DCUE Dental

Dakota County United Educators
Dental Reimbursement Fund
Plan Booklet

Effective September 1, 2025

Previous Printings:
September 1, 2024
September 1, 2022
September 1, 2020
September 1, 2019
September 1, 2018
September 1, 2014
September 1, 2011
September 1, 2010
October 1, 2006
August 15, 2003
August 15, 1998 and
September 1, 1996

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

6950 146th Street West Suite 114 Apple Valley MN 55124
952-432-4033

Dakota County United Educators
Dental Reimbursement Fund

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DECLARATION

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, amended the 1st day of September 2020, amended the 1st day of September 2022, amended the 1st day of September 2024 and amended the 1st day of September 2025;

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

DCUE 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, see full Exclusions & Limitations- Appendix B) that are not covered under the eligible Participant's medical 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 and maintenance of abnormal dental relationships including related abnormalities in facial structure, along with related retainers and/or devices, 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.

2.13 "Change of Employment" status means Participant's employment status has changed to termination, resignation, retirement, leave of absence, separated or divorced, disability, or death.

2.14 "Enrolled" means the Participant has completed, submitted and been approved for the current plan year using the online enrollment form for DCUE Dental.

2.15 "Open Enrollment" means the time period between August 1 and June 1 in which the online enrollment form is available for all active Participants to complete for eligibility.

2.16 "Dependent" means a biological, adopted or step child under 26 years old. You must be legally married to your stepchild's parent.

2.17 "Foster" refers to a child (ward, legal guardianship, legal custody) in which you have full and permanent legal and physical custody up to age of 26.

ARTICLE III
Eligibility

3.01 Each .5 or greater FTE employee who is covered in the Agreement between ISD 196 and DCUE, enrolled and in good standing with 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. (see Section 3.04)

3.02 Each Participant must enroll themselves, spouse and dependent children (if applicable) each plan year during the Open Enrollment window (August 1-June 1). Enrollment is required for every active Participant in order to be eligible for reimbursement.

3.03 Dependent and Retirement Coverage

A. Spouses are covered, if enrolled. A copy of the marriage certificate/license may be required to determine eligibility.
   1. You have 60 Days from the date of the event to notify the Fund Administrator of any marital status change.

B. Dependent or Foster children will be covered to age 26.
   1. You have 60 Days from the date of the event to notify the Fund Administrator of any dependent status change.
   2. Foster children (ward, legal guardianship, legal custody) in which you have full and permanent legal and physical custody may require additional legal documentation to determine eligibility.

C. Disabled children: Anyone who is a disabled child, but who is not covered by a federal, state, or county insurance program is eligible for coverage by the DCUE Dental Reimbursement Fund over the age of 26. Legal documentation may be requested to determine eligibility.

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 D – 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 D-Continuation of Rights under COBRA)

   2. A new plan year begins. There cannot be a discontinuation of payment between current plan year and new plan year.

3.04 Special Coverage Situations (where applicable, see Appendix D – COBRA Benefits & HIPPA Regulations).

A. Part-time district employees: Employees who work between .5 and .74 FTE 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 and members are required to carry coverage for the entire plan year or the duration of time under the part-time status, once electing coverage.

B. 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 and members are required to carry coverage for the entire plan year or the duration of time under the part-time status, once electing coverage.

C. Part-time district employees: Employees who work less than .5 FTE are NOT eligible for this Fund unless an exception is addressed in the Collective Bargaining Agreement.

D. District employees who experience a change in status may continue coverage via COBRA.

E. Enrolled dependents who have reached age 26 may continue coverage via COBRA.

F. Leave of Absence employees may continue coverage, by paying the full premium, until they return to work or have a change is status.

1. Leave of Absence members who continue coverage must be in good standing with the Fund to be offered coverage with a change in status, other than returning to work.

G. 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 enrollment, continuation of coverage election notice and are working with the Fund Administrator on collection of premium.

3.05 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 them self, 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 using the appropriate DCUE Dental Reimbursement Fund Claim Form (see Appendix C - Forms). The request must be received at the DCUE Dental Office (located within the DCUE office), either through U.S./District mail, or drop-off, within sixty (60) days of the date the expense was incurred (the Treatment Date) or must be filed within an additional thirty (30) days from the date of treatment, if primary insurance is involved. 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, if applicable;

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. Oral Surgery/Wisdom Teeth Removal claims must be submitted to medical insurance first, and then dental insurance if applicable. 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, adjustments 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) 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 as defined in MN State Statute 609.611 will result in immediate termination from the Fund and possible legal action.

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, they shall submit the appropriate reimbursement Claim Form and required documentation. The Claim Form must be completely filled out and signed by the Participant. This must be submitted along with, but not limited to, the statement/ledger showing the patient's name and relationship to employee, the treatment date, the charges, the discounts, the primary insurance payment, adjustments 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 (see Article II 2.09 - Definitions).

4.05 No expenses will be reimbursed from this Fund if the individual 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, they 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 an individual's expenses incurred during any one plan year shall not exceed the ANNUAL maximum.

4.08 If a Participant in the Fund has for any reason been 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 the appropriate Dental Reimbursement Fund Claim Form in accordance with section 4.03.

7.02 If a claim is denied due to lack of enrollment the Participant will receive notification in writing, within a reasonable period of time. The Participant will not be offered the right to Appeal denial of said claim.

7.03 If a claim is wholly or partially denied, notice of decision, in accordance with section 7.04 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 receipt of claim. 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.

7.04 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 7.05 and 7.06 below.

7.05 The purpose of the review procedure set forth in this section and in section 7.06 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 their 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 C - Forms);

B. Review pertinent Fund documents, and

C. Submit issues and comments in writing.

D. A claimant, or their 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 their claim.

7.06 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.

7.07 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, amended September 1, 2019, amended September 1, 2020, amended September 1, 2022 and amended September 1, 2024.

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 them 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, amended the 1st day of September 2019, amended the 1st day of September 2020, amended the 1st day of September 2022, amended the 1st day of September 2024 and amended the 1st day of September 2025.

Dakota County United Educators Dental Reimbursement
Board of Trustees

By: _____
Kate Schmidt, DCUE President

By: _____
Justine Kolb, Fund Administrator

By: _____
Jenifer Stehr, Trustee

By: _____
Angela Rice, Trustee

By: _____
Angela Mahowald, Trustee

By: _____
Thomas Gallaher, Trustee

By: _____
Peggy Ringgenberg, Trustee

By: _____
Emma Ryan, Trustee

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 & eligible part time employees. The monthly premium for a full time member covers the employee and any eligible dependents enrolled in the program. There are no out-of-pocket premiums paid by the full time employee. Job Share and part time employees with .5 - .74 FTE pay one-half the premium if they elect to carry dental coverage. Employees working less than .5 FTE 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. Most Dental treatments are 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. (full Exclusions & Limitations - see Appendix B)

C. Participants are reimbursed AFTER submitting an itemized statement showing proof of payment and any documentation from primary insurance, along with the appropriate 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 under the Dental tab on the website and the back of the claim forms.

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 and then submit this balance to the Fund (within 90 days from date of treatment) for payment according to the filing instructions.

1.03 Annual Benefits Per Individual

The maximum annual payable benefit for dental claims per individual is $1,400. 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 Paid	Amount Reimbursed
Tier 1	First $600	100%	$600
Tier 2	Next $400	75%	$300
Tier 3	Last $1000	50%	$500
Total Claimed	**$2,000**		**Total Paid $1,400**

Figure 1: Annual Dental Claim Benefit Reimbursement Scale

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

	Claim Amount	Percentage Paid	Amount Reimbursed
	up to $2,000	100%	up to $2,000
Total Claimed	**$2,000**		**Total Paid $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.

Most dental and orthodontic (up to age 26) procedures are considered eligible 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 they practice.

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. Select the appropriate claim for to complete, based on treatment performed (see Filing Information under Dental tab on the website).

B. Submit a separate Claim Form for each individual, filling in all appropriate fields. Omitting information will delay reimbursement**.**

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

D. 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.

E. 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.

F. 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.

G. 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 address changes.

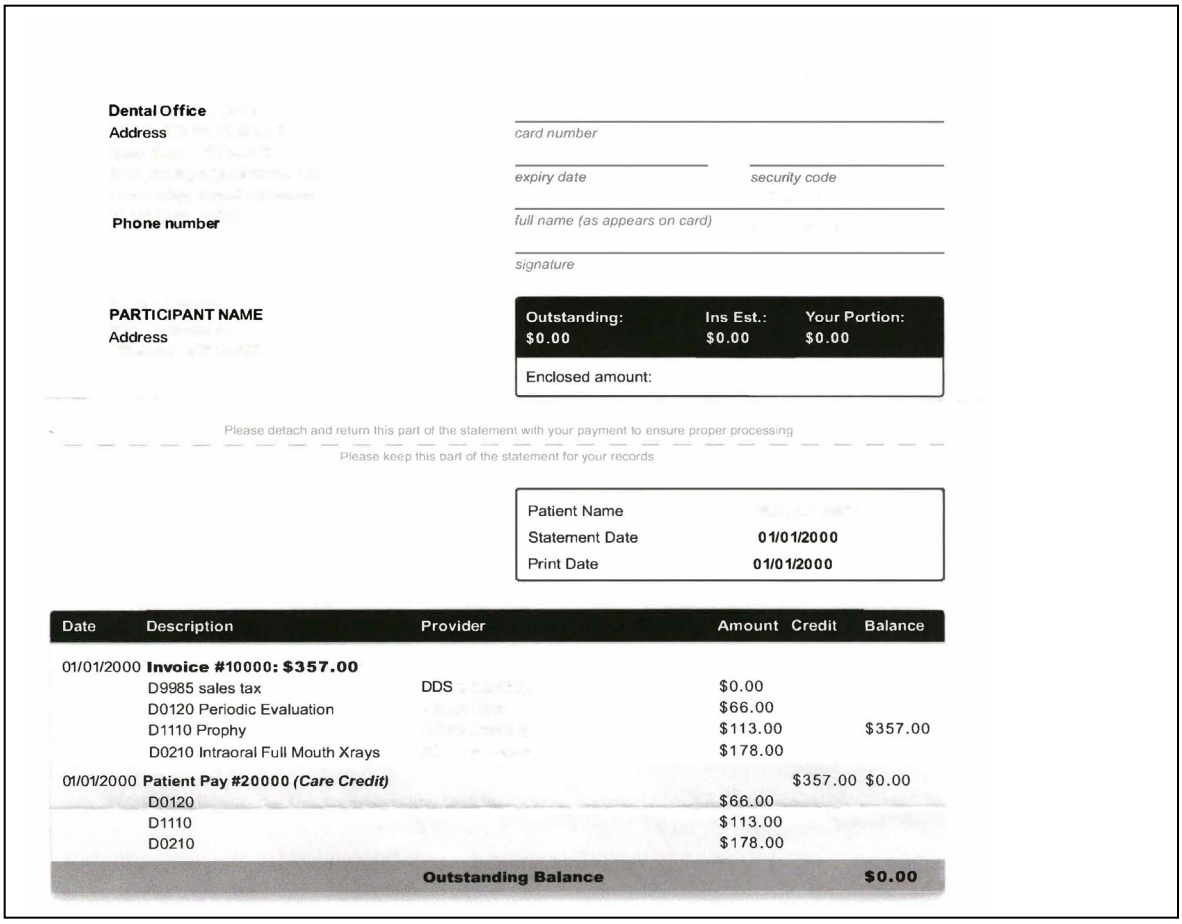
H. A reimbursement check will be considered forfeited if the check has been outstanding for at least six (6) months, the member has not responded to notifications of outstanding check and the original amount of the check is under $250.01. If the original check is issued for $250.01 or more then the un-cashed check will follow state guidelines for unclaimed property. Additional fees may apply when claiming your property.

I. 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 1-4 are samples of itemized statements and ledgers from dental offices. Simple charge clips, receipts, hand written paid and copies of checks are not adequate for proof of payment. Shown are the kind of statements 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 5 and 6 are examples of Explanation of Benefits from primary insurance companies. This must be attached to all claims for which primary insurance paid first, and are proof of when that payment was made and what the patient responsibility or eligible claim amount is.



Dental Office
Address

Phone number

card number

expiry date

security code

full name (as appears on card)

signature

PARTICIPANT NAME
Address

Outstanding:	Ins Est.:	Your Portion:
$0.00	$0.00	$0.00

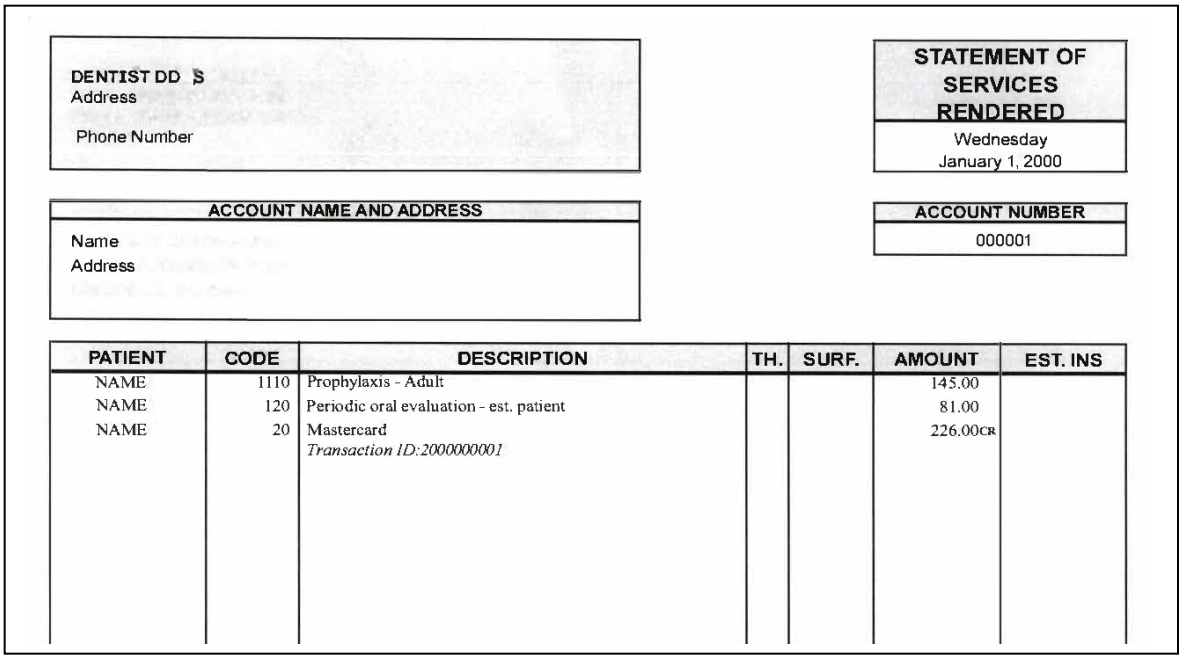
Enclosed amount:

Please detach and return this part of the statement with your payment to ensure proper processing

Please keep this part of the statement for your records

Patient Name	
Statement Date	01/01/2000
Print Date	01/01/2000

Date	Description	Provider	Amount	Credit	Balance
01/01/2000	**Invoice #10000: $357.00**				
	D9985 sales tax	DDS	$0.00		
	D0120 Periodic Evaluation		$66.00		
	D1110 Prophy		$113.00		$357.00
	D0210 Intraoral Full Mouth Xrays		$178.00		
01/01/2000	**Patient Pay #20000** ***(Care Credit)***			$357.00	$0.00
	D0120		$66.00		
	D1110		$113.00		
	D0210		$178.00		
	Outstanding Balance				**$0.00**



DENTIST DD S
Address

Phone Number

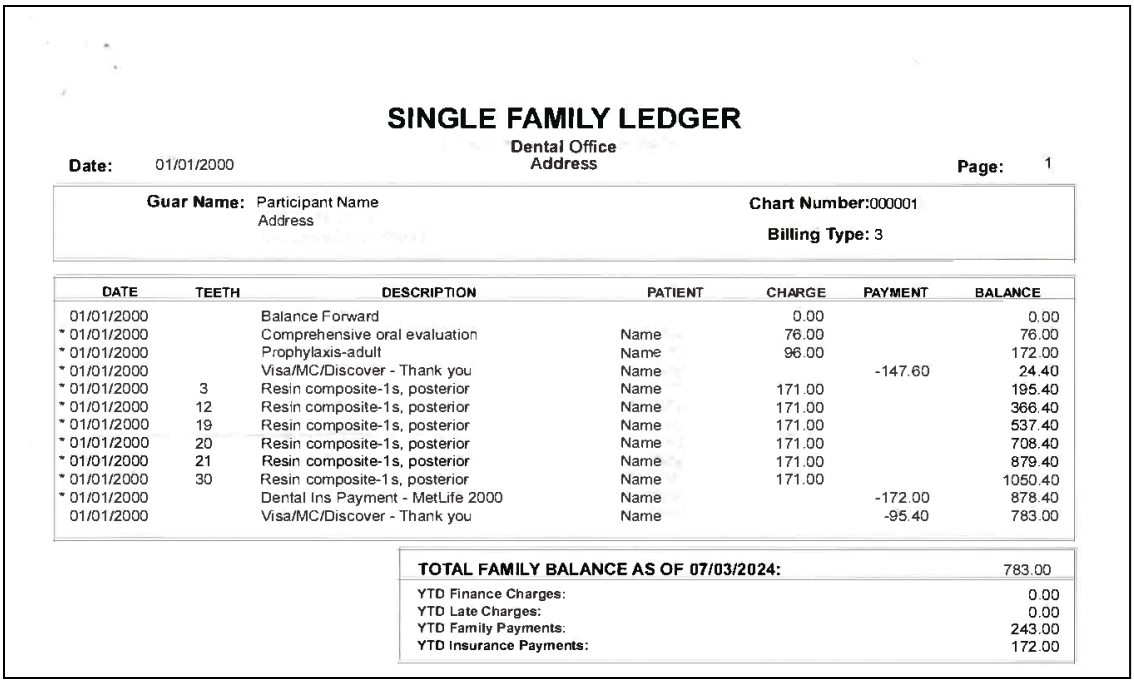
STATEMENT OF SERVICES RENDERED
Wednesday
January 1, 2000

ACCOUNT NAME AND ADDRESS
Name
Address

ACCOUNT NUMBER
000001

PATIENT	CODE	DESCRIPTION	TH.	SURF.	AMOUNT	EST. INS
NAME	1110	Prophylaxis - Adult			145.00	
NAME	120	Periodic oral evaluation - est. patient			81.00	
NAME	20	Mastercard *Transaction ID:2000000001*			226.00CR	

Figure 1 & 2: *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).*



SINGLE FAMILY LEDGER

Dental Office
Address

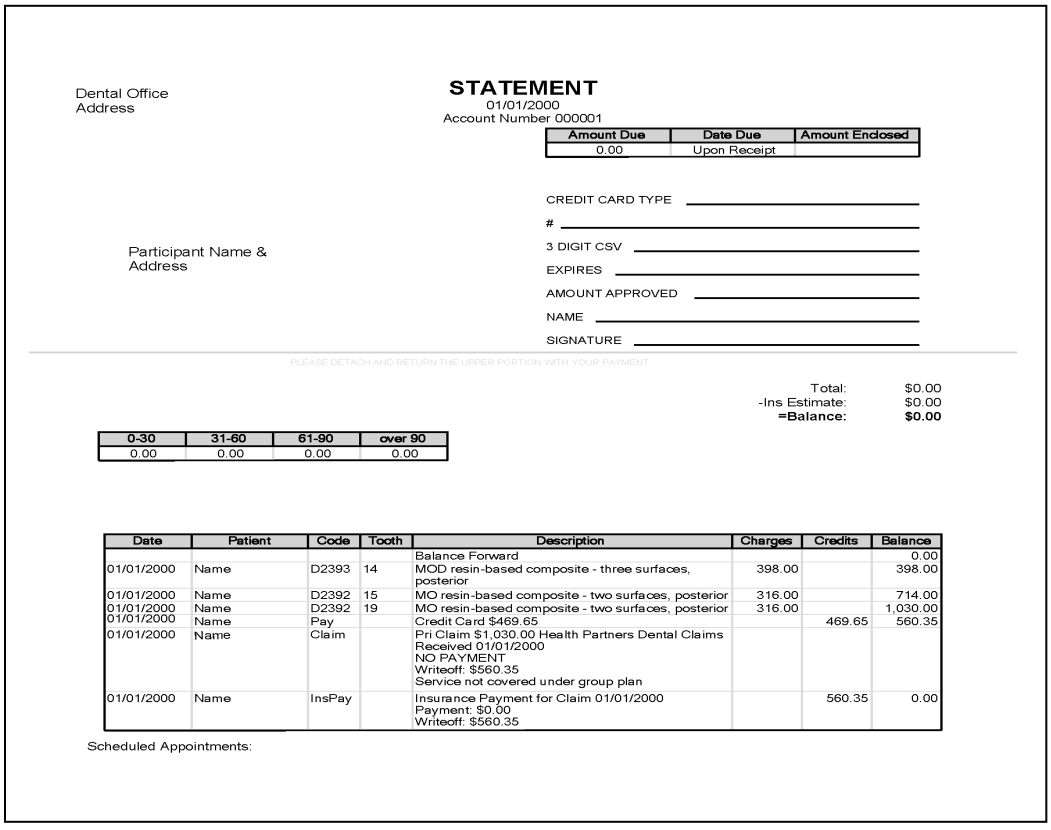
Date: 01/01/2000 **Page:** 1

Guar Name: Participant Name
Address

Chart Number:000001
Billing Type: 3

DATE	TEETH	DESCRIPTION	PATIENT	CHARGE	PAYMENT	BALANCE
01/01/2000		Balance Forward		0.00		0.00
* 01/01/2000		Comprehensive oral evaluation	Name	76.00		76.00
* 01/01/2000		Prophylaxis-adult	Name	96.00		172.00
* 01/01/2000		Visa/MC/Discover - Thank you	Name		-147.60	24.40
* 01/01/2000	3	Resin composite-1s, posterior	Name	171.00		195.40
* 01/01/2000	12	Resin composite-1s, posterior	Name	171.00		366.40
* 01/01/2000	19	Resin composite-1s, posterior	Name	171.00		537.40
* 01/01/2000	20	Resin composite-1s, posterior	Name	171.00		708.40
* 01/01/2000	21	Resin composite-1s, posterior	Name	171.00		879.40
* 01/01/2000	30	Resin composite-1s, posterior	Name	171.00		1050.40
* 01/01/2000		Dental Ins Payment - MetLife 2000	Name		-172.00	878.40
01/01/2000		Visa/MC/Discover - Thank you	Name		-95.40	783.00

TOTAL FAMILY BALANCE AS OF 07/03/2024:	783.00
YTD Finance Charges:	0.00
YTD Late Charges:	0.00
YTD Family Payments:	243.00
YTD Insurance Payments:	172.00



Dental Office
Address

STATEMENT
01/01/2000
Account Number 000001

Amount Due	Date Due	Amount Enclosed
0.00	Upon Receipt	

CREDIT CARD TYPE _____
_____
3 DIGIT CSV _____
EXPIRES _____
AMOUNT APPROVED _____
NAME _____
SIGNATURE _____

Participant Name &
Address

PLEASE DETACH AND RETURN THE UPPER PORTION WITH YOUR PAYMENT

Total: $0.00
-Ins Estimate: $0.00
=Balance: $0.00

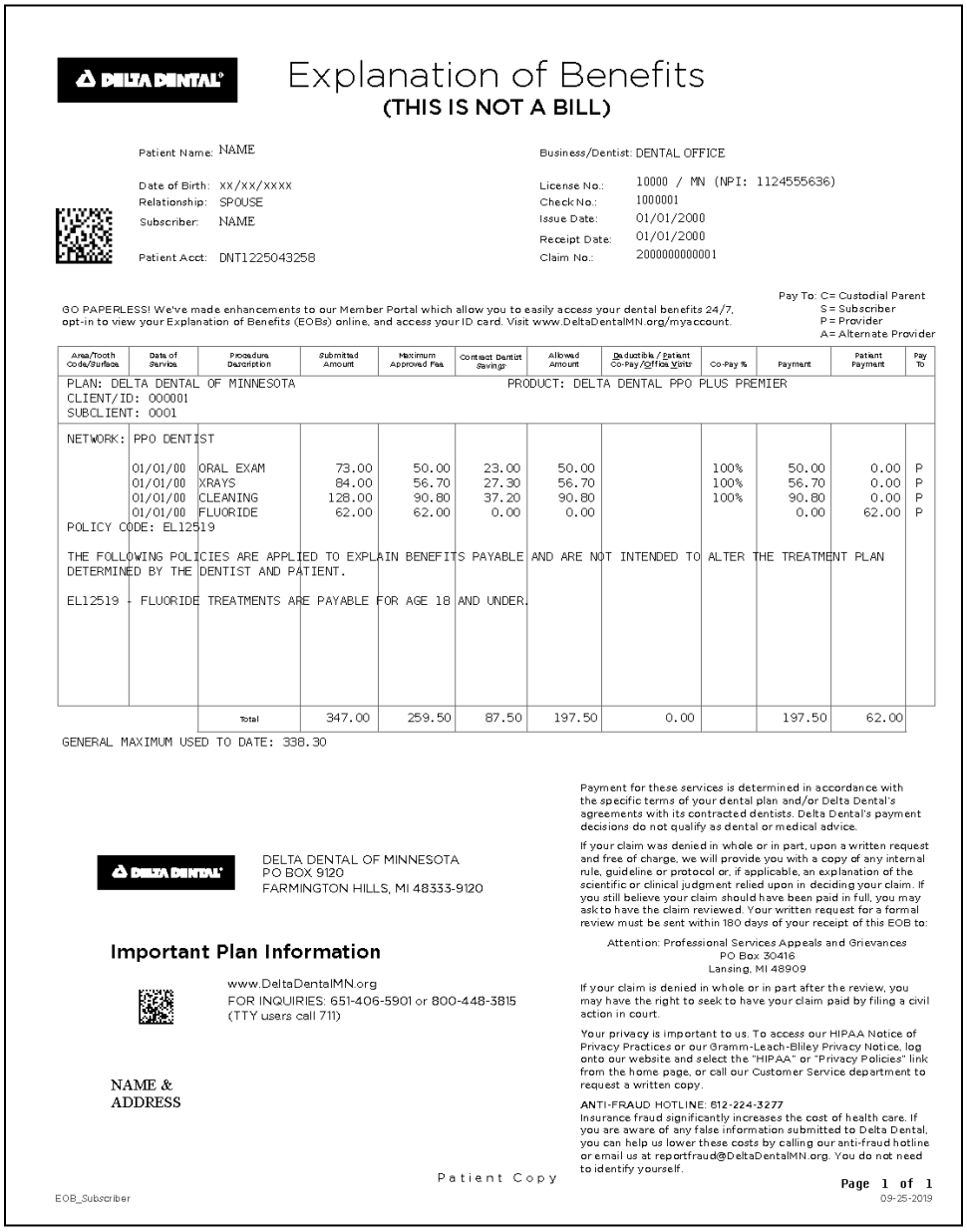
0-30	31-60	61-90	over 90
0.00	0.00	0.00	0.00

Date	Patient	Code	Tooth	Description	Charges	Credits	Balance
				Balance Forward			0.00
01/01/2000	Name	D2393	14	MOD resin-based composite - three surfaces, posterior	398.00		398.00
01/01/2000	Name	D2392	15	MO resin-based composite - two surfaces, posterior	316.00		714.00
01/01/2000	Name	D2392	19	MO resin-based composite - two surfaces, posterior	316.00		1,030.00
01/01/2000	Name	Pay		Credit Card $469.65		469.65	560.35
01/01/2000	Name	Claim		Pri Claim $1,030.00 Health Partners Dental Claims Received 01/01/2000 NO PAYMENT Writeoff: $560.35 Service not covered under group plan			
01/01/2000	Name	InsPay		Insurance Payment for Claim 01/01/2000 Payment: $0.00 Writeoff: $560.35		560.35	0.00

Scheduled Appointments:

Figure 3 & 4: *Sample dental office statement shows patient information, including name, date of treatment, charges, credits of insurance payment and patient payments (an insurance EOB would be required documentation in this scenario).*

Ledgers and statements may contain information for more than one patient



DELTA DENTAL

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: NAME

Date of Birth: XX/XX/XXXX
Relationship: SPOUSE
Subscriber: NAME

Patient Acct: DNT1225043258

Business/Dentist: DENTAL OFFICE

License No.: 10000 / MN (NPI: 1124555636)
Check No.: 1000001
Issue Date: 01/01/2000
Receipt Date: 01/01/2000
Claim No.: 2000000000001

GO PAPERLESS! We've made enhancements to our Member Portal which allow you to easily access your dental benefits 24/7, opt-in to view your Explanation of Benefits (EOBs) online, and access your ID card. Visit www.DeltaDentalMN.org/myaccount.

Pay To: C= Custodial Parent
S= Subscriber
P= Provider
A= Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Description	Submitted Amount	Maximum Approved Fee	Contract Dentist Savings	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: DELTA DENTAL OF MINNESOTA CLIENT/ID: 000001 SUBCLIENT: 0001					PRODUCT: DELTA DENTAL PPO PLUS PREMIER						
NETWORK:	PPO DENTIST										
	01/01/00	ORAL EXAM	73.00	50.00	23.00	50.00		100%	50.00	0.00	P
	01/01/00	XRAYS	84.00	56.70	27.30	56.70		100%	56.70	0.00	P
	01/01/00	CLEANING	128.00	90.80	37.20	90.80		100%	90.80	0.00	P
	01/01/00	FLUORIDE	62.00	62.00	0.00	0.00			0.00	62.00	P
POLICY CODE: EL12519											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
EL12519 - FLUORIDE TREATMENTS ARE PAYABLE FOR AGE 18 AND UNDER.											
		Total	347.00	259.50	87.50	197.50	0.00		197.50	62.00	

GENERAL MAXIMUM USED TO DATE: 338.30

DELTA DENTAL

DELTA DENTAL OF MINNESOTA
PO BOX 9120
FARMINGTON HILLS, MI 48333-9120

Important Plan Information

www.DeltaDentalMN.org
FOR INQUIRIES: 651-406-5901 or 800-448-3815
(TTY users call 711)

NAME &
ADDRESS

Payment for these services is determined in accordance with the specific terms of your dental plan and/or Delta Dental's agreements with its contracted dentists. Delta Dental's payment decisions do not qualify as dental or medical advice.

If your claim was denied in whole or in part, upon a written request and free of charge, we will provide you with a copy of any internal rule, guideline or protocol or, if applicable, an explanation of the scientific or clinical judgment relied upon in deciding your claim. If you still believe your claim should have been paid in full, you may ask to have the claim reviewed. Your written request for a formal review must be sent within 180 days of your receipt of this EOB to:

Attention: Professional Services Appeals and Grievances
PO Box 30416
Lansing, MI 48909

If your claim is denied in whole or in part after the review, you may have the right to seek to have your claim paid by filing a civil action in court.

Your privacy is important to us. To access our HIPAA Notice of Privacy Practices or our Gramm-Leach-Bliley Privacy Notice, log onto our website and select the "HIPAA" or "Privacy Policies" link from the home page, or call our Customer Service department to request a written copy.

ANTI-FRAUD HOTLINE: 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@DeltaDentalMN.org. You do not need to identify yourself.

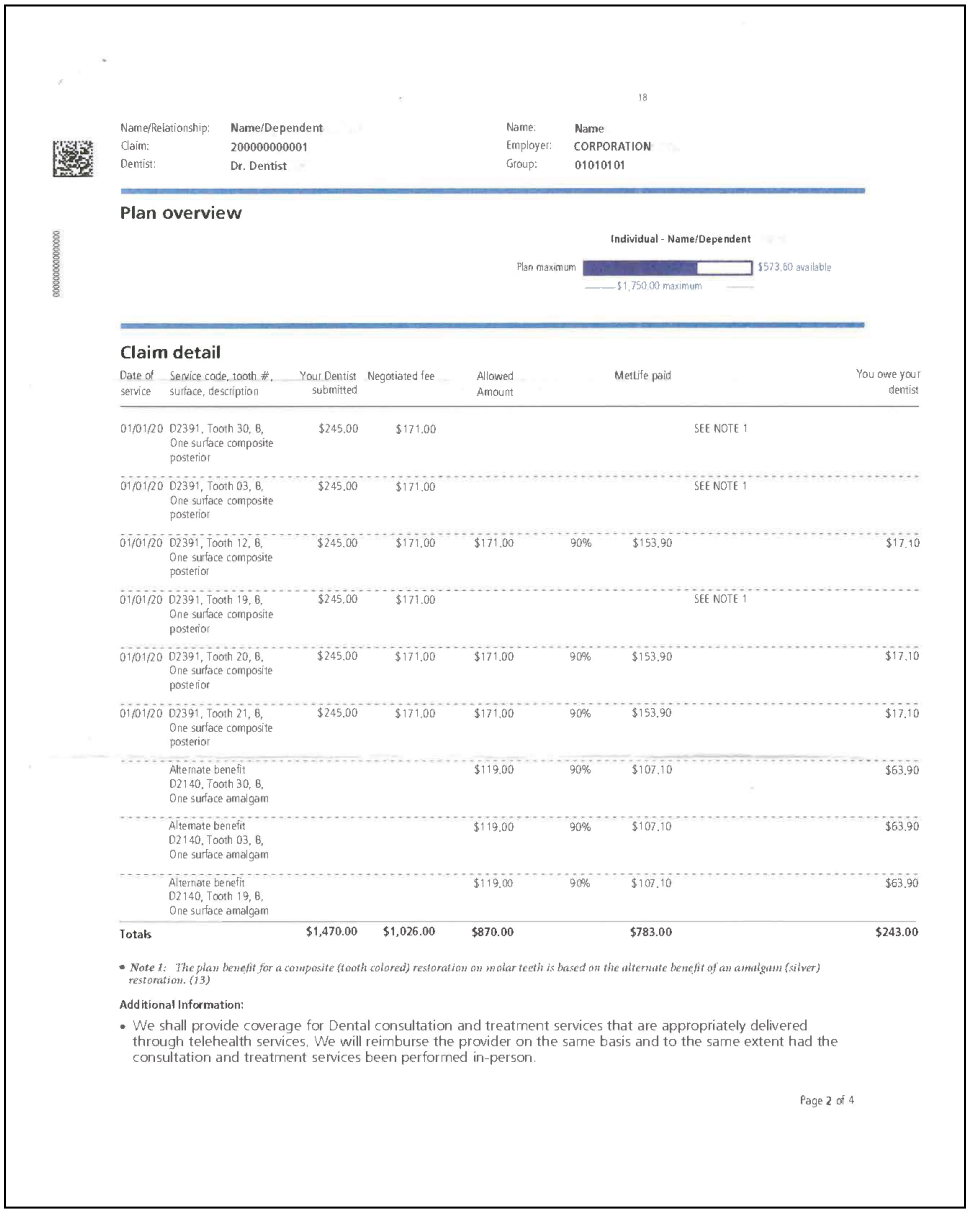
Patient Copy

Page 1 of 1

EOB_Subscriber

09-25-2019

Figure 5: *Sample Explanation of Benefits (EOB) from a primary insurance provider shows patient information including name, treatment date, amount submitted for payment, allowed amount, insurance payment amount and amount of patient responsibility (this is the amount that you can then submit to DCUE Dental Reimbursement Fund).*



18

Name/Relationship: Name/Dependent
Claim: 200000000001
Dentist: Dr. Dentist

Name: Name
Employer: CORPORATION
Group: 01010101

Plan overview

Individual - Name/Dependent

Plan maximum $573.60 available
$1,750.00 maximum

Claim detail

Date of service	Service code, tooth #, surface, description	Your Dentist submitted	Negotiated fee	Allowed Amount		MetLife paid		You owe your dentist
01/01/20	D2391, Tooth 30, B, One surface composite posterior	$245.00	$171.00				SEE NOTE 1	
01/01/20	D2391, Tooth 03, B, One surface composite posterior	$245.00	$171.00				SEE NOTE 1	
01/01/20	D2391, Tooth 12, B, One surface composite posterior	$245.00	$171.00	$171.00	90%	$153.90		$17.10
01/01/20	D2391, Tooth 19, B, One surface composite posterior	$245.00	$171.00				SEE NOTE 1	
01/01/20	D2391, Tooth 20, B, One surface composite posterior	$245.00	$171.00	$171.00	90%	$153.90		$17.10
01/01/20	D2391, Tooth 21, B, One surface composite posterior	$245.00	$171.00	$171.00	90%	$153.90		$17.10
	Alternate benefit D2140, Tooth 30, B, One surface amalgam			$119.00	90%	$107.10		$63.90
	Alternate benefit D2140, Tooth 03, B, One surface amalgam			$119.00	90%	$107.10		$63.90
	Alternate benefit D2140, Tooth 19, B, One surface amalgam			$119.00	90%	$107.10		$63.90
Totals		**$1,470.00**	**$1,026.00**	**$870.00**		**$783.00**		**$243.00**

• ***Note 1:*** *The plan benefit for a composite (tooth colored) restoration on molar teeth is based on the alternate benefit of an amalgam (silver) restoration. (13)*

Additional Information:

• We shall provide coverage for Dental consultation and treatment services that are appropriately delivered through telehealth services. We will reimburse the provider on the same basis and to the same extent had the consultation and treatment services been performed in-person.

Page 2 of 4

Figure 6: *Sample Explanation of Benefits (EOB) from a primary insurance provider shows patient information including name, treatment date, amount submitted for payment, amount allowed (covered), amount paid by insurance and amount of patient responsibility (this is the amount that you can then submit to DCUE Dental Reimbursement Fund).*

Formal Explanation of Benefits from the primary insurance company is required, estimate of benefits, claims details page or claim summary are not considered proper supporting documentation.

DCUE Dental Reimbursement Fund

Appendix B- Exclusions & Limitations

Exclusions & Limitations

Most Dental treatment is covered, except for certain cosmetic procedures, bleaching, take-home dental products and medications.

The summary of exclusions and limitations is provided for your convenience. Exclusions and limitations are not limited to the listing below.

The Dental Board of Trustees has the power to amend the plan and the exclusions and limitations of covered services at anytime.

There are no pre-existing condition restrictions or approvals required.

You can see any licensed dental or orthodontic provider of your choice, in or out of state. Out of the country providers can be covered if all required supporting documentation is provided in English, along with proof of payment in U.S. dollars.

Coverage is not provided for:

- New, experimental or investigational dental techniques or services may be denied until there is dental coding under ADA standards and/or provider letter given to the satisfaction of the plan
- Credit card processing fees
- Insurance payments, discounts or adjustments given by the provider or insurance company
- Co-pay fees collected by the provider due to insurance company used
- Purchase fee for an "in-house" dental benefit plan of any type, design, dollar amount
- Therapies performed for conditions such as TMJ, Sleep Apnea, Tongue and Lip Tie releases are not covered under the plan (i.e. physical therapies, myofunctional/myofascial therapies)
- Bleaching or whitening treatments or kits of any kind
- Veneers
- Odontoplasty or enameloplasty treatments done for cosmetic purposes
- Take home products and/or medication not administered in office

Limitations:

- Over the counter Athletic/Mouth Guards are not covered. *Mouth guards that are specifically formed and designed for an individual's mouth are considered a covered expense.*
- Orthodontic coverage is not available to individuals over the age of 26. *A $2000 lifetime benefit towards orthodontic treatment and appliances can be received by individuals up to age 26, coverage ends the last day of the month in which an individual turns 26.*
- Generally speaking for conditions such as TMJ, Sleep Apnea, Lip and Tongue Ties the plan does not cover treatment and diagnostic costs associated. *Charges for appliances, injections, surgery/laser procedures (i.e. frenectomies/frenotomy) specifically for each of these conditions is generally an eligible expense to submit for reimbursement, additional information from your dental provider may be requested before claim approval is made. DCUE Dental encourages you to first check with your medical benefit plan to find if there is coverage for these conditions and treatments needed.*

DCUE Dental Reimbursement Fund

Appendix C- Forms

DCUE Dental Reimbursement Fund

6950 146th Street West, Suite 114, Apple Valley, MN 55124 (952) 432-4033 ISD 196 Teachers & Nurses

2023-2024 Enrollment Form

Employee Information:

Employee #1 ID Number:	Last Name	First Name	MI	Date of Birth	Sex F/M/X
				mm/dd/yyyy	

Address	City	State	Zip

Phone Number:

Seniority Date/Original Hire Date: mm/dd/yyyy

Is your spouse an employee of the district AND eligible for coverage in the ISD196 collective bargaining unit DCUE? No

Spouse/Dependent Information:

Dependents	Last Name	First Name	MI	Date of Birth	SEX(F/M)
Spouse				mm/dd/yyyy	
Other Dependents				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	
				mm/dd/yyyy	

Do you and/or your family members have Primary Dental Insurance through your spouse? (coverage other than DCUE Dental)

My initials constitutes a request for participation in the DCUE Dental Reimbursement Fund. My initials certifies 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 #1

Initials: Date: 07/15/2024

Sample Online Enrollment Form

DCUE Dental Reimbursement Fund

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

Claim Form (A): Dental or Orthodontic Treatment

Complete ALL Sections in FULL- *see page 2 for Filing Information*

Section 1: Employee Information

Employee #1 **ID Number:**	Last Name	First	Date of Birth	School	COBRA/Retired YES / NO
Employee #2 **ID Number:**	Last Name	First	Date of Birth	School	COBRA/Retired YES / NO
☐ **Mark here if new address**	Address		City	State	Zip

Section 2: Dental or Orthodontic Treatment Information

Name of Patient: *(one patient per claim form)*

Relationship to Employee: ☐ Self ☐ Spouse ☐ Child

☐ The dependent child listed is my natural, step, adopted or foster child.

Dental Only Date of Treatment: _____ *(one date of treatment per claim form)*

*Amount paid by Participant: _____

"Amount paid by participant" is the final charges you are responsible for after insurance payments, discounts and adjustments have been made.

Ortho Only (under 26 years old)

Date of Payment(s): _____

(multiple payments per claim form is acceptible)

Amount of ortho Payment(s): _____

☐ **1st ortho claim submission; copy of treatment plan is attached**

Name of Dental Provider/Office: _____

Dental Provider Phone: _____

Section 3: Coverage Verification Required

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. **See Section 4- EOB Required

Section 4: Supporting Documentation Required

Required

☐ I have **attached** an **itemized statement** from the dental office showing name of patient, date of treatment, specific completed charges, discounts and payments made; balancing my amount requested for reimbursement.

Required IF Insurance Applies **See Claim Form Filing Information

☐ I have **attached** the **Explanation of Benefits (EOB)** from the primary insurance provider or other reimbursement plan for the treatment claimed on this claim form. Patient responsibility portion indicated on the EOB matches my payment(s) made.

☐ Orthodontic claims only: I have attached a receipt showing payment details made, i.e. date of payment, dollar amount of payment, how payment was made.

1st time ortho claim: attach a copy of the treatment plan/financial agreement.

I certify that the amount in which I am requesting reimbursement is not covered and/or has not been submitted to any other dental or medical insurance, and that the amount has been paid and is accurate. In addition, I understand that my claim will be returned if ALL required documentation is not attached.

Signature of ISD 196 Employee _____ Date _____

June 1, 2025

Sample Claim Form (A): Dental or Orthodontic Treatment

DCUE Dental Reimbursement Fund
Claim Form Filing Information

Submit a **separate Claim Form for each individual by 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 assessed a 20% late penalty. 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 DCUE Dental Reimbursement Fund either through school district interoffice mail or U.S. Mail
-DCUE Dental • 6950 146th Street West Suite 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 address on file. If you have any changes in name(s), address or additions to family log into the Dental Members page, found at dcue.org, and edit your enrollment form during months August-May. June thru July notify DCUE Dental office by email. You must be enrolled in the current plan year to receive reimbursement. Open Enrollment closes June 1 of each plan year.

If you have any questions, please call the DCUE Dental Reimbursement office at (952) 432-4033 or email dental@dcue.org.

Employee #1 – if you are the ISD 196 employee who has benefit coverage under the DCUE Dental Reimbursement Fund, your name and information goes here. Your identification number is required to process. *COBRA members should use their former Emp # or the ID # provided to them at the time of election. This field is for the account holder's information.*

Employee #2 – if both spouses are ISD 196 employees with benefit coverage under the DCUE/ISD 196 Collective Bargaining Agreement, the second employee's name and information must be provided to get the dual coverage. *Both employee numbers are required.*

COBRA/Retired – Answer yes to COBRA if you are not an active employee and paying a monthly premium for DCUE Dental coverage. If your status is Retired, LOA, Termination, Dependent Age 26, etc. you are considered COBRA status.

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 – indicate your relationship to the patient by checking the appropriate box.

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* – is your claim amount. Amount needs to match charges minus any discounts, adjustments and primary insurance pymts. Payment(s) **MUST BALANCE with charges, discounts and adjustments itemized. Proof of payment details needed are pymt type, how much, when it was paid. If other insurance is involved the amount(s) paid need to match patient responsibility amount on your EOB.

Date Ortho Payment(s) – date payment was actually made. **Multiple payments can be on one claim form.** ***Age 26 limit***
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/financial agreement from orthodontist.

Name /Phone of Dental Provider/Office –information is necessary for processing and follow-up if needed.

A check mark- indicating whether you are covered under another dental or medical program is required for processing. **If you are covered by another insurance/program see below.

A complete itemized statement- showing name of patient, date of treatment, specific treatment completed, charges, and payments actually made must be attached. Discounts and/or adjustments given must be itemized on the statement.

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

Signature of ISD 196 Employee / Date – signature is required for processing. Specify the date this Claim Form was completed.

Sample Claim Form (A), Side 2

DCUE Dental Reimbursement Fund

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

Claim Form (B): Oral Surgery/Wisdom Teeth Removal

Complete ALL Sections in FULL- *see page 2 for Filing Information*

Section 1: Employee Information

Employee #1 **ID Number:**	Last Name	First	Date of Birth	School	COBRA/Retired YES / NO
Employee #2 **ID Number:**	Last Name	First	Date of Birth	School	COBRA/Retired YES / NO
☐ **Mark here if new address**	Address		City	State	Zip

Section 2: Oral Surgery Treatment Information

Name of Patient: *(one patient per claim form)*

Relationship to Employee: ☐ Self ☐ Spouse ☐ Child
☐ The dependent child listed is my natural, step, adopted or foster child.

Oral Surgery Only Date of Treatment: _____ *(one date of treatment per claim form)*

*Amount paid by Participant: _____

"Amount paid by participant" is the final charges you are responsible for after insurance payments, discounts and adjustments have been made.

Section 3: Provider Information

Name of Oral Surgeon Provider/Office: _____

Oral Surgeon Provider Phone: _____

Oral surgeon provider MUST submit treatment charges to primary medical insurance first.

Supporting document required

Attach the final **itemized statement from the oral surgeon's office** showing name of patient, date of treatment, specific treatment completed, charges, insurance payments, discounts and your payments made; statement of account shows a zero balance.

Section 4: Medical Insurance

Circle one

YES / NO There are charges **covered under medical insurance** for the treatment claimed on this claim form.

Supporting document required

Attach the **Explanation of Benefits (EOB) or denial of coverage letter** from the **medical insurance** provider for the treatment claimed on this claim form. Patient responsibility portion indicated on the EOB matches my payment(s) made.

Section 5: Additional Dental Insurance Program

Circle one

YES / NO Patient **IS covered under another dental program** for the treatment claimed on this claim form.

If Yes, supporting document required

Attach the **Explanation of Benefits (EOB)** from the **dental insurance** provider for the treatment claimed on this claim form.

I certify that the amount in which I am requesting reimbursement is not covered and/or has not been submitted to any other dental or medical insurance, and that the amount has been paid and is accurate. In addition, I understand that my claim will be returned if ALL required documentation is not attached.

Signature of ISD 196 Employee _____ Date _____

May 15, 2025

Sample Claim Form (B): Oral Surgery/Wisdom Teeth Removal

DCUE Dental Reimbursement Fund
Oral Surgery/Wisdom Teeth Removal Claim Form Filing Information

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

Claims MUST be filed within ninety (90) days of the treatment date with other insurance involved. Late claims are assessed a 20% late penalty. Call to explain special circumstances. Absolute deadline is October 31st for prior plan year claims. Plan year is September 1 – August 31.

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 DCUE Dental Reimbursement Fund either through school district interoffice mail or U.S. Mail
-DCUE Dental • 6950 146th Street West Suite 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 address on file. If you have any changes in name(s), address or additions to family, log into the Dental Members page, found at dcue.org, and edit your enrollment form during months August-May. June thru July notify DCUE Dental office by email. You must be enrolled in the current plan year to receive reimbursement. Open Enrollment closes June 1 of each plan year.

If you have any questions regarding your claim, please call the DCUE Dental Reimbursement office at (952) 432-4033 or email dental@dcue.org.

Oral surgery claims MUST be processed and finalized by your medical insurance prior to submitting to DCUE Dental for reimbursement.

Section 2 – complete each field in full. Amount paid by participant is the amount you are requesting reimbursement for. This is your final out of pocket expense after insurance payments, adjustments, discounts and refunds have been applied. Payment(s) MUST BALANCE with charges, discounts and adjustments itemized on provider statement.

Section 3 – complete provider's business name and phone number. The oral surgeon must submit your treatment charges to your medical insurance first. The provider should also submit to your primary dental insurance, if you have one.
Required documentation from the provider needs to list name of patient, date of treatment, specific treatment completed, charges, insurance payments, discounts and your payment(s) made and if any refunds were given. This statement or multiple statements combined should have all the final numbers listed after insurance has processed and paid. Make sure your account balance is at zero.

It is necessary for DCUE Dental to have the final documentation from your provider to ensure your claim is being processed once for the accurate amount you are eligible for.

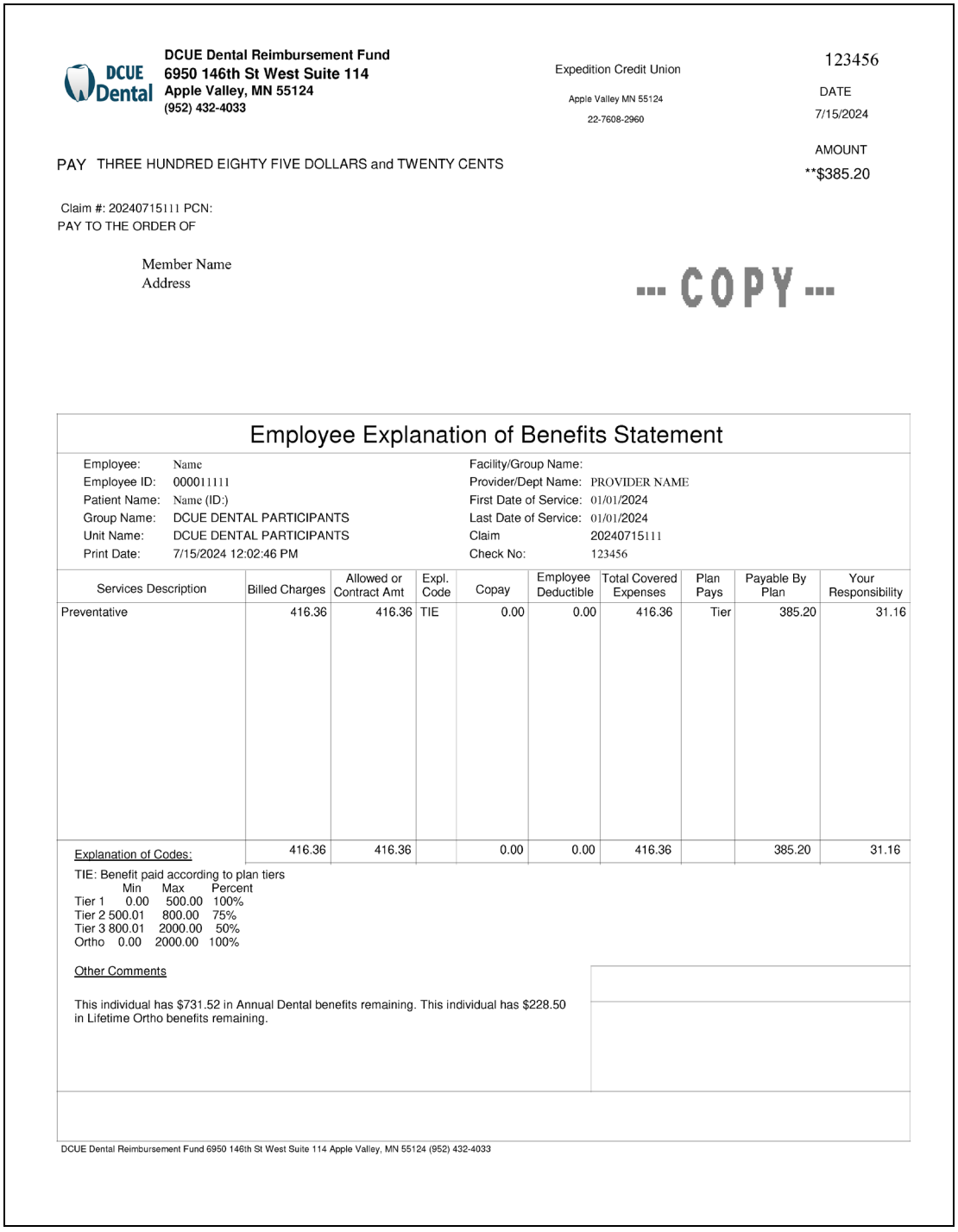
Section 4 – circle yes or no, whether your medical insurance is covering all or a portion of the treatment charges. Even if a portion or all of the treatment is not covered by medical insurance it is required to provide a copy of the Explanation of Benefits (EOB) stating what was or was not covered. If an EOB was not generated by the insurance co. then you must provide a denial of coverage letter from the medical insurance co.

Section 5 – circle yes or no, whether there is primary dental insurance or another dental benefit program involved in this claim. This is any dental coverage, other than DCUE Dental. If you have dental coverage through another program then an EOB from that benefit provider is required.

Signature of ISD 196 Employee – the District 196 employee must sign and date the claim form in which you are requesting reimbursement.
By signing this claim form you are certifying that the charges you are requesting reimbursement for have not and will not be covered by any other medical or dental provider.

If you are missing any required documentation your claim will be returned with a request for what is still needed in order to get reimbursed.

Sample Claim Form (B), Side 2



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

Expedition Credit Union
Apple Valley MN 55124
22-7608-2960

123456

DATE
7/15/2024

AMOUNT
**$385.20

PAY THREE HUNDRED EIGHTY FIVE DOLLARS and TWENTY CENTS

Claim #: 20240715111 PCN:
PAY TO THE ORDER OF

Member Name
Address

--- COPY ---

Employee Explanation of Benefits Statement

Employee:	Name	Facility/Group Name:	
Employee ID:	000011111	Provider/Dept Name:	PROVIDER NAME
Patient Name:	Name (ID:)	First Date of Service:	01/01/2024
Group Name:	DCUE DENTAL PARTICIPANTS	Last Date of Service:	01/01/2024
Unit Name:	DCUE DENTAL PARTICIPANTS	Claim	20240715111
Print Date:	7/15/2024 12:02:46 PM	Check No:	123456

Services Description	Billed Charges	Allowed or Contract Amt	Expl. Code	Copay	Employee Deductible	Total Covered Expenses	Plan Pays	Payable By Plan	Your Responsibility
Preventative	416.36	416.36	TIE	0.00	0.00	416.36	Tier	385.20	31.16
Explanation of Codes:	416.36	416.36		0.00	0.00	416.36		385.20	31.16

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	2000.00	50%
Ortho	0.00	2000.00	100%

Other Comments

This individual has $731.52 in Annual Dental benefits remaining. This individual has $228.50 in Lifetime Ortho benefits remaining.

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

Sample DCUE Dental Explanation of Benefits

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

NAME
ADDRESS

July 15, 2024

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 12:00pm/Noon on October 31, 2023

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: 9/1/2024

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.*

DCUE Dental

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

Notice of Right to Continue Dental Benefits

NAME
ADDRESS

Date of Notice: **7/15/2024**

Qualifying Event: **Resignation**

Date of Qualifying Event: **6/6/2024**

Dental Coverage Ends on: **5/31/2024**

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: **6/1/2024** Coverage May Continue Thru: **11/30/2025**

The first premium payment must cover all months that are current and past. An email will be sent to you to set up payment through our auto-pay system.

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

Payments will be automatically withdrawn on the 1st of the month. 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.
_____ I have completed and included my one-time COBRA enrollment form.
_____ I would like a Fiscal year-end receipt mailed to me.

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

Sample Notice of Right to Continue Dental Benefits Letter:

COBRA 18 Months of Coverage

DCUE Dental

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

Name
Address

July 15, 2024

Employee ID: _____

Re: Expiration of Coverage Warning

Name,

This letter is being sent as a courtesy to remind you that your dental coverage through DCUE Dental Reimbursement Fund will be expiring on **8/31/2024**.

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 $**86.55** and as of today you are paid thru **June** . If you have a balance due, your prompt payment is appreciated.

If you have signed up for our autopay your last premium payment will be withdrawn on the first day of your last month of coverage. If you have any withdrawals taken out after that contact me right away to get this corrected.

Please contact me if you have any questions.

Thank you.
Sincerely,

Justine Kolb
Fund Administrator
DCUE Dental Reimbursement Fund

Sample Expiration of Coverage Letter

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DCUE Dental Reimbursement Fund

Appendix D- COBRA Benefits and HIPPA Regulations

IMPORTANT INFORMATION

Continuation of Dental Coverage (COBRA)

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. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. 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."

End of employment qualifying events are Termination, Resignation or Retirement.

Retirees can remain on the Plan until they become entitled to Medicare (qualifying event); if already on Medicare at the time of retirement the employee can elect COBRA coverage for up to 18 months.

COBRA Continuation Coverage

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 to 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 becomes 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.

In the case of a dependent age 26 who is disabled, the disabled qualified beneficiary (or another person on their behalf) also must notify the Plan of the Social Security Administration determination. Notification needs to be given to the Plan within 60 days from the qualifying event date occurs, the date SSA issues the disability determination, or the date the qualified beneficiary loses (or would lose) coverage under the plan, whichever is later.

If the disability status changes the Plan must be notified within 60 days.

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.

An Election Notice and COBRA Enrollment Form will be sent to the qualified beneficiary. These forms are to be completed by the beneficiary and sent back to the Plan Administrator in order to elect COBRA Continuation Coverage. The qualified beneficiary has 60 days after the date of the notice or 60 days after the coverage would terminate, whichever is later, to send back the completed Election Notice and COBRA Enrollment Form.

If the Plan Administrator is not notified of the qualifying event for COBRA Continuation Coverage Election within the allowable period you and/or your dependents will be considered to have waived your right to COBRA Continuation Coverage.

COBRA Continuation Coverage Self-Contributions must be made monthly or paid ahead of time. Each monthly contribution is due on the first day of each month (due date) for which the self-contribution is being made. A self-contribution will be considered on time if it is received by the Plan Administrator within 30 days of the due date. You will receive a late premium reminder if your self-contribution is not received by the fifteenth of the month in which due.

The amount of the monthly self-contributions is determined during contract negotiations and based on

Federal regulations. The contribution amount is subject to change. When a change in self-contribution amount is made, proper notice and time for payment adjustment will be communicated.

Other Coverage Options besides COBRA Continuation Coverage

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

Additional Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Notification of Address Changes

In order to protect your family's rights, you should keep the Fund Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

Plan Contact Information

If you have questions regarding the information in this notice or need to provide notification as described in this notice, contact the Fund Administrator at:

Dakota County United Educators Dental Reimbursement Fund
6950 146th Street West Ste 114
Apple Valley, MN 55124
952-432-4033
dental@dcue.org

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Medical Data Privacy (HIPPA)

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.

B. 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.

C. **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.

D. **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.

E. **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 an 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).

F. **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.

G. **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.

H. **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.