.
- D. Send Claim Form to: DCUE Dental Reimbursement Fund either through District mail or through the U.S. Mail to: DCUE Dental Reimbursement Fund, 6950 146th St W Ste 114, Apple Valley MN 55124, or submit in person at the DCUE office.
- E. Reimbursement checks will be made payable to the district employee, and will be distributed through U.S. Mail to your home address. Please notify the DCUE Dental Reimbursement Office of any changes in address.
- F. A reimbursement check will be considered forfeited if the check has been outstanding for at least six (6) months, the member has not responded to notifications of outstanding check and the original amount of the check is under \$250.01. If the original check is issued for \$250.01 or more then the un-cashed check will follow state guidelines for unclaimed property. Additional fees may apply to claiming your property.
- G. If you have any questions regarding your claim, please call the DCUE Dental Reimbursement office at 952-432-4033.

2.0 Samples of Claim Form Supporting Documentation

- A. Figures 1, 2, and 3 are samples of itemized statements and ledgers from dental offices. Simple charge slips, receipts, and copies of checks are not adequate for proof of payment. Shown are the kind of statements now required to be attached to your Claim Form as proof of dental procedures completed and payment made for that work. If your statement/ledger shows payment, a separate receipt is not necessary. If multiple family members' claims are made at the same time, one statement with all necessary information for each patient is adequate.

- B. Figure 4 is an example of an Explanation of Benefits from a primary

Dentist/Dental Office Name and Address					STATEMENT OF SERVICES RENDERED		
					Monday August 10, 1998		
ACCOUNT NAME AND ADDRESS					ACCOUNT NUMBER		
Participant Name and Address							
PATIENT	CODE	DESCRIPTION	TH.	SURF.	AMOUNT	TAX	EST. INS
Thomas	150	Comprehensive Oral Evaluation			24.00		24.00
Thomas	1110	Adult Prophylaxis			49.00		49.00
Thomas	50	Insurance Write Off			2.19CR		
Thomas	3	Check Payment-thank You!			70.81CR		
PREVIOUS ACCOUNT BALANCE		TODAY'S CHARGES	TODAY'S TAX	TODAY'S PAYMENTS	NEW ACCOUNT BALANCE	OUTSTANDING INSURANCE	PLEASE PAY THIS AMOUNT
0.00		70.81	0.00	70.81	0.00	73.00	0.00
Next Appt.	Day	Date	Time	Reason			

Figure 1: Sample dental office statement shows patient information, including date of service, patient name, description of treatment, amount charged, amount credited (paid) and balance due (in this case zero).

OFFICE OF: PROVIDER INFORMATION:

Dentist/Dental Office Name and Address **Dentist/Dental Office Name**
State License #:

STATEMENT FOR:

Participant Name and Address Date: 08/11/1998
Acct. No.:

Date	Name Proc. Code	Description	Tooth No.	Charges
08/11/1998	K 00120	Recall Patient Exam		28.00
08/11/1998	K 01110	Prophylaxis-Adult		53.00
08/11/1998		MINNESOTA HEALTH CARES TAX		0.42
08/11/1998		MINNESOTA HEALTH CARES TAX		0.80
08/11/1998	K 9	Credit Card Payment, Thank you.		-78.11
08/11/1998	K 38	Discount for Payment in Full		-4.11
-----			Total Due:	0.00

Figure 2: Sample dental office statement shows patient information, including name, date of treatment, charges, credits and total due, if any.

Dentist/Dental Office Name and Address

PATIENT TRANSACTIONS
From 07/06/98 to 07/28/98

ACCOUNT : **Participant Name**

PATIENT : **Patient Name**

DATE	PATIENT	ID	CODE	DR	PR	I	SUBL	DESCRIPTION	PROD.	CHARGES	CHG ADJ.	PAYMENT	PAY. ADJ.	BALANCE
07/06/98	Jessica	132002	120	40	40	A		Periodic Oral Examinal	25.00					25.00
07/06/98	Jessica	132002	220	40	42	A		Periapical-First Film	20.00					45.00
07/06/98	Jessica	132002	230	40	42	A		Periapical-Each Additio	15.00					60.00
07/06/98	Jessica	132002	230	40	42	A		Periapical-Each Additio	15.00					75.00
07/06/98	Jessica	132002	230	40	42	A		Periapical-Each Additio	15.00					90.00
07/06/98	Jessica	132002	274	40	42	A		Four Decay Detecting Fl	35.00					125.00
07/06/98	Jessica	132002	1110	40	42	A		Adult Prophylaxis	60.00					185.00
07/28/98	Jessica	132002	3	40		A		Check Payment-thank You				185.00		0.00
PATIENT TOTALS:									185.00	0.00	0.00	185.00	0.00	

Total tax on productions and charges \$ 0.00

**The above totals reflect only those transactions during the dates selected.

The full account balance is: 0.00.
The full patient balance is: 0.00.

Account BP Balance \$ 0.00

Figure 3: Sample dental office ledger shows patient transactions over a specific time period. Ledgers and statements may contain information for more than one patient.



DELTA DENTAL PLAN OF MINNESOTA
 7807 CREEKRIDGE CIRCLE, P.O. BOX 330
 WINNEAPOLIS, MN 55440
 FOR INQUIRIES CALL MNI 612-944-0391 (MPLS/ST.PAUL)
 OR 1-800-553-9536

ASSOCIATED CHECK NO.
 DATE 07/20/98

EXPLANATION OF BENEFITS
 THIS IS NOT A BILL



TO

Participant Name
 and Address

PROVIDER NAME ORAL MAXILLOFACIAL SURG
 PROVIDER ID 410962917-248 (B.C.#003381)
 CLAIM NO. GROUP NO.

TOOTH NO.	DATE SERVICE COMPLETED	PROCEDURE CODE	PROCEDURE DESCRIPTION	AMOUNT SUBMITTED	AMOUNT ALLOWED	DEDUCTIBLE	CO PAY %	PATIENT RESPONSIBILITY	PLAN PAYMENT	*NOTES
05	07/02/98	07110	EXTRACTION SINGLE	130.00	87.10	25.00	90	31.21	55.89	
12	07/02/98	07120	EXTRACTION ADDL	85.00	70.40	0.00	90	7.04	83.36	
21	07/02/98	07120	EXTRACTION ADDL	85.00	70.40	0.00	90	7.04	83.36	
28	07/02/98	07120	EXTRACTION ADDL	85.00	70.40	0.00	90	7.04	83.36	
	07/02/98	00140	LIMITED ORAL EVAL	28.00	28.00	0.00	100	0.00	28.00	22
	07/02/98	09899	UNSPECIFIED, REPORT	18.00	0.00	0.00	0	0.00	0.00	40
CHECK NO. 0091814341 PLAN 024				427.00	324.30	25.00		52.33	271.97	

ISSUE DATE 07/20/98
 FOR CUSTOMER SERVICE REGARDING BENEFIT INFORMATION, ELIGIBILITY OR TO CHECK CLAIMS STATUS PLEASE CALL (612)944-0391 OR (800)553-9536.
 *A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.
 *WHETHER PAYMENTS INCREASE HEALTH CARE COSTS IF YOU WISH TO REPORT ANY INSTANCES OF SUSPECTED FRAUD, ABUSE OR WASTE OF HEALTH CARE BENEFITS PLEASE CALL THE PROFESSIONAL SERVICES DEPARTMENT. ALL INFORMATION RECEIVED IS CONFIDENTIAL.
 REVIEW AND APPEAL PROCEDURE: WITHIN 90 DAYS RECEIPT OF THIS VOUCHER YOU MAY MAKE A WRITTEN REQUEST FOR THE REVIEW OF ANY DENIED SERVICES. YOUR REQUEST MUST STATE YOUR BASIS FOR RE-EVALUATION AND INCLUDE THE CLAIM NUMBER, YOUR NAME, THE EMPLOYEE'S SOCIAL SECURITY NUMBER AND GROUP NUMBER.

SUBSCRIBER NAME
 SUBSCRIBER ID#
 PATIENT NAME
 DATE OF BIRTH
 RELATIONSHIP

*NOTES
 22 PROCEDURE PROCESSED PER LIMITATION OF GROUP CONTRACT.
 40 CHARGES FOR THIS PROCEDURE WHEN SUBMITTED SEPARATELY FROM THE CHARGE FOR THE COMPLETE PROCEDURE ARE NOT BENEFITTED.

Figure 4: Sample Explanation of Benefits from a primary insurance provider shows patient information including name, treatment date, amount submitted for payment, amount allowed (covered) and amount of patient responsibility (this is the amount that you can then submit to DCUE Dental Reimbursement fund).

DCUE Dental Reimbursement Fund

Appendix B Forms

- ☐ Home
- ☐ Clinic Staff
- ☐ Dental
- ☐ Benefits
- ☐ Members
- ☐ Directors

DAKOTA COUNTY UNITED EDUCATORS



DCUE Dental Reimbursement Fund

685 West 140th Street Suite 114, Apple Valley, MN 56204 (507) 436-6888 MO: 100 Teachers & Homes

2018-2019 Enrollment Form

Employee Information:

Employee ID Number:	Last Name	First Name	MI	Date of Birth	Sex (M)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		City	State	Zip	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Phone Number: <input type="text"/>					
Recently Own/Original HSA Date: mm/yy/yyyy		Is your spouse an employee of the district AND eligible for coverage in the DCUE collective bargaining unit? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="text"/>		<input type="text"/>			

Spouse/Dependent Information:

Dependent	Last Name	First Name	MI	Date of Birth	SSN/POB
Spouse	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other Dependents	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

My initials constitute a request for participation in the DCUE Dental Reimbursement Fund. My initials certify that all information provided is true and accurate. Omission of information or provision of false information may result in forfeiture of my eligibility for myself and any dependents enrolled in the Fund.

Employee ID#
 Initials: Please type initials here. Date: 08/28/18

Sample Online Enrollment Form

DCUE Dental Reimbursement Fund**Claim Form**

6950 146th Street W. #114, Apple Valley, MN 55124 (952) 432-4033 ISD 196 Teachers, Nurses & Counselors

Complete ALL applicable fields- see page 2 for filing information

Section 1: Employee Information

Employee #1 ID Number:	Last Name:	First:	Date of Birth:	School:	CEBRA YES / NO
Employee #2 ID Number:	Last Name:	First:	Date of Birth:	School:	CEBRA YES / NO
<input type="checkbox"/> Mark here if near address		Address:		City:	State: Zip:

Section 2: Dental OR Orthodontic Treatment Information

Name of Patient: <small>(see patient per claim form)</small>	Relationship to Employee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> The dependent child (label is any natural, step, adopted or foster child).
<u>Dental Only</u> Date of Treatment: _____ <small>(see date of treatment per claim form)</small>	*Amount paid by Participant: _____ <small>**Amount paid by participant* is the final charges you are responsible for after insurance payments, discounts and adjustments have been made.</small>
<u>Ortho Only</u> Date of Payment(s): _____ <small>(multiple payments per claim form is acceptable)</small>	Amount of ortho Payment(s): _____ <input type="checkbox"/> But ortho claim submission; copy of treatment plan is attached
Name of Dental Provider/Office: _____ Dental Provider Phone: _____	

Section 3: Coverage Verification

Choose One

Patient IS NOT covered under another dental or medical program, other than DCUE Dental Reimbursement Fund, for the treatment claimed on this claim form.

Patient IS covered under another dental or medical program, other than DCUE Dental Reimbursement Fund, for the treatment claimed on this claim form.

Section 4: Supporting Documentation Required

Required

I have attached an itemized statement showing name of patient, date of treatment, specific treatment completed, charges, and payments made for which I am requesting reimbursement.
*Required if Insurance Applies **See Claim Form Filing Information

I have attached the Explanation of Benefits from the primary insurance provider or other reimbursement plan for the treatment claimed on this claim form.

I certify that the charges for which I am requesting reimbursement are not covered under any other dental or medical insurance, and that they have been paid and are accurate. In addition, I understand that my claim will be returned if ALL required documentation is not attached.

Signature of ISD 196 Employee: _____ Date: _____

January 1, 2013

Sample Claim Form

DCUE Dental Reimbursement Fund *Claim Form Filing Information*

Submit a separate Claim Form for each individual.
Submit a separate Claim Form for each date of treatment.

Claims **MUST** be filed within sixty (60) days of the treatment date, or **MUST** be filed within an additional thirty (30) days from the date of treatment, if your Primary Insurance Provider is other than DCUE Dental Reimbursement Fund. Late claims are processed on 80% of amount claimed. Call to explain special circumstances. Claims filed after sixty (60) days past the end of the Plan Year (August 31) will be denied. Absolute deadline is October 31st.

If you have not paid your bill in full- Contact our office prior to submitting your claim to discuss your situation.

Send this Claim Form to the DCUE Dental Reimbursement Fund either through school district interoffice mail or through U.S. Mail.

DCUE Dental Reimbursement Fund
8850 148th Street West, #114
Apple Valley, MN 55124

Reimbursement checks will be made payable to the district employee, and will be distributed through U.S. Mail to your home address. If you have any changes in name(s), address or additions to family complete and send in a Member Change Form found at www.dcue.org, under the Dental Tab.

If you have any questions regarding your claim, please call the DCUE Dental Reimbursement office at (852) 432-4033 or email at dental@dcue.org.

Employee #1 – if you are the ISD 106 employee who has benefit coverage under the DCUE Dental Reimbursement Fund, your name and information goes here. Your identification number is required to process.

Employee #2 – if both spouses are ISD 106 employees with benefit coverage under the DCUE/ISD 106 Collective Bargaining Agreement, the second employee's name and information must be provided to get the dual coverage. Both employee numbers are required.

Address – list current address of employee. Mark the appropriate box if this is a new address.

Name of Patient – list the first name (and last name if different from Employee #1) of the patient for whom dental reimbursement is requested on this form. Do NOT list more than one patient on a claim form.

Relationship to Employee – specify if this Claim Form is filed for yourself, your spouse or your child and check box when appropriate.

Date of Treatment – date of dental visit for treatment requesting reimbursement on this claim form. Do NOT list more than one date of treatment on a claim form.

Amount Paid by Participant – actual payment made for treatment specified on itemized statement, minus any expenses the plan does not cover (i.e. discounts, bleaching/whitening products or take-home products).

Date Ortho Payment(s) – date payment was actually made. Multiple payments can be on one claim form.

Amount of Ortho Payment(s) – amount of payment made or the total of multiple payments. Check box if this is the first ortho claim submitted for that individual; if yes, attach a copy of the treatment plan from orthodontist.

Name of Town of Dental Provider/Office – specify requested information for processing and follow-up if necessary.

A check mark indicating whether you are covered under another dental or medical program is required for processing.

A complete itemized statement showing name of patient, date of treatment, specific treatment completed, charges, and payments actually made must be attached.

***Required if Insurance Applies:** If patient is covered by a primary insurance, such as Delta Dental, Blue Cross-Blue Shield, or another reimbursement plan, you must attach a copy of the Explanation of Benefits (EOB) from the insurance/other provider. EOB is specific to date of treatment and individual requesting reimbursement for.

Signature of ISD 106 Employee / Date – signature is required for processing. Specify the date this Claim Form was completed.

Sample Claim Form, Side 2



DCUE Dental Reimbursement Fund
 6950 146th St West Suite 114
 Apple Valley, MN 55124
 (952) 432-4033

United Educators CU
 Woodbury, MN 55125
 22-7808-2980

142075

DATE
 6/26/2018

AMOUNT
 ***\$89.41

PAY EIGHTY NINE DOLLARS and FORTY ONE CENTS

Claim #: 2018062600 PCN:

PAY TO THE ORDER OF

Members Name
 Members Address on file

... COPY ...

⑆0⑆④②0⑆5⑆ ⑆0000⑦608④⑆ ⑦0009030②268⑆

Employee Explanation of Benefits Statement

Employee: Members Name	Facility/Group Name:
Employee ID: 00000	Provider/Dept Name: Dental Office
Patient Name: (ID.)	First Date of Service: 6/26/2018
Group Name: DCUE DENTAL PARTICIPANT	Last Date of Service: 6/26/2018
Unit Name: DCUE DENTAL PARTICIPANT	Claim No: 2018062600
Print Date: 6/26/2018 1:16:43 PM	Check No: 142075

Services or Benefit Description	Billed Charges	Allowed or Contract Amt	Expl. Code	Copay	Employee Deductible	Total Covered Expenses	Plan Pays	Payable By Plan	Your Responsibility
Preventative	152.29	152.29	TIE	0.00	0.00	152.29	Tier	89.41	62.87
Explanation of Codes:	152.29	152.29		0.00	0.00	152.29		89.41	62.87

TIE: Benefit paid according to plan tiers

	Min	Max	Percent
Tier 1	0.00	500.00	100%
Tier 2	500.01	800.00	75%
Tier 3	800.01	1200.00	50%
Ortho	0.00	2000.00	100%

Other Comments

This individual has \$ _____ in Annual Dental benefits remaining. This individual has \$ _____ in Lifetime Ortho benefits remaining.

Sample DCUE Dental Explanation of Benefits



DCUE Dental Reimbursement Fund
@950 146th Street W Ste 114
Apple Valley, Minnesota 55124
952-432-4033 • dental@dcue.org

Members Name
Members Address

June 28, 2018

Re: Denial of Recently Submitted Claims

It is necessary to deny and return the attached claim(s) without processing. Each Plan Year includes dental service dates from September 1 through August 31 (like the school year). All claims for a given plan-year must be received on or before the end of the 60 day grace period, which is October 31.

All claims for the Plan Year beginning 9/1 and ending 8/31 must meet the following 3 criteria:

- 1) include properly completed claim forms,
- 2) include all required supporting documentation and
- 3) be received on or before October 31.

One or more of the previously stated criteria is missing.

If you would like to appeal the decision to deny this claim, please complete the Request for Review of Claim Reimbursement form included. Kindly return it, with your claim, within 10 working days from the date of this letter. We will review all appeals at the next scheduled Dental Board of Trustees meeting. You will be notified, in writing, of the Board's decision.

Next Board meeting is scheduled to be held:

Please be aware: should the Board decide in your favor, this claim will be paid using current Plan Year money, as the previous Plan Year books have been officially closed for auditing.

Please call if you have any questions.

Thank you.

Sincerely,

Justine Kolb
Fund Administrator
DCUE Dental Reimbursement Fund

Sample Claim Denial Letter

Request for Review of Claim Reimbursement

Date: _____

Employee: _____ Employee #: _____

I hereby request a review of the decision for denial of claim according to plan guidelines, and request that the following information be considered:

(Signature of Employee)

(Date)

PLEASE READ: Requests for Review must be filed within ten working days of receipt of this letter. A Board decision will be made as promptly as possible, depending on scheduled Board of Trustees meetings. The Board will either, 1) assess a late fee of 20% of the claimed amount, 2) pay in full as per schedule, or 3) deny in full, depending on circumstances as described on this appeal form. After Board review, the decision will be delivered to you, in writing, setting forth specific reasons for this decision. The Board decision will be final. *Please be aware: should the Board decide in your favor, this claim will be processed using current Plan Year money, as the previous Plan Year books have been officially closed for auditing.*

Sample Request for Review of Claim Reimbursement Form



DCUE Dental Reimbursement Fund
 6950 146th St West Suite 114
 Apple Valley, MN 55124
 (952) 432-4033

Members Name _____
 Members Address _____

Date of Notice: 6/25/2018
 Qualifying Event: Resignation
 Date of Qualifying Event: 7/25/2018
 Dental Coverage Ends on: 7/31/2018

Due to the qualifying event stated above, your dental coverage and dependent coverage (if applicable) will terminate on the date stated above. You have the option to maintain your group dental benefits for 18 months, in accordance with COBRA, or until you obtain coverage under another group plan, whichever is shorter. You may continue your coverage if:

1. This notice is signed and returned within 60 days of the date of this notice, AND
2. Your premium payment is made within 45 days of electing to continue benefits.

Cost Per Month: \$ _____ Continuation Begins on: 8/1/2018 Coverage May Continue Thru: 1/31/2020

The first premium payment must cover all months that are current and past. Please make checks payable to DCUE Dental Reimbursement Fund.

Please send your payment and this election form to:
 DCUE Dental Reimbursement Fund
 6950 146th Street West, Suite #114
 Apple Valley, MN 55124

Future payments are due by the 1st of the month of coverage. Failure to make future payments within 30 days of the date due will result in loss of coverage.

Please check the appropriate spaces and sign

- _____ I DO NOT elect to continue dental coverage through DCUE Dental Reimbursement Fund.
 _____ I elect to continue dental coverage through DCUE Dental Reimbursement Fund.
 _____ Premium enclosed (\$ _____ per month) for months that are current and past.

Signature: _____ Date: _____ Employee #: _____
 Permanent Address: _____
 _____ Phone: _____

Sample Notice of Right to Continue Dental Benefits Letter: COBRA 18 Months of Coverage



DCUE Dental Reimbursement Fund
6950 146th Street West #114
Apple Valley, Minnesota 55124
952-432-4033 dental@dcue.org

Members Name
Members Address

June 28, 2018

Employer ID: 99999

Re: Expiration of Coverage Warning

This letter is being sent as a courtesy to remind you that your dental coverage, through DCUE Dental Reimbursement Fund, will be expiring on 8/31/2018.

Dental claims with a treatment date on or prior to your coverage expiration date can and should be submitted within 60 days. Outstanding dental claims are subject to the same late penalty guidelines and deadlines.

For your records, your monthly premium is \$_____ and as of today you are paid thru _____. If you have a balance due, your prompt payment is appreciated.

If your payments are made automatically, through your financial institution, please be sure to cancel them.

Please contact me if you have any questions.

Thank you,
Sincerely,

Justine Kells
Fund Administrator
DCUE Dental Reimbursement Fund

Sample Expiration of Coverage Letter

This side intentionally blank.

DCUE Dental Reimbursement Fund

Appendix C **COBRA Benefits and HIPPA Regulations**

insurance company. This must be attached to all claims for which primary insurance paid first, and are proof of when that payment was made.

IMPORTANT INFORMATION

CONTINUATION OF DENTAL COVERAGE

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Federal law requires that most employers sponsoring group health and dental plans offer employees and their families the opportunity for a temporary extension of health and/or dental coverage (called “Continuation of Coverage” or COBRA) at group rates in certain instances where coverage under the Fund would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation of coverage provisions in the law.

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 you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

COBRA Qualifying Events

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 than 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."

COBRA continuation coverage is a 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 coverage 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 Fund 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. You must provide notice to the Fund Administrator within 60 days of the Social Security Disability Administration Determination of Disability. Additionally, you must provide a copy of the Social Security Administration

determination of disability to receive the disability coverage extension.

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 to 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.

Notice must be provided to the Fund Administrator within 60 days of the occurrence of one of the above noted events. In providing notice, you must provide documentation in support the occurrence of the event. For example, in case of a divorce, a copy of the divorce decree or other document supporting the occurrence of the divorce must be provided. In case of a loss of dependent status, documentation supporting the loss of dependent status must be provided to the Fund Administrator.

Notification Responsibilities – From Employer

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund 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, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Fund Administrator within 30 days of the qualifying event.

COBRA Notification Responsibilities – From Employee

When the qualifying event is 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 Fund Administrator within 60 days after the qualifying event occurs. In providing notice, you must provide documentation to support the occurrence of the qualifying event. In case of a divorce, you must provide a copy of a divorce decree or similar document evidencing the divorce is final, or in the case of loss of dependent status, documentation supporting the loss of dependent status.

COBRA Self-Contribution Procedures and Rules

Once the Fund 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.

Medical Data Privacy

Introduction

The federal Department of Health and Human Services has issued regulations governing the Plan's use and disclosure of your health information. The regulations arose from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). While the Plan has always taken care to protect the privacy of your health information, these regulations require the Plan have formal procedures and inform you about these procedures in this booklet. The information below discusses ways in which the Plan uses and discloses your health information.

Under HIPAA, the Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to tell you about:

1. The Plan's uses and disclosures of Protected Health Information ("PHI");
2. Your privacy rights with respect to your PHI;
3. The Plan's duties with respect to your PHI;
4. Your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
5. The person or office to contact for further information about the Plan's privacy practices.

A. The Plan's Use and Disclosure of PHI

The Plan will use Protected Health Information ("PHI") to the extent of and according to the uses and disclosures allowed by the Medical Data Privacy Regulations ("Privacy Regulations") adopted under HIPAA, including for purposes related to *Health Care Treatment, Payment, and Health Care Operations*.

The Plan will enter into agreements with other entities known as "Business Associates" to perform some of these functions on behalf of the Plan. Each Business Associate will be allowed to use and disclose only the minimum amount of PHI needed to perform the Business Associate's duties on behalf of the Plan. The Plan's agreements with its Business Associates will also meet the other requirements of the Privacy Regulations.

Use of PHI for Treatment Purposes

Treatment includes the activities relating to providing, coordinating or managing health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. As a health plan, the Plan is generally not involved in treatment situations but may, from time-to-time, release PHI to assist providers in your treatment.

Use of PHI for Payment and Health Care Operations

Payment includes the Plan's activities to obtain premiums, contributions, self-payment, and other payments to determine or fulfill the Plan's responsibility for coverage and providing benefits under the Plan. It also includes the Plan obtaining reimbursement or providing reimbursement for providing health care that has been provided. These activities include but are not limited to the following:

1. Determining eligibility or coverage under the Plan;
2. Adjudicating claims for benefits (including claim appeals and other benefit payment disputes);
3. Subrogation;
4. Coordination of Benefits;
5. Establishing self-payments by persons covered under the Plan;
6. Billing and collection activities;
7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to covered persons' inquiries about payments;
8. Obtaining payment under stop-loss or similar reinsurance;
9. Reviewing whether claims are payable under the Plan, including whether they are Medically Necessary, Reasonable and Customary, or otherwise payable;
10. Reviewing coverage under the Plan, appropriateness of care, or justification of charges;
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective reviews;
12. Disclosing to consumer reporting agencies certain information related to collecting contributions or reimbursement (the information that may be released is: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the plan.

Health Care Operations can include any of the following activities. While the Plan does not currently use or release PHI for all of these activities, it may do so in the future to perform health care operations of the Plan:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines as long as general knowledge is not the primary purpose of these studies; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competency or qualifications of health care professionals; evaluating provider performance; accreditation, certification, licensing or credentialing activities;
3. Underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract (or reinsurance) or health benefits under the Plan;
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Planning and development, such as conducting cost-management and planning related analyses relating to managing and operating the Plan (including formulary development and administration, development or improvement of methods of payment or coverage policies); and
6. Management and general administrative activities of the Plan, including but not limited to:
 - a. Managing activities related to implementing and complying with the Privacy Regulations;
 - b. Resolving claim appeals and other internal grievances;
 - c. Merging or consolidating the Plan with another Plan, including related due diligence; and
 - d. As permitted under the Privacy Regulations, creating de-identified health information or a limited data set.

B. Other Uses and Disclosures of PHI

The Privacy Regulations permit certain other uses and disclosures of your PHI. These include, for example, releasing PHI to personal representatives of deceased covered persons, releasing PHI for public health activities, releasing PHI for court proceedings, and releasing PHI for law enforcement and similar purposes. If the Plan releases PHI in any of these other permitted situations, it will do so according to the requirements of the Privacy Regulations.

The Privacy Regulations also permit the Plan to release PHI if it receives a valid authorization from you. If the Plan receives a valid authorization, the Plan will disclose PHI to the person or organization you authorize to receive the information. This may include, for example, releasing information to your spouse, to the pension plan, other retirement plans, vacation plan or similar plan for the purposes related to administering those plans.

C. Release of PHI to the Board of Trustees

The Plan will disclose PHI to the Board of Trustees, which is considered the Plan Sponsor under the Privacy Regulations. The Plan has received a certificate from the Board of Trustees that the plan documents, including this Summary Plan Description, have been amended to incorporate the following provisions. The Board of Trustees will receive and use PHI only for the Plan administration functions that the Trustees perform for the Plan. In addition, the Trustees will:

1. Not use or further disclose PHI other than as permitted or required by the Summary Plan Description or as required by law.
2. Ensure that any agents of the Trustees, including subcontractors, to whom the Board of Trustees provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the person who is the subject of the PHI;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the person who is the subject of the information;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the allowed uses or disclosures of which it becomes aware;
6. Make PHI available to a person who is the subject of the information according to the Privacy Regulation's requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI according to the requirements of the Privacy Regulations;
8. Make available the PHI required to provide an accounting of disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Regulations; and

10. If feasible, return or destroy all PHI received from the Plan that the Trustees maintain in any form, and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

D. Trustee Access to PHI for Plan Administration Functions

As required under the Privacy Regulations, the Plan will give access to PHI only to the following persons:

1. The Board of Trustees.

The Plan will release PHI to the Trustees, and the Trustees will be able to use PHI, for purposes of hearing and determining claim appeals; making other determinations concerning claims payments; assisting covered persons with eligibility and benefit issues; Plan benefit design; amending, modifying and terminating the Plan; and Plan management issues.

2. The Trustees' agents, such as the Trustees' staff, only to the extent reasonable to assist the Trustees in fulfilling their duties consistent with the above uses and disclosures of PHI.

E. Noncompliance Issues

If the persons described above do not comply with this Summary Plan Description, the Board of Trustees will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

F. Plan's Privacy Officer and Contact Person

As required by the Privacy Regulations, the Plan has named a Privacy Officer to oversee the Plan's compliance with the Privacy Regulations. The Plan has also named a Contact Person to help answer your questions concerning the Privacy Regulations and your PHI. You can also call the Contact Person if you have any complaints concerning the use or disclosure of your PHI. If you have any questions or complaints concerning your PHI, please contact the Plan Administrator and ask to speak with the Plan's Contact Person; DCUE President.

