MASSACHUSETTS STATE HEALTH CARE PROFESSIONALS' DENTAL FUND

333 WESTCHESTER AVENUE, N101
WHITE PLAINS, NY 10604
(800) 338-4330

NOTICE TO MEMBERS

September 2019

Dear Member and Family:

It has come to the attention of the Massachusetts State Health Care Professionals' Dental Fund (the "Fund") that the Fund's Summary Plan Description (SPD) does not, in some places, clearly distinguish between the overall annual dollar maximum that is applied to dental services under the Fund and the lifetime dollar maximum that is applied to orthodontia services. The purpose of this Notice is to clarify how the annual dollar maximums and lifetime dollar maximums are implemented under the Fund.

Standard Plan

Under the Standard Plan, the overall annual dollar maximum for dental services is $2,500 each calendar year for each covered person under the Plan. This amount excludes orthodontia services. However, the Plan includes a separate lifetime maximum of $1,000 that applies to orthodontia services for each covered person. In addition, for implant-related procedures, there is an annual maximum of $1,000 for each covered person under the Plan. These amounts are summarized in the table below.

STANDARD PLAN DENTAL PLAN MAXIMUMS	
Overall **Annual** Dollar Maximum for Dental Services, excluding services for Orthodontia and Implant-Related Procedures	**$2,500**
Lifetime Maximum for Orthodontia Services	**$1,000**
Annual Maximum for Implant-Related Procedures	**$1,000**

High Option Plan

Under the High Option Plan, the overall annual dollar maximum for dental services is $3,000 each calendar year for each covered person under the Plan. This amount excludes orthodontia services. However, the Plan includes a separate lifetime dollar maximum of $2,000 that applies to

orthodontia services for each covered person. In addition, for implant-related procedures, there is an annual dollar maximum of $2,000 for each covered person under the Plan. These amounts are summarized in the table below.

HIGH OPTION PLAN DENTAL PLAN MAXIMUMS	
Annual Maximum Amount for overall dental services, excluding services for Orthodontia and Implant-Related Procedures	**$3,000**
Lifetime Maximum Amount for Orthodontia Services	**$2,000**
Annual Maximum Amount for Implant-Related Procedures	**$2,000**

This clarification is effective as of January 1, 2019, the effective date of the Fund's SPD.

Please keep a copy of this information with your Summary Plan Description. If you have general questions related to this notice or your eligibility for Fund benefits, please call Alicare at 1-800-338-4330, or write to the Massachusetts State Health Care Professionals' Dental Fund, c/o Alicare, 333 Westchester Avenue, N101, White Plains, NY 10604.

Sincerely,

Board of Trustees

Massachusetts State Health Care

Professionals' Dental Fund

Summary Plan Description

Effective January 1, 2019

Contact Information at a Glance

Delta Dental is responsible for processing all dental claims for the Massachusetts State Health Care Professionals' Dental Fund. *Davis Vision* is responsible for insuring and processing vision claims. *Alicare* is responsible for various administrative matters, including eligibility. If you have questions related to the Fund, please refer to the brief summary below before contacting Delta Dental, Davis Vision or Alicare.

ALICARE:

- Answers any questions regarding a member's or dependent's eligibility for benefits. (Alicare is responsible for maintaining the list of those who are eligible for Fund benefits.)
- Administers members' and dependents' enrollment in the Plan.
- Responds to questions regarding member premium contributions for the High Option Dental Plan.
- Answers questions regarding COBRA enrollment, benefits and costs.

DELTA DENTAL:

- Processes claims for Dental Benefits.
- Answers questions regarding Dental Benefits provided by the Fund and whether a dental procedure is covered.
- Answers any questions concerning the reimbursement amount for a covered dental procedure.
- Responds to questions about the networks of dentists.
- Is responsible for sending out Delta Dental Identification Cards.

DAVIS VISION

- Insures and processes claims for Vision Benefits.
- Answers questions regarding the Vision Benefits provided by the Fund and whether a service or supply is covered.
- Answers questions concerning the coverage amount for a covered service or supply.
- Responds to questions regarding the vision network of providers.
- Is responsible for sending out Davis Vision Identification Cards.

A FEW IMPORTANT THINGS:

- The Delta Dental networks of dentists are available to all members, those covered by the Standard Plan or High Option Plan. Delta Dental can be reached at 1-800-872-0500 or at customer.care@deltadentalma.com.
- Alicare can be reached at 1-800-338-4330 or at MassNursesEnrollments@alicare.com.
- Davis Vision can be reached at 1-877-923-2847 or at DavisVision.com. The client code for the plan is 3194.

For a copy of this Summary Plan Description and additional information, go to www.massnurses.org/dental-fund.

VISIT www.massnurses.org/dental-fund On Your Phone:

Scan this code with a QR reader app to view the new portal on your mobile phone.

If your mobile phone supports a QR reader app, but you do not have a QR reader app, simply go to your app store (or www.mobile-barcarcodes.com) to find the appropriate QR code reader for your mobile phone. Follow the instructions to download the application and then install it on your phone.

MASSACHUSETTS STATE HEALTH CARE PROFESSIONALS' DENTAL FUND

333 Westchester Avenue, N101
White Plains, NY 10604
1-800-338-4330

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Novak Francella LLC, Fund Auditors

CONSULTANTS AND ACTUARIES

Segal Consulting

FUND ADMINISTRATOR

Alicare

Dear Member:

This booklet describes the dental and vision benefits that you and your eligible dependents are entitled to under the Massachusetts State Health Care Professionals' Dental Fund. This booklet replaces and supersedes any prior information regarding your dental and vision benefits.

While the Board of Trustees is pleased to offer this Plan of Benefits, it **reserves the right to amend, modify, discontinue or terminate all or part of this Plan whenever, in its judgment, conditions so warrant**. Benefits under this plan are not vested or guaranteed.

Please read this booklet carefully and keep it with your important papers.

YOU SHOULD COMPLETE AN ENROLLMENT FORM if you have never completed an enrollment form or if you need to update the Fund's information about you (if you have a change in name, a new dependent, or significant life event as noted on page 32). No claims will be processed until a completed enrollment form is on file

Your Trustees worked diligently in reviewing various Plan options and believe that these Plans and these levels of benefits will provide quality dental and vision coverage for you and your family. We urge you to take full advantage of these important benefits.

Sincerely,

BOARD OF TRUSTEES

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DENTAL PLANS

Dental Plan Election

Members employed by the University of Massachusetts Dartmouth, UMass Memorial Medical Center, the University of Massachusetts Medical School or the Commonwealth of Massachusetts, Unit 7, may annually elect to enroll in one of the following dental plans: the Standard Plan or the High Option Dental Plan. Elections for members become effective each July 1 and remain in effect through each June 30. This twelve-month period is called the "Plan Year." During a Plan Year you are only able to change your Dental Plan election during the annual open enrollment period, except for qualifying changes-in-status as described on page 32. For open enrollment information, please see page 31.

Covered Dental Services

Benefits are payable only for services listed in the Schedules of Benefits and only for amounts up to the Maximum Payment. See page 3 for the Schedules of Benefits for the Standard and High Option Dental Plans.

Standard Dental Plan

Maximum Payment for the Standard Plan

$2,500 each calendar year for each covered person, excluding orthodontia. For implant-related procedures, there is a separate $1,000 maximum payment for each calendar year for each covered person. There is an additional $1,000 lifetime maximum for each covered person for orthodontia.

No Member Contributions for the Standard Plan

Your employer makes a monthly contribution to the Fund on your behalf to support your dental benefits. Your employer makes the same level of contributions toward either the Standard Plan or the High Option Plan, if you are eligible to participate in either Plan.

If you are in the Standard Plan, you are not required to contribute to the cost of the Plan. Your employer's monthly contribution to the Fund on your behalf supports your dental benefits.

High Option Dental Plan

Maximum Payment for the High Option Plan

$3,000 each calendar year for each covered person, excluding orthodontia. For implant-related procedures, there is a separate $2,000 maximum payment for each calendar year for each

covered person. There is an additional $2,000 lifetime maximum for each covered person for orthodontia.

Member Contributions for the High Option Dental Plan

Your employer makes a monthly contribution to the Fund on your behalf to support your dental benefits. Your employer makes the same level of contributions toward either the Standard Plan or the High Option Plan, if you are eligible to participate in either Plan.

If you enroll in the High Option Plan, you are required to make an employee contribution each month. The contribution amount is set by the Trustees and is subject to change from time to time at the Trustees' discretion. Members employed by UMass Memorial Medical Center pay for these contributions via pre-tax payroll deduction. Members employed by the University of Massachusetts Dartmouth, the University of Massachusetts Medical School and the Commonwealth of Massachusetts, Unit 7 presently pay for these contributions via payroll deductions on an after-tax basis. The tax treatment of the contributions is determined by the particular employer, and is subject to change.

You make member contributions in the month preceding the month for which dental coverage is provided. For example, deductions made in February provide you with High Option Benefits in March.

Eligibility to Participate in the High Option Dental Plan

You are eligible to participate in the High Option Dental Plan, i.e., make the required pre-tax or after-tax payroll deductions, on the first day of the month following the date you return the required enrollment/deduction forms to Alicare. You must enroll in the High Option Dental Plan within thirty (30) days of being notified of your eligibility or your coverage may be delayed.

Missed Member Contributions

- In General:

  If a member fails to make the monthly contribution to the High Option Dental Plan, the member will become covered under the Standard Plan beginning on the first day of the month following the month in which member contributions cease, provided the member is still eligible for Fund benefits.

- Exception for Sick Leave, Leave of Absence or Leave Without Pay that is a Non-Family Medical Leave Act (FMLA) Leave:

  If member contributions are not made because the member is on sick leave, leave of absence or leave without pay that is not considered FMLA leave, the member must notify Alicare of the occurrence of the leave. Upon notification, the member may self-pay the contributions if notification is made within 60 days of the commencement of the leave.

The member will be required to pay all of the member contributions that have not been made during the Plan Year.

Schedules of Dental Benefits (Maximum Payments)
Effective as of January 1, 2019

Code	Exams and X-rays	Standard Plan Pays	High Option Plan Pays
***These services are not subject to the annual plan maximum**			
D0120	Periodic oral evaluation (maximum of two per calendar year)*	100%	100%
D0140	Limited oral evaluation - problem focused (maximum of two per calendar year)*	100%	100%
D0145	Oral Evaluation under three years of age, over three years of age will be disallowed	100%	100%
D0150	Comprehensive oral evaluation - new or established patient (maximum of two per calendar year)*	100%	100%
D0160	Detailed and extensive oral evaluation - problem focused, by report	100%	100%
D0180	Comprehensive periodontal evaluation	100%	100%
D0210	Intraoral - complete series (including bitewings) (once in 36 months)	100%	100%
D0220	Intraoral - periapical first film	100%	100%
D0230	Intraoral - periapical each additional film	100%	100%
D0240	Intraoral - occlusal film	100%	100%
D0250	Extra oral - 2D radiographic image	100%	100%
D0270	Bitewing - single film	100%	100%
D0272	Bitewings - two films	100%	100%
D0273	Bitewings - three films	100%	100%
D0274	Bitewings - four films	100%	100%
D0277	Vertical bitewings - 7 to 8 films	100%	100%
D0321	Other temporomandibular joint films, by report	100%	100%
D0330	Panoramic film	100%	100%
D0340	Cephalometric Film	100%	100%
D0350	Oral/Facial Photographic Images	100%	100%
D0414	Lab processing for microbial specimen	100%	100%
D0415	Bacteriologic studies for determination of pathologic agents	100%	100%
D0460	Pulp Vitality Tests - Only for diagnostic and emergency conditions	100%	100%
D0470	Diagnostic casts	100%	100%
D1110	Prophylaxis – adult (maximum of two per calendar year)*	100%	100%
D1120	Prophylaxis – child (maximum of two per calendar year)*	100%	100%
*Maximum of two cleanings and two oral evaluations per calendar year.			

Code	Cleanings, Fluoride and Sealants	Standard Plan Pays	High Option Plan Pays
***These services are not subject to the annual plan maximum**			
D1206	Topical fluoride varnish	100%	100%
D1208	Topical application of fluoride (maximum of two per calendar year)*	100%	100%
D1351	Sealant - per tooth (applied to unrestored permanent molars, once per tooth every four years through age 15. Also extended to covered members to age 19 who had a recent cavity and are at risk for future decay).	100%	D1351
D1352	Preventive resin restoration is a moderate to high caries risk patient permanent tooth conservative restoration of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating	100%	100%
*Maximum of two cleanings and two oral evaluations per calendar year.			

Code	Space Maintainers	Standard Plan Pays	High Option Plan Pays
***These services are not subject to the annual plan maximum**			
D1510	Space maintainer - fixed - unilateral (before age 19)	100%	100%
D1516	Space maintainer - fixed – bilateral, maxillary (before age 19)	100%	100%
D1517	Space maintainer – fixed – bilateral, mandibular	100%	100%
D1520	Space maintainer - removable - unilateral	100%	100%
D1526	Space maintainer - removable – bilateral, maxillary	100%	100%
D1527	Space maintainer - removable – bilateral, mandibular	100%	100%
D1550	Re-cementation of space maintainer	100%	100%
D1555	Removal of Fixed Space Maintainer, covered only when done by a dentist who did not place the original appliance	100%	100%
D1575	Distal Shoe Space Maintainer - fixed unilateral (for first molars only for premature loss of second primary molars – A J K T)	100%	100%

Code	Periodontal Services	Standard Plan Pays	High Option Plan Pays
***These services are not subject to the annual plan maximum**			
D4346	Scaling in the presence of a generalized moderate or severe gingival inflammation-full mouth after overall evaluation	100%	100%
D4355	Full Mouth Debridement to enable comprehensive evaluation	100%	100%
D4910	Periodontal maintenance (following active periodontal therapy – Four periodontal cleanings per calendar year, not to exceed two periodontal cleanings per calendar year if combined with preventive cleanings). *Not subject to annual plan maximum	100%	100%

Code	Amalgam (silver) Fillings	Standard Plan Pays	High Option Plan Pays
D2140	Amalgam - one surface, primary or permanent	$49.24	$82.09
D2150	Amalgam - two surfaces, primary or permanent	$65.65	$107.12
D2160	Amalgam - three surfaces, primary or permanent	$75.91	$125.22
D2161	Amalgam - four or more surfaces, primary or permanent	$98.48	$162.77

Code	Composite (white) Fillings	Standard Plan Pays	High Option Plan Pays
D2330	Resin-based composite - one surface, anterior	$67.70	$109.91
D2331	Resin-based composite - two surfaces, anterior	$77.96	$128.00
D2332	Resin-based composite - three surfaces, anterior	$100.53	$165.56
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$116.94	$196.16
D2390	Resin-based composite crown, anterior	$116.94	$196.16
D2391	Resin-based composite - one surface, posterior	$82.06	$116.87
D2392	Resin-based composite - two surfaces, posterior	$112.84	$158.61
D2393	Resin-based composite - three surfaces, posterior	$147.71	$208.69
D2394	Resin-based composite - four or more surfaces	$172.33	$242.08

Code	Endodontics (root canals)	Standard Plan Pays	High Option Plan Pays
D3110	Pulp cap - direct (excluding final restoration)	$35.90	$57.39
D3120	Pulp cap - indirect (excluding final restoration)	$35.90	$57.39
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$94.89	$156.52
D3221	Pulpa Debridement, primary and permanent teeth, disallowed when endodontic treatment is completed by the same dentist/dental office	$111.63	$184.14
D3310	Anterior (excluding final restoration)	$433.40	$714.76
D3320	Bicuspid (excluding final restoration)	$589.83	$975.61
D3330	Molar (excluding final restoration)	$759.09	$1,255.60
D3346	Retreatment of previous root canal therapy - anterior	$464.17	$768.67
D3347	Retreatment of previous root canal therapy - bicuspid	$551.37	$914.75
D3348	Retreatment of previous root canal therapy - molar	$648.82	$1,074.74
D3410	Apicoectomy/periradicular surgery - anterior	$394.93	$653.89
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$410.32	$681.72
D3425	Apicoectomy/periradicular surgery - molar (first root)	$418.01	$692.15
D3426	Apicoectomy/periradicular surgery (each additional root)	$394.93	$653.89
D3430	Retrograde filling - per root	$84.63	$140.86
D3920	Hemisection, not including root canal therapy, only per posterior tooth per lifetime	$188.02	$304.72

Code	Periodontics	Standard Plan Pays	High Option Plan Pays
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$264.66	$374.24
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	$158.79	$224.55
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$266.71	$443.81
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	$160.02	$266.28
D4245	Apically positioned flap	$266.71	$443.81

Code	Periodontics	Standard Plan Pays	High Option Plan Pays
D4249	Clinical crown lengthening - hard tissue	$258.50	$428.51
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	$594.96	$985.01
D4261	Osseous surgery (including flap entry and closure) - 1-3 teeth/quadrant	$356.98	$591.00
D4263	Bone replacement graft - first site in quadrant	$104.63	$173.90
D4264	Bone replacement graft - each additional site in quadrant	$125.15	$208.69
D4265	Biologic Materials to aid soft/osseous tissue regeneration, once per site on natural teeth, not to exceed two sites/tooth per quadrant per 36 months	$116.34	$205.27
D4266	Guided tissue regeneration-resorb barrier, per site, once per site on natural teeth, not to exceed two sites/tooth per quadrant per 36 months	$249.52	$401.31
D4267	Guided tissue regeneration-nonresorb barrier, per site, once per site on natural teeth, not to exceed two sites/tooth per quadrant per 36 months	$249.52	$401.31
D4270	Pedicle soft tissue graft procedure	$369.29	$612.15
D4273	Subepithelial connective tissue graft procedures	$367.24	$609.37
D4274	Distal or Proximal Wedge procedure	$169.84	$281.82
D4275	Soft tissue allograft	$367.24	$609.37
D4276	Combined connective tissue and double pedicle graft	$367.24	$609.37
D4277	Free Soft Tissue Graft Procedure (including donor site surgery), first tooth or edentulous tooth position in graft	$275.43	$634.33
D4278	Free Soft Tissue Graft Procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	$91.81	$152.34
D4283	Autogenous connective tissue graft procedure each additional contiguous tooth – two graphs per 36 month, per quadrant	$220.34	$365.63
D4285	Non-autogenous connective tissue graft procedure each additional contiguous tooth – two graphs per 36 month, per quadrant	$220.34	$365.63
D4320	Provisional splinting - intracoronal	$112.84	$186.43
D4321	Provisional splinting - extracoronal	$123.10	$204.52
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant. Two quadrants are allowed on the same date of service. Additional quadrants will be denied.	$116.94	$196.16

Code	Periodontics	Standard Plan Pays	High Option Plan Pays
D4342	Periodontal scaling and root planing - one to three teeth/ quadrant	$118.99	$198.95
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	45.76	$76.51
D4920	Unscheduled dressing change (by someone other than treating dentist)	$43.08	$73.73

Code	Inlays and Onlays	Standard Plan	High Option Plan
D2510	Inlay - metallic - one surface	$489.12	$654.24
D2520	Inlay - metallic - two surfaces	$491.42	$660.54
D2530	Inlay - metallic - three or more surfaces	$502.90	$674.40
D2542	Onlay - metallic-two surfaces	$505.20	$674.40
D2543	Onlay - metallic-three surfaces	$507.49	$681.96
D2544	Onlay - metallic-four or more surfaces	$518.98	$695.83
D2610	Inlay - porcelain/ceramic - one surface	$502.90	$674.40
D2620	Inlay - porcelain/ceramic - two surfaces	$491.42	$660.54
D2630	Inlay - porcelain/ceramic - three or more surfaces	$489.12	$654.24
D2642	Onlay - porcelain/ceramic - two surfaces	$505.20	$674.40
D2643	Onlay - porcelain/ceramic - three surfaces	$507.49	$681.96
D2644	Onlay - porcelain/ceramic - four or more surfaces	$518.98	$695.83
D2650	Inlay - resin-based composite - one surface	$509.79	$681.96
D2651	Inlay - resin-based composite - two surfaces	$369.71	$496.66
D2652	Inlay - resin-based composite - three or more surfaces	$420.23	$566.00
D2662	Onlay - resin-based composite - two surfaces	$505.20	$674.40
D2663	Onlay - resin-based composite - three surfaces	$507.49	$681.96
D2664	Onlay - resin-based composite - four or more surfaces	$518.98	$695.83

Code	Crowns	Standard Plan Pays	High Option Plan Pays
D2710	Crown - resin (indirect)	$555.72	$743.73
D2712	Crown- ¾ resin based composite (indirect)	$555.72	$743.73
D2720	Crown - resin with high noble metal	$555.72	$743.73
D2721	Crown - resin with predominantly base metal	$555.72	$743.73
D2722	Crown - resin with noble metal	$555.72	$743.73
D2740	Crown - porcelain/ceramic substrate	$555.72	$743.73
D2750	Crown - porcelain fused to high noble metal	$555.72	$743.73
D2751	Crown - porcelain fused to predominantly base metal	$555.72	$743.73
D2752	Crown - porcelain fused to noble metal	$555.72	$743.73
D2780	Crown - 3/4 cast high noble metal	$555.72	$743.73
D2781	Crown - 3/4 cast predominantly base metal	$555.72	$743.73
D2782	Crown - 3/4 cast noble metal	$555.72	$743.73
D2783	Crown - 3/4 porcelain/ceramic	$555.72	$743.73
D2790	Crown - full cast high noble metal	$555.72	$743.73
D2791	Crown - full cast predominantly base metal	$555.72	$743.73
D2792	Crown - full cast noble metal	$555.72	$743.73
D2794	Crown - titanium	$555.72	$743.73
D2799	Provisional crown	$555.72	$743.73

Code	Other Restorative Services	Standard Plan Pays	High Option Plan Pays
D2910	Recement inlay	$35.82	$53.87
D2915	Recement or re-bond indirectly fabricated or Prefabricated Post and Core	$39.80	$58.77
D2920	Recement crown	$39.80	$58.77
D2930	Prefabricated stainless steel crown - primary tooth	$121.40	$183.65
D2940	Sedative filling	$43.78	$67.34
D2941	Interim therapeutic restoration – primary tooth	$43.78	$67.34
D2950	Core buildup, including any pins	$94.15	$127.32
D2951	Pin retention - per tooth, in addition to restoration	$19.90	$26.93
D2952	Cast post and core in addition to crown	$218.15	$293.71
D2953	Each additional indirectly fabricated post - same	$135.48	$182.78
D2954	Prefabricated post and core in addition to crown	$169.93	$226.90
D2960	Labial veneer (resin laminate) - chairside	$349.05	$466.41
D2961	Labial veneer (resin laminate) - laboratory	$394.97	$526.92
D2962	Labial veneer (porcelain laminate) - laboratory	$477.64	$637.85
D2980	Crown Repair, by report, once per year per tooth after 24 months of crown insertion	$99.52	$130.02

Code	Dentures	Standard Plan Pays	High Option Plan Pays
D5110	Complete denture, upper (maxillary)	$615.42	$826.93
D5120	Complete denture, lower (mandibular)	$601.64	$804.24
D5130	Immediate denture, upper (maxillary)	$626.90	$840.80
D5140	Immediate denture, lower (mandibular)	$654.46	$878.62
D5211	Maxillary partial denture -resin base	$567.20	$760.12
D5212	Mandibular partial denture - resin base	$578.68	$776.51
D5213	Maxillary partial denture - cast medal framework with resin bases	$714.16	$956.77
D5214	Mandibular partial denture - cast metal framework with resin bases	$711.87	$951.73
D5221	Immediate maxillary partial denture – resin base	$572.87	$767.72
D5222	Immediate mandibular partial denture – resin base	$584.93	$784.73
D5223	Immediate Maxillary partial denture - cast medal framework with resin denture bases	$721.30	$966.34
D5224	Immediate Mandibular partial denture - cast metal framework with resin denture bases	$719.55	$962.02
D5225	Maxillary partial denture - flexible base	$567.20	$760.12
D5226	Mandibular partial denture - flexible base	$578.68	$776.51
D5282	Rem. unilateral partial denture-1 piece cast metal, maxillary	$296.96	$403.87
D5283	Rem. unilateral partial denture-1 piece cast metal, mandibular	$296.96	$403.87
D5820	Interim partial denture (maxillary), to replace anterior permanent teeth during the healing period after an extraction, also in children 16 years of age and under for missing anterior teeth	$209.37	$292.30
D5821	Interim partial denture (mandibular) to replace anterior permanent teeth during the healing period after an extraction, also in children 16 years of age and under for missing anterior teeth	$209.37	$292.30

Code	Repairs and Adjustments to Prosthetic Appliances	Standard Plan Pays	High Option Plan Pays
D5410	Adjust complete denture - maxillary	$31.84	$48.97
D5411	Adjust complete denture - mandibular	$37.81	$56.32
D5421	Adjust partial denture - maxillary	$35.82	$53.87
D5422	Adjust partial denture - mandibular	$41.79	$62.44
D5511	Repair of broken complete denture base, mandibular (lower arch) - Once per 12 months (after 6 months from insertion)	$65.68	$96.73
D5512	Repair of broken complete denture base, maxillary (upper arch) - Once per 12 months (after 6 months from insertion)	$65.68	$96.73
D5520	Replace missing or broken teeth - complete denture (each tooth)	$43.78	$67.34
D5611	Repair resin partial denture base, mandibular (lower arch). Once per 12 months (after 6 months from insertion).	$55.72	$83.25
D5612	Repair resin partial denture base, maxillary (upper arch). Once per 12 months (after 6 months from insertion).	$55.72	$83.25
D5621	Repair cast partial framework, mandibular (lower arch). Once per 12 months (after 6 months from insertion).	$61.70	$91.83
D5622	Repair cast partial framework, maxillary (lower arch). Once per 12 months (after 6 months from insertion).	$61.70	$91.83
D5630	Repair or replace broken clasp	$65.68	$99.17
D5640	Replace broken teeth - per tooth	$47.76	$72.24
D5650	Add tooth to existing partial denture	$55.72	$83.25
D5660	Add clasp to existing partial denture	$73.64	$110.19
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$309.47	$464.62
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$309.47	$464.62
D5710	Rebase complete maxillary denture (once in three years)	$173.14	$258.33
D5711	Rebase complete mandibular denture (once in three years)	$173.14	$258.33
D5720	Rebase maxillary partial denture (once in three years)	$185.09	$280.37
D5721	Rebase mandibular partial denture (once in three years)	$185.09	$280.37
D5730	Reline complete maxillary denture (chairside)	$113.44	$172.63

Code	Repairs and Adjustments to Prosthetic Appliances	Standard Plan Pays	High Option Plan Pays
D5731	Reline complete mandibular denture (chairside)	$91.55	$134.67
D5740	Reline maxillary partial denture (chairside)	$107.47	$161.61
D5741	Reline mandibular partial denture (chairside)	$91.55	$134.67
D5750	Reline complete maxillary denture (laboratory)	$135.33	$202.01
D5751	Reline complete mandibular denture (laboratory)	$161.20	$239.96
D5760	Reline maxillary partial denture (laboratory)	$163.19	$242.41
D5761	Reline mandibular partial denture (laboratory)	$163.19	$242.41
D5862	Precision attachment, by report	$282.45	$376.91
D5863	Overdenture – Complete, upper arch	$615.42	$826.93
D5864	Overdenture – Partial, upper arch	$578.68	$776.51
D5865	Overdenture – Complete, lower arch	$615.42	$826.93
D5866	Overdenture – Partial, lower arch	$578.68	$766.51

Code	Implants	Standard Plan Pays	High Option Plan Pays
	Separate Annual Maximum	**$1,000.00**	**$2,000.00**
D6010	Surgical placement of Implant body (once per tooth in 60 months)	$520.83	$1,030.66
D6013	Surgical placement of Mini-Implant body (once per tooth in 60 months)	$260.42	$515.33
D6056	Prefabricated Abutment (once per tooth in 60 months)	$147.15	$290.04
D6057	Custom Abutment (if a cast post and core was performed on the tooth within 60 months of the implant abutment, the implant abutment will be denied)	$196.56	$387.45
D6058	Implant abutment supported porcelain/ceramic crown	$555.72	$743.73
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$555.72	$743.73
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$555.72	$743.73
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$555.72	$743.73
D6062	Abutment supported cast metal crown (high noble metal)	$555.72	$743.73
D6063	Abutment supported cast metal crown (predominantly base metal)	$555.72	$743.73

Code	Implants	Standard Plan Pays	High Option Plan Pays
	Separate Annual Maximum	**$1,000.00**	**$2,000.00**
D6064	Abutment supported cast metal crown (noble metal)	$555.72	$743.73
D6065	Implant supported porcelain/ceramic crown	$555.72	$743.73
D6066	Implant supported porcelain fused to metal crown	$555.72	$743.73
D6067	Implant supported metal crown	$555.72	$743.73
D6068	Abutment Supported Retainer Porc/Ceramic FPD, alternate benefit of a partial denture or bridge	$609.38	$815.50
D6085	Provisional Implant Crown	$555.72	$743.73
D6090	Repair Implant Supported Prosthesis, by report	$75.60	$112.05
D6092	Recement implant/abutment supported crown	$39.80	$58.77
D6093	Recement implant/abutment supported fixed partial denture (once per tooth after 6 month have elapsed from the initial seating date by the same dentist/dental office)	$36.86	$80.14
D6095	Repair implant abutment, by report (once per 12 months after 24 months have elapsed from the initial insertion date of the crown)	$70.88	$137.52
D6100	Implant removal (once per tooth per lifetime)	$60.68	$117.71
D6110	Implant/Abutment Complete Denture-Removable Upper Arch	$615.42	$826.93
D6111	Implant/Abutment Complete Denture-Removable Lower Arch	$615.42	$826.93
D6112	Implant/Abutment Partial Denture-Removable Upper Arch	$714.16	$956.77
D6113	Implant/Abutment Partial Denture-Removable Lower Arch	$714.16	$956.77

Code	Bridgework	Standard Plan Pays	High Option Plan Pays
D6210	Pontic - cast high noble metal	$656.76	$882.40
D6211	Pontic - cast predominantly base metal	$484.53	$649.19
D6212	Pontic - cast noble metal	$493.72	$663.06
D6214	Pontic - titanium	$656.76	$882.40
D6240	Pontic - porcelain fused to high noble metal	$656.76	$882.40
D6241	Pontic - porcelain fused to predominantly base metal	$484.53	$649.19
D6242	Pontic - porcelain fused to noble metal	$493.72	$663.06
D6245	Pontic - porcelain/ceramic	$656.76	$882.40
D6250	Pontic - resin with high noble metal	$470.75	$629.02

Code	Bridgework	Standard Plan Pays	High Option Plan Pays
D6251	Pontic - resin with predominantly base metal	$470.75	$629.02
D6252	Pontic - resin with noble metal	$470.75	$629.02
D6545	Retainer-Cast Metal for resin bonded fixed prosth	$236.32	$305.47
D6608	Onlay - porcelain/ceramic, two surfaces	$505.20	$674.40
D6609	Onlay - porcelain/ceramic, three or more surfaces	$507.49	$681.96
D6610	Onlay - cast high noble metal, two surfaces	$505.20	$674.40
D6611	Onlay - cast high noble metal, three or more surfaces	$507.49	$681.96
D6612	Onlay - cast predominantly base metal, two surfaces	$505.20	$674.40
D6613	Onlay - cast predominantly base metal, three or more surfaces	$507.49	$681.96
D6614	Onlay - cast noble metal, two surfaces	$505.20	$674.40
D6615	Onlay - cast noble metal, three or more surfaces	$507.49	$681.96
D6634	Onlay - titanium	$507.49	$681.96
D6720	Crown - resin with high noble metal	$555.72	$743.74
D6721	Crown - resin with predominantly base metal	$555.72	$743.74
D6722	Crown - resin with noble metal	$555.72	$743.74
D6740	Crown - porcelain/ceramic	$555.72	$743.74
D6750	Crown - porcelain fused to high noble metal	$675.13	$903.82
D6751	Crown - porcelain fused to predominantly base metal	$585.57	$787.86
D6752	Crown - porcelain fused to noble metal	$603.94	$809.29
D6780	Crown - 3/4 cast high noble metal	$555.72	$743.73
D6781	Crown - 3/4 cast predominantly base metal	$555.72	$743.73
D6782	Crown - 3/4 cast noble metal	$555.72	$743.73
D6783	Crown - ¾ porcelain/ceramic	$555.72	$743.73
D6790	Crown - full cast high noble metal	$560.31	$751.30
D6791	Crown - full cast predominantly base metal	$555.72	$743.73
D6792	Crown - full cast noble metal	$555.72	$743.73
D6794	Crown - titanium	$560.31	$751.30
D6930	Recement fixed partial denture	$47.76	$72.24
D6940	Stress breaker	$144.67	$191.61
D6950	Precision attachment	$282.45	$376.91
D6980	Fixed partial denture repair, by report	$93.54	$139.57

Code	Oral Surgery	Standard Plan Pays	High Option Plan Pays
D7111	Coronal remnants, deciduous tooth	$75.91	$107.12
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$77.96	$109.91
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$133.35	$219.82
D7220	Removal of impacted tooth - soft tissue	$160.02	$265.73
D7230	Removal of impacted tooth - partially bony	$217.47	$361.73
D7240	Removal of impacted tooth - completely bony	$256.45	$425.73
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$256.45	$425.73
D7250	Surgical removal of residual tooth roots (cutting procedure)	$131.30	$217.04
D7280	Surgical access of an unerupted tooth	$272.86	$449.38
D7285	Biopsy of oral tissue - hard (bone, tooth)	$133.35	$219.82
D7286	Biopsy of oral tissue - soft (all others)	$100.53	$165.56
D7288	Brush Biopsy-transepithelial sample collection	$39.21	$74.21
D7290	Surgical Repositioning of teeth	$80.42	$114.17
D7296	Corticomy-one to three teeth spaces per quadrant. Once per lifetime per quadrant. Subject to Orthodontia maximum.	$160.02	$266.28
D7297	Corticomy-four or more teeth space per quadrant. Once per lifetime per quadrant. Subject to Orthodontia maximum.	$266.71	$443.81
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$94.37	$153.04
D7311	Alveoloplasty in conjunction with extractions 1 to 3 teeth or tooth spaces per quad	$56.62	$91.83
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$168.23	$278.25
D7321	Alveoloplasty not in conjunction with extractions 1 to 3 teeth or tooth spaces per quad	$100.94	$166.95
D7410	Excision of Benign Lesion up to 1.25cm covered only with a pathology report with claim-medical plan will cover	$189.70	$318.32
D7510	Incision and drainage of abscess - intraoral soft tissue	$82.06	$137.74
D7520	Incision and drainage of abscess - extraoral soft tissue	$92.32	$150.26
D7950	Osseous, Osteoperiosteal, or Cartilage Graft of	$1,346.02	$1,562.83

Code	Oral Surgery	Standard Plan Pays	High Option Plan Pays
	the Mandible or Maxilla – autogenous or nonautogenous, by report		
D7952	Sinus Augmentation via a verticle approach	$655.43	$1,026.20
D7953	Bone Replacement Graft for Ridge Preservation – per site	$211.32	$324.29
D7960	Frenectomy	$218.17	$315.02
D7979	Non-Surgical Siaolithitomy. Once per lifetime.	$80.42	$114.17

Code	Minor Treatment to Control Harmful Habits	Standard Plan Pays	High Option Plan Pays
D8210	Removable appliance therapy	$90.00	$220.00
D8220	Fixed appliance therapy	$90.00	$220.00
D8695	Removal of Fixed Orthodontic Appliances for reasons other than completion of treatment. Once per lifetime, per quadrant. Subject to Orthodontia lifetime maximum.	$74.91	$93.32

Code	Unclassified Treatment	Standard Plan Pays	High Option Plan Pays
D9110	Palliative treatment of dental pain, minor procedure	$41.03	$70.23
D9222	Deep sedation/general anesthesia –first 15 minutes (pre-set up time). Covered in conjunction with impacted teeth only up to one hour.	$93.67	$139.85
D9223	Deep sedation/general anesthesia –each subsequent 15 minute increment, allowed with covered surgical impacted teeth only (up to one hour)	$78.67	$124.85
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide. If documented as necessary on patient record to complete treatment, then covered once per patient per date of service (for children under age 19 only)	$41.88	$64.16
D9239	Intravenous moderate conscious sedation/analgesia – first 15 minutes (pre-set up time) covered in conjunction with impacted teeth only (up to one hour)	$86.87	$129.27
D9243	Intravenous moderate conscious sedation/analgesia – each subsequent 15 minute increment, allowed with covered surgical impacted teeth only (up to one hour)	$71.87	$114.27
D9248	Non-intravenous conscious sedation (Only for eligible dependent children age 19 and under)	$40.45	$64.29

Code	Unclassified Treatment	Standard Plan Pays	High Option Plan Pays
D9930	Treatment of Complications (post-surgical)-unusual circumstances, individual consideration	$45.43	$81.03
D9944	Occlusal Guard – hard appliance, full arch	$199.75	$321.37
D9945	Occlusal Guard – soft appliance, full arch	$49.94	$80.34
D9946	Occlusal Guard – soft appliance, partial arch	$79.90	$128.55
D9951	Occlusal adjustment - limited	$89.88	$148.40
D9952	Occlusal adjustment - complete	$127.00	$209.35
D9973	External bleaching, per tooth	$175.85	$291.50

Orthodontia (Braces)

All valid Orthodontia CDT codes are reimbursable.

The reimbursement amount will depend on which CDT code is billed and reimbursement is subject to the maximums denoted in the chart below ($2,500 lifetime maximum is payable under the Standard Plan or $3,000 lifetime maximum is payable under the High Plan). In no case will the total benefits issued exceed the Plan's lifetime maximums.

Reimbursement will be based on 24-months of active treatment and the dentist's total submitted case fee, which will be divided by 12-months to determine the monthly payment amount. This amount will be paid out on a monthly basis until the lifetime maximum has been reached. The first payment is based on the date of banding (the date the braces are put on) and additional monthly payments will be issued automatically assuming the member is still eligible for orthodontia benefits.

Orthodontia treatment must be administered/supervised by a licensed dentist. Mail order kits are not covered under this plan.

Delta Dental PPO Plus Premier Network

Delta Dental is the Fund's dental network provider. Delta Dental PPO *Plus Premier* is available to you. It is a dental plan arrangement that combines dentists in two of the Delta Dental's networks.

What is Delta Dental PPO *Plus Premier*?

When you need dental services, you can select a dentist from either the Delta Dental Premier or the Delta Dental PPO network of dentists. Delta Dental will process your claims depending on the dentist that you have selected to provide services to you.

- The Delta Dental Premier network is a large network of dentists, with approximately 96% of dentists in Massachusetts. Savings are created through Delta Dental negotiated dentists' fees.

- The Delta Dental PPO network is a smaller network of dentists who have agreed to fees that are up to 25%-30% less than what dentists normally charge. Approximately 30% of dentists who participate with Delta Dental Premier in Massachusetts also participate with the Delta Dental PPO. Most often, the Delta Dental PPO network will result in greater out-of-pocket savings for you because of deeper dentist discounts, as compared to the Delta Dental Premier network.

Regardless of which dentist you select, the Fund's Schedules of Dental Benefits under the Standard and High Option Plans are the same. Delta Dental PPO *Plus Premier* prohibits participating dentists from billing a patient above a predetermined amount. This arrangement is expected to result in protection and out-of-pocket savings for members who receive services from participating dentists.

Members or eligible dependents who receive services from a dentist who does not contract with Delta Dental are still eligible for coverage, but without the benefit of the Delta Dental discount. In this case, you will be "balance billed" for the difference between the dentist's charge and the Maximum Payment allowed by the Fund.

Pre-Treatment Estimates

If your dentist expects that dental treatment will involve a series of covered services (over $300), he or she should file a copy of the treatment plan with *Delta Dental* BEFORE these services are rendered. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charges for each service.

Upon receipt of the treatment plan, Delta Dental will notify you and your dentist about the maximum extent of your benefits for the services reported.

NOTE: Pre-treatment estimates are calculated based on current available benefits and the patient's eligibility at the time services are completed and a claim is submitted for payment. If

your dentist does not file a treatment plan for a pre-treatment estimate, Delta Dental will decide the extent of your benefits based on a review of those services using standards that are generally considered as accepted dental practices.

Finding a Dentist

To verify if your dentist is part of the Delta Dental PPO or Delta Dental Premier network, refer to *Find a Dentist* on Delta Dental's website www.deltadentalma.com. You can also call Delta Dental's Customer Service department at 1-800-872-0500.

Identification Cards

All you will need to do is show your Delta Dental Identification Card to your participating dentist to indicate that you are enrolled in Delta Dental PPO *Plus Premier*. (All ID cards are issued in the employee's name, but can be used by any dependent covered by the plan.)

Other Information About Out-of-Pocket Expenses

If you received treatment that is not covered under the Plan, you may be billed at the dentist's normal fee rather than Delta Dental's negotiated fee. Also, if you receive a covered service when you have already exhausted your maximum or you receive a treatment which will cause you to exceed your maximum, you may be billed at the dentist's negotiated fee. To avoid any unexpected out of pocket expenses, it is recommended that you visit Delta Dental's website, www.deltadentalma.com, or call Customer Service at 1-800-872-0500 to determine your remaining benefit.

Dental Expense Benefits For You and Your Family

If you or an eligible member of your family incurs covered dental charges, this Plan will pay for the expenses actually incurred up to the amount specified in the Schedules of Dental Benefits, but not to exceed in the aggregate the Maximum Payment as shown in those Schedules. Benefits are payable only for services listed in the Schedules of Benefits when performed by a legally qualified dentist.

Limitations and Exclusions

- Benefits are only provided for necessary and appropriate services.

- Benefits will not be provided for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition as determined by *Delta Dental*.

    - To be necessary and appropriate, a service must be:

      Consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist.

    - Who determines what is necessary and appropriate under the terms of the *Plan*:

      That decision is made by *Delta Dental* based on a review of dental records describing your condition and treatment. Delta Dental may decide a service is not necessary and appropriate under the terms of the *Plan* even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

- Services are not provided for:

    - A service or procedure that is not generally accepted as determined by *Delta Dental*.
    - A service or procedure that is not described in the Schedules of Dental Benefits.
    - Services that are rendered due to the requirements of a third party, such as an employer or school.
    - Travel time and related expenses.
    - An illness or injury that Delta Dental determines arose out of and in the course of your employment.
    - A service for which you are not required to pay, or for which you would not be required to pay if you did not have Fund coverage.
    - An illness, injury or dental condition for which benefits in one form or another are available, in whole or in part, through a government program or would have been available if you did not have Fund coverage. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare. We will not provide benefits if you could have received

government benefits by applying for them within the appropriate agency's time limitation.

- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Consultations.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or *fracture*, such as erosion, abrasion, or attrition.
- Services that are meant primarily to change or to improve your appearance.
- Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding).
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.
- Photographs.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing overdentures.
- Services related to congenital anomalies. However, this exclusion does not apply to orthodontic services that may be covered by the Plan's orthodontic rider.
- Tooth desensitization.
- Occlusal adjustment.

VISION BENEFITS

Your employer makes a monthly contribution to the Fund on your behalf to support your vision benefits. You are not required to contribute to the cost of vision benefits.

You are automatically enrolled in the Vision Plan upon your enrollment in the Dental Plan. The Vision Plan covers eye exams, glasses and frames, and contact lenses. See the Schedule of Benefits below for more information.

The vision benefit year is September 1 through August 31.

Schedule of Benefits
Effective January 1, 2019

Benefit	Frequency (Plan year is 9/1 – 8/31)	In-Network	Out-of-Network (You pay 100% and apply for reimbursement)
Eye Exam	Once per year	You pay: $25 copay	$74.20
Frames	Once every other year (Once per year for dependents under age 14)	• Davis Vision Exclusive Collection: you pay $0 • Visionworks frames: $150 allowance, plus 20% off any balance. • Other frames: $100 allowance, plus 20% off any balance.	$120
Spectacle lenses	Once every other year (Once per year for dependents under age 14)	You pay: $15 copay	• Single Vision - $66.60 • Bifocal - $101.80 • Trifocal - $125 • Lenticular - $225
Contact Lenses (in lieu of eyeglasses)	Once every other year (Once per year for dependents under age 14) Number of boxes allowed varies depending on type of lens	• Davis Vision: you pay $0 • Other contacts: $100 allowance plus 15% off any balance • Visually required (with prior approval): you pay $0	• Elective: $80 • Visually required (with prior approval): $240
Contact Lens Evaluation, Fitting, and Follow Up Care	Once every other year (Once per year for dependents under age 14)	• Davis Vision Collection: you pay $15 copay • Other contacts: 15% discount	$63

The following additional options are available to you for the charge noted:

Benefit	Charge to You
Scratch-resistant coating	$0
Tinting of plastic lenses	$0
Oversize lenses	$0
Polycarbonate lenses	Children: $0 Adults: $30
Ultraviolet coating	$12
Anti-reflective coating	Standard: $35 Premium: $48 Ultra: $60
Progressive Lenses	Standard: $50 Premium: $90 Ultra: $140
High-index lenses	$55
Polarized lenses	$75
Plastic photochromic lenses	$65
Scratch protection plan	Single vision: $20 Multifocal lenses: 40

Davis Vision Network

Davis Vision is the Fund's vision network provider. When you need vision services, you can select a vision provider from the Davis Vision network or outside the Davis Vision network. You will receive the greatest value by staying in-network.

If you visit an out-of-network provider, you will pay the provider at the time of service, then submit a claim to Davis Vision. Davis Vision will reimburse you a set amount, which may not be the full amount billed. The reimbursement amount depends on the service provided. See the Schedule of Benefits for reimbursement amounts. Out-of-network claims should be submitted to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

To find a Davis Vision provider, visit www.davisvision.com or call 1-800-999-5431. Enter client code 3194.

The Davis Vision Collection offers a great selection of fashionable and designer frames, most of which are covered in full. Visit www.davisvision.com or participating network locations to see available frames. If you purchase glasses outside of the Davis Vision Collection, you will have a $150 allowance at Visionworks locations or $100 allowance at other locations. You will then receive a 20% discount on any remaining balance. (You will not receive a 20% discount at Walmart, Sam's Club or Costco locations.)

Contacts are also available from the Davis Vision Collection. Evaluation, fitting, and follow-up care is subject to a $15 copay and contact lenses are covered in full. Outside the Davis Vision Collection, you will have a $100 allowance for contacts and will receive a 15% discount on evaluation, fitting, and follow-up care and charges for contacts over the $100 allowance.

Limitations and Exclusions

There are no benefits for professional services or materials connected with:

- Medical treatment of eye disease or injury
- Vision therapy
- Special lens designs or coatings other than those specifically described herein
- Replacement of lost eyewear
- Non-prescription (plano) lenses
- Contact lenses and eyeglasses in the same benefit cycle
- Services not performed by licensed personnel
- Two pair of eyeglasses in lieu of bifocals

FILING DENTAL AND VISION CLAIMS

Claims Administrator	Type of Claims
Alicare	Eligibility
Delta Dental	Dental Claims
Davis Vision	Vision Claims

Claims and Appeals Procedures

This section describes the procedures for filing claims for benefits from the Plan. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you or your provider must complete, sign and submit a dental or vision claim form, as appropriate. Generally, your provider submits claims on your behalf. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

When Claims Must Be Filed

Claims must be filed within 12 months following the date the charges were incurred. Failure to file claims within the time required shall invalidate or reduce any claim.

Dental Benefits

How to File a Dental Claim

Delta Dental PPO and Delta Dental Premier Dentists:

Delta Dental PPO and Delta Dental Premier dentists will file claims directly with Delta Dental for the services covered under the dental plan. Delta Dental will make payments for covered services to the dentist directly.

Delta Dental Non-Participating Dentists:

If you use a non-participating dentist, the dentist may ask you to file the claim.. Claim payments will be made directly to you. It is your responsibility to pay the dentist. You will be responsible for paying the dentist the difference between the dentist's charge and *Delta Dental's* payment.

When a claim is filed for the services of a dentist who does not participate in *Delta Dental PPO or Premier*, the following rules apply. After your completed forms are received *Delta Dental* will (a) send you a check for your claim to the extent of your benefits under this Plan; (b) send you a notice in writing (EOB or Explanation of Benefits) of why *Delta Dental* is not paying your claim; or (c) send you a notice in writing of what additional information or records is needed to decide if your claim should be paid. It is up to you to pay your dentist. If you have any questions, contact *Delta Dental's* Customer Service department at 1-800-872-0500.

Vision Benefits

How to File a Vision Claim

Davis Vision Providers

Davis Vision providers will file claims directly with Davis Vision. Davis Vision will make payments for covered services and eyewear to the providers directly.

Davis Vision Non-Participating Providers

If you use a non-participating provider, you will pay the full amount at the time of service. Then submit a claim to Davis Vision for reimbursement. Download the Direct Reimbursement Claim Form at www.davisvision.com. The client code is 3194.

Use the same form for reimbursement for services and eyewear. Include all services, charges, and service dates. Only the services and items listed are eligible for reimbursement. Both you (the member—not necessarily the patient) and the provider must sign the form. Please submit a separate claim reimbursement form for each patient. If the form is incomplete, your claim may be delayed or denied.

Mail the completed claim form to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Decisions on Claims

The appropriate Claims Administrator will provide you with written notice of a denial of claim within 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that such extension is necessary and you are notified before the expiration of the initial 30-day period. If the extension is necessary because additional information is needed, you will be afforded at least 45 days to provide the additional information.

The written notice of denial of your claim will include the following:

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on a medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Request for Review of Denied Dental or Vision Claim

If your claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you may request an appeal by the Claims Administrator. You have 180 calendar days following receipt of a notice of denial of claim to submit a written request for appeal. The Claims Administrator will not accept appeals filed after this 180-day period.

Additional information about the process for appeals of dental claims is available in the Delta Dental Subscriber Certificate. Contact Alicare for a copy of this document.

Review Process

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine, and who was not consulted in connection with the original decision, will be consulted.

If a dental or vision expert is consulted, the expert will be identified to you, regardless of whether the expert's advice was relied on in making the decision.

Timing of Notice of Decision on Appeal

A written notice regarding the Claims Administrator's determination on your appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Claims Administrator. This period may be extended one time for up to 60 days, provided that such extension is necessary and you are notified before the expiration of the initial 30-day period. The extension cannot extend beyond 60 days from the end of the initial 30-day determination period.

Second Level Appeal

If you disagree with the Claims Administrator's decision on your appeal, you may request that the Claims Administrator reconsider the appeal decision. The Claims Administrator will then make a second determination no later than 30 calendar days from its receipt of the second appeal. This 30-day period may be extended due to special circumstances if you are notified of the extension within the initial 30-day period. The extension cannot extend beyond 30 days from the end of the initial 30-day determination period. A different person, not involved in the initial determination on appeal, will make the second determination on appeal.

Voluntary Review Process By The Fund's Board Of Trustees:

If your claim is denied in whole or in part, or if you disagree with the final decision made by the Claims Administrator and you have followed the review procedure, you may also seek a voluntary review by the Fund's Board of Trustees. Your request for voluntary review must be made in writing to Alicare within 180 days after you receive notice of the final denial of your claim on review by Delta Dental or Davis Vision.

Ordinarily, decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you

will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will include:

- The specific reason(s) for the determination
- Reference to the specific plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit May be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which dental or vision services were provided or denied.

GENERAL INFORMATION

Employee Eligibility

You are eligible to participate in the Plan if you are covered by a collective bargaining agreement requiring contributions to this Fund. You are eligible for benefits after one month of contributions have been remitted on your behalf to the Trust Fund. The date your coverage begins will depend on when your employer forwards contributions to the Plan. Contact your employer for more information.

See page 1 of this Summary Plan Description for information on your eligibility to elect to participate in the High Option Dental Plan.

If you are on unpaid leave of absence, or are receiving Worker's Compensation you may be covered for three (3) months after the end of the month during which your leave of absence or Worker's Compensation begins. If your unpaid leave of absence is covered by the Family and Medical Leave Act (FMLA), federal law requires your employer to maintain your coverage during the period of your FMLA leave under the conditions explained on page 44. Under FMLA, you may have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent, or child. If you think that this law may apply to you, please contact your employer or Alicare.

When you return from an unpaid leave, you will be covered under the Plan as of the first day of the month following the date of your return, provided you meet all other eligibility requirements.

Dependent Eligibility

Your eligible dependents include your spouse and your child(ren), none of whom are eligible for coverage under the Plan as employees. To be eligible, your young adult child(ren) must not yet have reached age 26.

Your "spouse" is the person to whom you are legally married and with whom you may file a federal tax return. The term "child" includes a son or daughter, a stepchild, eligible foster child, legally adopted child, and child placed with you for lawful adoption. It may also include a child for whom you are a court-appointed guardian if you provide more than one-half of the child's support for the calendar year, the child is not a "qualifying child" of any other person, and meets the relationship criteria of Section 152(d)(2) of the Internal Revenue Code.

If your child(ren) age 26 or older is permanently and totally disabled and the incapacity continues after age 26, coverage will be continued, if such young adult child(ren) still meets the definition of a "qualifying relative," and if he or she became disabled prior to the date coverage would otherwise terminate. Proof of the continued existence of such incapacity shall be periodically required to maintain coverage and shall be furnished to Alicare upon request.

If your spouse or child is covered under the Plan as an employee, s/he cannot also be covered as your dependent to obtain duplicate coverage. If you and your spouse are each covered under this Plan as employees, however, and you seek to add a dependent child or children to your coverage, you may do so if either you or your spouse elects family coverage for you, your spouse and child(ren). In this case, the spouse not electing the coverage will be covered only under the family coverage elected (as a dependent), and will not be permitted to obtain coverage both as a covered employee and a dependent, or under both the Standard and High Option Dental Plans.

In order for dependents to receive benefits from the Fund, you must provide Alicare with the name, sex, date of birth and social security number of each dependent. This information must be supplied by completing an enrollment form which will be provided to you by the Fund once you become eligible for benefits. Your dependent's coverage will become effective on the date your coverage becomes effective. Coverage for anyone who becomes your dependent after that date will be effective once the required documentation is furnished to Alicare. In all cases, proof of support, guardianship and other appropriate documentation must be submitted to the Fund in the form requested.

Your Dependent's eligibility for benefits will terminate on the earliest of the following dates:

- in the case of your dependent children, the last day of the month in which the Dependent ceases to qualify as a Dependent due to turning age 26;
- in the case of your spouse, on the date of your divorce from your spouse unless otherwise required by court documentation;
- the date your employee eligibility terminates or, in the event of your death, the end of the period for which you earned coverage;
- the date the Dependent enters military service; or
- the date the Plan terminates.

Open Enrollment

Open Enrollment is the period of time each year designated by the Fund during which eligible employees may make changes in their elections. Enrollment packages will be sent to you.

Elections Available During Open Enrollment

During the Open Enrollment period, you may elect for yourself and your eligible dependents who are enrolled for coverage, to:

- **enroll** in the Standard or High Option Dental Plan; or
- **add** eligible dependents for dental and vision coverage; or
- **discontinue** coverage under the Standard or High Option Dental Plan for yourself and/or any of your eligible dependents.

Restrictions on Elections During Open Enrollment

- No dependent may be covered unless you are covered.
- You and all your covered eligible dependents must be enrolled in the same dental program.
- All relevant parts of the enrollment form must be completed and the form must be submitted before the end of the Open Enrollment period.

Changes to Coverage Following Open Enrollment

All changes in or discontinuance of coverage will become effective on the first day of the Plan Year following Open Enrollment, July 1.

Failure to Make a New Election During Open Enrollment

If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, you will be considered to have made an election to retain the same dental coverage you had during the preceding Plan Year.

Failure to Enroll During Open Enrollment - Very Important Information

If you fail to enroll yourself and/or any of your eligible dependents during Open Enrollment, you and they will be required to wait until the next Open Enrollment period to enroll in the Plan, except if a qualifying change in status occurs. See page 32 for a description of qualifying changes in status.

HIPAA Special Enrollment Rights

Government regulations generally require that your Plan coverage elections remain in effect throughout the Plan Year, but this plan extends to you special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA). You may be able to make some changes during the year if the Plan Administrator or its designee determines that you have a qualifying change in your status affecting your benefit needs.

If, and only if, you have one of the following qualifying changes in status, you can change your dental coverage option and/or who is covered under the Plan during the Plan Year.

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment or death of a spouse;

- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child;

- **Change in employment status or work schedule**, including the start or termination of employment by you, your spouse or any dependent child, or an increase in hours of employment by you, your spouse or any dependent child, including a switch between part-time and full-time employment, a strike or lock-out, or the start of or return from an unpaid leave of absence;

- **Change in dependent status under the terms of this Plan**, including changes due to attainment of age, or any other reason provided under the definition of dependent;

- **Change of residence or worksite** by you, your spouse or any dependent child;

- **Change required under the terms of a Qualified Medical Child Support Order (QMCSO),** including a change in your election to provide coverage for the child specified in the order, or to cancel coverage for the child if the order requires your former spouse to provide coverage**.**

You may also make a prospective election change that is on account of and corresponds with a change made under the plan of your spouse's, former spouse's, or dependent's employer if a plan of your spouse's, former spouse's, or dependent's employer (1) permits the participant to make an election change that would be permitted under federal regulations or (2) permits participants to make an election for a period of coverage that is different from the period of coverage under the Plan.

A change of election during the Plan Year due to a "change in family or employment status" must be "consistent" with that change. For example, adding a dependent to your dental coverage would be consistent with the birth of the child. However, the birth of a child would not be consistent with a change to single coverage. An employee may also elect to increase payments under the Plan in order to pay for continuation coverage under the group health plan as provided in the Consolidated Omnibus Budget Reconciliation Act (COBRA) or any similar state law.

A change in election must be made within 60 days after the qualifying change-in-status occurs, and will be effective for the balance of the Plan Year in which the election is made, beginning on the first day of the month following the month in which the election is made. However, in the event of birth, adoption or placement for adoption, the change in election will be effective as of the date of the birth, adoption or placement for adoption.

If you and/or your dependents decline coverage under this Plan because you and/or your dependents are covered under either the State Children's Health Insurance Program ("CHIP") or under Medicaid and you lose eligibility for this coverage or you become eligible for financial assistance under either of these programs, you and your dependents may be able to enroll in the Plan so long as you and your dependents otherwise satisfy all the eligibility requirements described in this booklet. If you request enrollment in the Plan within 60 days of losing coverage under CHIP or Medicaid or becoming eligible for financial assistance, coverage will be effective retroactive to the date CHIP or Medicaid coverage terminated or financial assistance was granted.

To request special enrollment in the Plan, contact Alicare.

Qualified Medical Child Support Orders (QMCSOs)

A QMCSO is a court judgment, decree or order (including the approval of a settlement agreement) that creates or recognizes an alternative recipient—such as a child or stepchild—to be eligible under your dental and vision benefits.

The Fund will recognize a QMCSO that (1) provides for child support of your child/ren under those benefits, (2) provides for health coverage to your child/ren under state domestic relations law (including a community property law) and (3) relates to those dental and vision benefits.

The Fund has procedures for determining whether an order is a QMCSO. You and each alternative recipient will be notified if Alicare receives an order which applies to your benefits. You will also receive a copy of the order and of the Fund's procedures for determining whether it qualifies as a QMCSO.

Coordination of Benefits

If you or your dependent is entitled to benefits under any other plan which will pay part or all of the expenses incurred for any benefits received or services rendered under this Plan, the amount of benefits payable under this Plan and/or any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. However, in no event will the amount of benefits paid under the Plan exceed the amount which would have been paid if there were no other plan involved.

The term "plan" refers to any plan providing benefits or services for hospital, medical or dental or vision care or treatment, that is: (a) group or blanket insurance coverage, (b) group Blue Cross, Blue Shield and other prepayment coverage provided on a group basis, (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or any other arrangement of benefits for individuals of a group and (d) any coverage under governmental programs, and any coverage required or provided by any statute.

When duplicate coverage arises, and both plans contain a Coordination of Benefits provision, the plan that insures the person incurring the claim as an employee is the primary plan. If an individual is insured under two plans through two jobs, the plan which has insured him for the longer period of time pays first.

If a claim is filed for a dependent child, the group plan that insures the parent whose birth date (month and day, NOT YEAR) occurs first in the calendar year is primary. When another plan does not contain a Coordination of Benefits provision, it will always be considered the primary plan. Payment under the secondary plan is made after the amount payable under the primary plan has been determined.

If two or more plans cover a child as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- first, the plan of the parent with legal custody of the child;
- then the plan of the spouse of the parent with custody of the child; and
- finally, the plan of the parent not having custody of the child.

However, if a court order makes one parent financially responsible for the dental or vision care expenses of the child, that parent's plan will pay first. A copy of the court order must be furnished to Alicare.

If Delta Dental or Davis Vision has made payment of any amount that is in excess of that permitted by the Coordination of Benefits rules, the Fund Administrator's Office has the right to recover such amount from any party that has received such overpayment.

Subrogation

The Massachusetts State Health Care Professionals' Dental Fund is not obligated to pay benefits or claims in those circumstances where a third party is liable for the injury giving rise to the claim for benefits. The Fund may withhold payment of benefits payable in connection with accidental injuries when any party other than the covered person or this Fund may be liable for expenses, until such liability is legally determined.

The Fund, in its sole discretion, may make payment of benefits before a finding of liability is made, subject to the agreement of the covered person and his or her counsel, if any, to hold any proceeds of litigation, settlement, or judgment in trust for the Fund and to acknowledge that the proceeds are a plan asset. Payment may be conditioned upon receipt of a subrogation and constructive trust agreement or similar document signed by the covered person and his or her legal representative. In the event of any payment for services under this Plan, the Fund shall, to the extent of such payment, be subrogated to all the rights of recovery of the covered person, and shall be entitled to immediate payment of amounts due before any distribution to or on behalf of the covered person. The covered person will be required to reimburse the Fund for any and all benefits paid under the Plan out of any monies recovered as the result of:

- Judgment
- Settlement, or
- Any other cause

Upon receipt by the covered person or the legal representative, the monies recovered shall become an asset of the Fund. The covered person and the legal representative shall hold the monies recovered as a result of judgment, settlement, or any other cause in trust for the Fund. The Fund is entitled to payment in full, without set-off for attorney's fees, of 100% of benefits paid, whether or not the covered person or participant is made whole.

The Trustees may, in their sole discretion, compromise the amount due under this provision when, in their judgment, the compromise is more likely to result in a higher recovery for the Fund than if no compromise were made.

The covered person must take such action, furnish such information and assistance, and execute and deliver all necessary instruments as the Fund may require to facilitate the enforcement of its rights. If the covered person fails to cooperate with the Fund in the enforcement of its rights, the Fund may suspend payment of all benefits subject to subrogation, enforce its right to restitution of amounts paid and to equitable enforcement of the Plan, and seek such other legal or equitable relief to which it is entitled. In addition, if the covered person fails to cooperate with the Fund in the enforcement of its rights, the Fund may offset all present and future payments due the covered person under the Plan against amounts paid pursuant to the Agreement.

This Fund has the right to recover against any proceeds from other sources received in connection with the accident or injury.

Termination of Coverage

Your benefits and your dependents' benefits under this Plan terminate 30 days after the end of the month when you leave the employ of your employer, unless you elect to continue your dental and vision coverage under COBRA, as described on the following pages.

However, a dependent's benefits under this Plan will terminate when he or she ceases to be an eligible dependent as described on page 30, even if you are still eligible for benefits, unless the dependent elects to continue dental and vision coverage under COBRA, as described on the following pages.

If the Plan is terminated, all benefits under the Plan will also terminate at that time.

Coverage may not be retroactively terminated unless due to fraud, intentional misrepresentation, or non-payment of required contributions.

Continuation of Coverage (COBRA)

COBRA Continuation Coverage in General

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA, you and your eligible dependents are offered the opportunity to temporarily continue your health care coverage at group rates when coverage under the Plan would otherwise end.

If you or your spouse and/or dependent child(ren) are covered under this Plan, you and/or your dependents can continue coverage for a time if coverage ends for one of several reasons.

Qualifying Events and Maximum Periods of Continuation of Coverage

Qualifying Event	Employee	Spouse	Dependent Child(ren)
Employee is terminated from employment (for other than gross misconduct)	18 months	18 months	18 months
Reduction in hours worked by the employee (making employee in-eligible for the same coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employee is divorced or legally separated from spouse	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Dependent child ceases to have dependent status	N/A	N/A	36 months

In the Event of Divorce or Legal Separation

If you are divorced or legally separated, your ex-spouse may remain covered under the Plan, unless the court decree provides otherwise. However, your ex-spouse's coverage will terminate when the first of the following occurs:

- on the date your coverage under this Plan terminates;
- on either you or your ex-spouse's remarriage, or;
- at such time as provided by the divorce decree.

If an employee's ex-spouse loses his or her coverage under the Plan because of any of the three reasons above within 36 months after the parties' divorce, the ex-spouse may elect

COBRA continuation coverage for the remainder, if any, of the 36-month period that began on the date of divorce. In no case is the ex-spouse entitled to COBRA continuation coverage for more than the remainder, if any, of the 36-month period that began on the date of divorce.

When the Plan <u>Must Be Notified</u> of a Qualifying Event – Very Important Information

As a covered employee or other qualified beneficiary, you are responsible for providing Alicare with timely notice of certain qualifying events. You must provide Alicare with notice of the following qualifying events:

- The divorce or legal separation of a covered employee from his or her spouse.
- A beneficiary ceasing to be covered under the plan as a dependent child of a participant.
- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation or child losing dependent status.
- In addition to these qualifying events, there are two other situations where a covered employee or other qualified beneficiary is responsible for providing the *COBRA* Fund *Processor* with notice within the timeframe noted in this section:
    - When a qualified beneficiary entitled to receive COBRA coverage for a maximum of 18 months has been determined by the Social Security Administration or the State Retirement Board to be disabled. If the determination is made at any time that an individual is disabled during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11 month extension of the 18 month maximum coverage period, for a total of 29 months of COBRA coverage.
    - When the Social Security Administration or State Retirement Board determines that a qualified beneficiary is no longer disabled.

You must make sure that Alicare is notified of any of these five occurrences listed above. Failure to provide this notice within the form and time frames described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

How Should A Notice Be Provided?

Notice of any of the five situations listed above must be provided in writing. You may use the Fund's "COBRA Notice Form for Covered Employees and Other Qualified Beneficiaries" to provide notice to the Fund. You may obtain a copy of this form by contacting Alicare at 800-338-4330. Alternatively, you may send a letter to the Fund containing the following information: your name, which of the five events listed above you are providing notice, and the date of the event.

To Whom Should the Notice Be Sent?
Notice should be sent to:

Alicare, COBRA Fund Processor
Massachusetts State Health Care Professionals' Dental Fund
P.O. Box 5439
White Plains, NY 10602-5439.

Notice may be sent by first class mail.

When Should the Notice Be Sent?
If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second qualifying event, you must send the Notice no later than **60 days after the later of** (1) the date of the relevant qualifying event; or (2) the date upon which coverage would be lost under the Plan as a result of the qualifying event.
If you are providing notice of a Social Security Administration or State Retirement Board determination of disability, Notice must be sent no later than **60 days after the later** of (1) the date of the disability determination by the Social Security Administration or State Retirement Board; (2) the date of the qualifying event; or (3) the date on which the qualified beneficiary would lose coverage under the Plan due to the qualifying event.

If you are providing notice of a Social Security Administration or State Retirement Board determination that you are **no longer** disabled, Notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration or State Retirement Board that you are no longer disabled.

These time periods to provide these notices will not begin until you have been informed of the responsibility to provide these notices and these notice procedures through the furnishing of a Summary Plan Description or a general (initial) notice by the Plan.

Who Can Provide a Notice?
Notice may be provided by the covered employee or other qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or other qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, her spouse and her child are all covered by the plan, and the child ceases to be a dependent under the plan, a single notice sent by the spouse would satisfy this requirement.

Where you or your dependents have provided notice to Alicare of a divorce or legal separation, a beneficiary ceasing to be covered under the Plan as a dependent, or a second qualifying event, but are not entitled to COBRA, Alicare will send you a written notice stating the reason why you are ineligible for COBRA. This will be provided within 14 days of receiving your notice.

After providing notice of a qualifying event, the Fund will then send you, your spouse and/or dependent child an election form and information about continuation coverage. Please note if you do not elect COBRA continuation coverage within the 60-day period allowed, (and

described above under "When Should the Notice Be Sent?"), you will forfeit all rights to COBRA continuation coverage and your Fund coverage will end.

If you and/or your eligible dependents become eligible to self-purchase this coverage due to any other event, the Fund Office will notify you and will send the election form and information within 60 days of the loss of coverage or the date you receive the notice, whichever is later.

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

No evidence of insurability is required.

Step 2. Once the Fund Office sends you your COBRA election materials, you have **60 days** to make an election. Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them may select the coverage. A parent or legal guardian may elect continuation coverage for a minor child. If you do not choose continuation coverage, your group health insurance coverage will end.

Step 3. Once the Fund Office receives your election material, they will notify you of the amount of premium you owe. You will have 45 days from the date you made your COBRA election to make payment for all premiums owed for the period. If payment is not received within that time, COBRA coverage will be cancelled retroactively to the date your coverage under the Plan terminated.

Step 4. Your monthly payments are due on the 1st day of each month. You will have a 30-day grace period in which to pay. Payments should be mailed to the Fund Office at the address below. If you do not make payment by the end of the grace period, your coverage will be cancelled retroactively to the last day of the previous month.

If you have any questions or need additional information about COBRA coverage, please contact Alicare, *COBRA Fund Processor* at:

Alicare, COBRA Fund Processor
Massachusetts State Health Care Professionals' Dental Fund
Post Office Box 5439
White Plains, NY 10602-5439
800-338-4330

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You also should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30

days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Coverage Provided When COBRA Continuation Coverage Is Elected

If you and/or your dependent(s) choose COBRA Continuation Coverage, the Plan is required to provide coverage that is identical to the current coverage under the Plan that is provided for similarly situated employees or family members.

If, during the period of COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, that spouse or dependent child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active employees. Also, if while you are enrolled for COBRA continuation coverage, your dependent(s) lose coverage under another group health plan, you may enroll the dependent(s) for coverage for the balance of the period of COBRA continuation coverage. Enrollment must occur no later than 30 days after the marriage, birth or placement for adoption or loss of other group health plan coverage. A child born or placed for adoption while you are on COBRA Continuation Coverage (but not a spouse you marry while you are on COBRA Continuation Coverage) will have all the same COBRA rights as your spouse or dependent children who were covered by the Plan before the event that resulted in your loss of coverage. Otherwise, the same rules about dependent status and qualifying changes in family status that apply to active employees will apply to those dependents. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

If, during the period of COBRA continuation coverage, the Plan's benefits change for active employees, the same changes will apply to you and/or your dependent(s).

Changes to Maximum Period of COBRA Continuation Coverage

Multiple Qualifying Events

- If your continuation coverage is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a spouse or dependent child to a 36-month period of continuation coverage, the 18-month period will be extended for that spouse or dependent child. The total period of coverage for any spouse or dependent child will never exceed 36 months from the date of the **first** qualifying event. For example, if you terminated employment and elected COBRA continuation coverage for 18 months for you and your covered spouse and/or dependent child(ren), and died during that 18-month period, the continuation coverage for your spouse and/or dependent child(ren) could be extended for the balance of 36 months from the date your employment terminated.

- However, if you become entitled to COBRA continuation coverage because of termination of employment or reduction in hours worked that occurred less than 18

months after the date you became entitled to Medicare, your spouse and/or dependent child(ren) would be entitled to a 36-month period of COBRA continuation coverage beginning on the date you became entitled to Medicare. For example, if termination of employment occurred less than 18 months after the date you become entitled to Medicare, your spouse and/or dependent child(ren) would be entitled to COBRA continuation coverage for a 36-month period beginning on the date you became entitled to Medicare.

Entitlement to Social Security Disability Income Benefits or to State Disability Retirement Benefits

If you, your spouse or any of your covered dependent child(ren) are entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the qualified beneficiary who is determined to be entitled to Social Security disability income benefits, or to State Disability Retirement Benefits from the State Retirement Board, and for any other covered family members, for up to 11 additional months if **all of the following conditions** are satisfied:

- The **disability occurred** on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage; and

- The disabled qualified beneficiary **receives a determination** of entitlement to Social Security disability income benefits from the Social Security Administration, or to State Disability Retirement Benefits from the State Retirement Board; and

- The Plan is notified on a timely basis.

This extended period of COBRA continuation coverage will end at the **earlier** of the end of 29 months from the date of the qualifying event or the date the disabled qualified beneficiary becomes entitled to Medicare.

Cost to You for COBRA Continuation Coverage

You, your covered spouse and/or your covered dependent child(ren) will have to pay 102% of the full cost of the coverage during the COBRA continuation period.

If:

- you, your spouse or dependent child(ren) have elected COBRA Continuation Coverage; and

- the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect; and

- a health care provider requests confirmation of coverage;

COBRA continuation coverage will be confirmed, but with notice to the provider that the cost of the COBRA continuation coverage has not been paid and that the COBRA continuation coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may be terminated if:

- your employer or the Plan no longer provides any dental or vision coverage to any of its similarly situated employees;
- you do not pay the applicable premium for your COBRA Continuation Coverage on time;
- the covered individual becomes entitled to Medicare; or
- the covered individual becomes covered under another group health plan that does not contain an exclusion or limitation that applies to any pre-existing condition of the covered individual, or by law, may no longer apply its pre-existing condition limitation or exclusion to that covered individual, or
- the employer that you worked for before the qualifying event has stopped contributions to the Fund; and the employer establishes one or more group health plans covering a significant number of the employer's employees formerly covered under the Plan; or the employer starts contributing to another multiemployer plan that is a group health plan.

If continuation coverage is terminated before the end of the maximum coverage period, the Fund Administrator will send you a written notice as soon as practicable following the Fund Administrator's determination that continuation coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

COBRA-Related Claims

You may appeal any COBRA-related claims that are denied. Please refer to the Fund's claims and appeals procedures on page 27.

If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

Name, Address and Telephone Number of the Party Responsible for COBRA Administration

Alicare, COBRA Fund Processor
Massachusetts State Health Care Professionals' Dental Fund
Post Office Box 5439
White Plains, NY 10602-5439
800-338-4330

Unavailability of Coverage

If you provide notice to the Fund of a qualifying event, but are not entitled to COBRA, the Fund will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same time frame that the Fund is required to provide an election notice.

Notice of Termination of COBRA

If continuation coverage is terminated before the end of the maximum coverage period, the Fund will send you a written notice as soon as practicable following the Fund's determination that continuation coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Keep the Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to Alicare. 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.)

Family and/or Medical Leave

The federal Family and Medical Leave Act ("FMLA") provides that family and medical leave must be available to eligible employees, based on certain rules. You should check with your

employer as to whether you are eligible. If you are eligible, your benefits may continue under the following rules:

During any FMLA leave your employer must maintain your coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during your leave. If you were required to make contributions toward the Plan cost before your FMLA leave, you are obligated to continue to make them during the leave period. Thus, if you are a member of the Standard Dental Plan, your dental and vision coverage under the Plan will be continued while you are on leave. If you are a member of the High Option Dental Plan, however, you must continue to pay the required monthly employee contribution for that Plan or your dental benefits (but not your vision benefits) under that Plan may lapse**.** You should check with your employer about the methods available for making the contributions due under the High Option Plan during your leave period.

Whether or not you keep your coverage while you are on Family or Medical Leave, if you return to work promptly at the end of that leave, your dental and vision coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your dependents who were covered by the Plan at the time you took your leave. Of course, any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your dependents in the same way they apply to all other employees and their dependents.

To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your employer.

USERRA

If you leave employment to enter service with the armed forces of the United States at a time when you are covered under the Plan, you may have the right to continue coverage for you and your dependents at your own expense for up to 24 months under the Plan. The cost of this continuation coverage will vary depending on the length of your military service. For more information, please call the Fund.

PROTECTED HEALTH INFORMATION USE OR DISCLOSURE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.

- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page Plan Sponsor53.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care

- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A dentist sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

  Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: A company such as Delta Dental contracts with us to provide dental benefits, and we provide that company with certain information about you to obtain pricing for claims or other charges.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many

conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Separation of Plan and Plan Sponsor

Only the following types of persons and employees under the control of the Plan Sponsor will be given access to the Protected Health Information: Fund Trustees, Fund Legal Counsel, Fund Consultant, Fund Administrator, Fund Privacy Official and Fund Administrative Manager. Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Fund in the ordinary course of business, will also be included in the definition above of Permitted Persons or Employees. The Permitted Employees or Persons may only use the Protected Health Information for Fund administrative functions that the Plan Sponsor performs for the Fund.

BOARD OF TRUSTEES' POLICY STATEMENTS

Each member may choose a provider who alone is responsible for the selection of the proper course of treatment and the provision of quality dental and vision care. The Massachusetts State Health Care Professionals' Dental Fund does not have any responsibility for the provider's failure to fulfill these obligations.

The Board of Trustees reserves the right to amend, modify, discontinue or terminate all or part of this Plan whenever, in its judgment, conditions so warrant. Copies of the Fund's annual reports are available for review at Alicare.

Only the Board of Trustees, or the Administrator acting on its behalf, has the authority to determine any question arising in connection with the administration, interpretation and application of the Plan, including any question regarding eligibility for benefits and the right to participate in this Plan; and either the Board's or the Administrator's determinations concerning the administration, application and interpretation of the Plan shall be conclusive and binding on all persons subject to the provisions of this Plan.

The Board of Trustees urges you to read this booklet so that you will know the plan of benefits that are available, offering both you and your family security and protection.

Please note that it is illegal for an individual to willfully and knowingly misrepresent any fact for the purpose of securing dental or vision benefits. Any individual who is found to have committed such misrepresentation shall immediately become ineligible for Fund benefits and will be required to reimburse the Fund for any service or reimbursements fraudulently obtained. Furthermore, the Fund will cooperate fully with law enforcement agencies in investigating and prosecuting criminal complaints, including claims of fraud or larceny, as they relate to Fund assets.

ADMINISTRATIVE INFORMATION

The following additional information concerning your Plan is being provided to you in accordance with government regulations.

Plan Name

The Plan is known as the Massachusetts State Health Care Professionals' Dental Fund.

Plan Sponsor

The Board of Trustees of the Massachusetts State Health Care Professionals' Dental Fund is the plan sponsor. The plan sponsor's address is:

Board of Trustees
Massachusetts State Health Care Professionals' Dental Fund
333 Westchester Avenue, N101
White Plains, NY 10604

Phone 1-800-338-4330

Plan Administrator and Type of Administration

A joint Board of Trustees, consisting of Union representatives and Employer representatives, is the administrator of the Plan. As the administrator of the plan, the Board of Trustees has broad discretion to determine eligibility for benefits and interpret plan language. Decisions of the Board of Trustees will receive judicial deference to the extent that they do not constitute an abuse of discretion. The Plan is fully liable for all benefits provided. Delta Dental administers payment of dental claims. Davis Vision insures and administers payment of vision claims. Alicare handles administrative matters for the Plan, such as eligibility. Alicare, Delta Dental, and Davis Vision do not guarantee any of the Plan's benefits.

Employer Identification Number and Plan Number

Board of Trustees' Employer Identification No.: 04-2946668
Plan Number: 501

Plan Year

The records of the Plan are kept on the basis of a fiscal year, which begins on February 1 and ends on the following January 31. For purposes of maintaining the Plan's fiscal records, the end of the Plan year is January 31. This fiscal year is also known as the "Plan Year."

Type of Plan

The Plan is a health and welfare plan that provides dental and vision benefits.

Funding Medium

Benefits are provided from the Fund's assets, which are accumulated under the provisions of Collective Bargaining Agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

The Fund's assets and reserves are invested in accordance with the instructions of the Board of Trustees. UBS is the Fund's custodian.

Source of Contributions

Contributions to the Plan are made by Employers in accordance with Collective Bargaining Agreements between the Massachusetts Nurses Association or the American Federation of Teachers and employers in the industry. The collective bargaining agreements require weekly contributions to the Plan per full-time equivalent. Contributions may also be made by Employees. A copy of such collective bargaining agreement may be obtained upon written request and is available for examination.

The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of participants working under a Collective Bargaining Agreement and, if so, with that employer's address.

Members who enroll in the High Option Dental Plan are required to make employee contributions each payroll period. If a member's pay in a payroll period is insufficient to deduct contributions, the member will be responsible to pay the missing contributions to the Fund.

Members, spouses and/or dependent children pay for the cost of COBRA continuation coverage, if such coverage is elected.

Agent for the Service of Legal Process

The Board of Trustees has been designated as the agent for the service of legal process. Process may be served at Alicare at Massachusetts State Health Care Professionals' Dental Fund
333 Westchester Avenue, N101 White Plains, NY 10604. You may also serve legal process upon any of the Trustees individually.

Disqualification, Ineligibility, Denial or Loss of Benefits

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are described in this booklet on page 30 and include the willful and knowing misrepresentation of facts as described on page 36.

Selection of Providers

The Plan provides health care benefits, but does not actually provide dental or vision services. Accordingly, the Plan is not responsible for any acts or omissions by dentists, vision care providers or other medical professionals.

Procedure for Obtaining Additional Plan Documents

If you wish to inspect or receive copies of additional documents relating to the Plan, you may contact the Fund at the following address and phone number:

Alicare
Massachusetts State Health Care Professionals' Dental Fund
333 Westchester Avenue, N101
White Plains, NY 10604
1-800-338-4330

You may be charged a reasonable fee to cover the cost of any materials you wish to receive.

Plan Regulations

Plan provisions are administered by Alicare.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Administrator's (Alicare) office at 333 Westchester Avenue, White Plains, NY 10604 and at other specified locations, such as worksites and union halls, all documents governing the plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the EBSA.

- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights.

- For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

- In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

- If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should (1) contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or 2) call the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272); or 3) visit the EBSA website at http://www.dol.gov/ebsa; or 4) write to the EBSA's Office of Participant Assistance at the following address:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Suite N-5625
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272).

BOARD OF TRUSTEES

EMPLOYER TRUSTEES	UNION TRUSTEES
Melinda T. Willis, Co-Chair Commonwealth of Massachusetts One Ashburton Place, Room 211 Boston, MA 02108	Kevin M. Hayes, Co-Chair Massachusetts Nurses Association 340 Turnpike Street Canton, MA 02021
Gary Spring UMASS Memorial Medical Center 306 Belmont Street, Suite 120 Worcester, MA 01604	Donna Guiney Massachusetts Nurses Association 340 Turnpike Street Canton, MA 02021
Tom Wallace University of Massachusetts, Dartmouth 285 Old Westport Road North Dartmouth, MA 02747	Judy A. Locke Massachusetts Nurses Association 340 Turnpike Street Canton, MA 02021
Joel Posner Executive Office of Health and Human Services 600 Washington Street, 7th Floor Boston, MA 02111	Martha Miraglia Massachusetts Nurses Association 6 Quincy Drive Derry, NH 03038
Deborah Crory Tewksbury Hospital/HR Office 365 East Street Tewksbury, MA 01876	Cheryl Lathum Office of Public Protection 239 Causeway Street; Suite 500 Boston, MA 02114

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