
**Littleton Public Schools
Dental Direct Reimbursement
Plan**

Dental Benefits

Summary Plan Description

Revised – July 1, 2008

Littleton Public Schools Dental Direct Reimbursement Plan Summary Plan Description

This is the official Summary Plan Description for the **Littleton Public Schools Dental Direct Reimbursement Plan** (the "Plan"). The Plan is a self-funded benefit plan that reimburses eligible employees and their eligible dependents for covered expenses. The Plan is available to the employees of **Littleton Public Schools** and Participating Charter Schools (the "District"). They do not involve an insurance company. **Littleton Public Schools** is the Plan Administrator and Wells Fargo Third Party Administrators, Inc. is the Plan's Claims Administrator.

If you elect to participate in the Littleton Public Schools Section 125 Plan ("Section 125 Plan"), your pay will be reduced on a pre-tax basis under the premium only component of the Section 125 Plan by the amount required to pay for the type of coverage you elect (unless you state in writing to the Plan Administrator that you want your reduction to be on an after-tax basis and waive participation in the Section 125 Plan). Effective for employees hired on or after July 1, 2008, if you are covered under the dental benefit, you will automatically participate in the premium only component of the Section 125 Plan to the extent of your premiums unless you elect not to participate.

You may elect to cover only yourself or you may elect to cover yourself and any of your eligible dependents. As you incur dental expenses, you may submit claims for reimbursement of these expenses. If your expenses are eligible for reimbursement under the terms of the Plan, you will receive a check for all or a portion of the reimbursable expenses as payable under the Plan.

This Summary Plan Description will explain in more detail how the Plan works. The Plan complies with the Privacy Regulations under Board Policies GCBC-R and GDBC-R. If you have any questions concerning your benefits under the Plan, please contact the Benefits Office in the Human Resources Department.

Littleton Public Schools reserves the right to amend or terminate the Plan at any time. Nothing in this Summary Plan Description is intended to provide vested or nonchangeable benefits. Littleton Public Schools can also change the benefits or contributions under the Plan or any other aspect of the Plan at any time and for any reason. The changes will apply to all covered persons, unless otherwise specified by Littleton Public Schools. Generally, these amendments will not apply to expenses incurred prior to the adoption date of the amendments.

Who Is Eligible?

All regular full-time employees who are at least half-time (.5) or whose assignments are for at least 20 hours per week and their eligible dependents may participate in either Plan. For more details regarding benefits eligibility you can access the District website under Employee Benefits or review the new employee Benefits booklet in the section entitled "Benefit Eligibility."

You can elect individual coverage for yourself only, or you can elect coverage for any of your eligible dependents. If you are divorced or separated from your spouse, you may be required under the terms of a "Qualified Medical Child Support Order" to provide dental coverage under the Plan to any of your children named in such order. It is the employee's responsibility to provide a copy of this order when enrolling the child in either Plan.

What Must I Pay For Coverage?

Please refer to the rate sheets for either the Dental Reimbursement High or Low Options for the current Plan Year to determine the amount of the total premium you must pay.

How Do I Enroll For Coverage?

If you want to cover yourself or your dependents under the Plan, you must:

- 1) apply for the coverage on the proper form; and
- 2) agree in writing to make the required contributions, if any.

Prior to the first day of each Plan Year (July 1-June 30) the District will provide an annual open enrollment period during which you may elect to be covered under the Plan or, if you are already covered, to change the type of coverage (for example, from individual to family coverage).

The coverage that you elect during the annual open enrollment period will become effective on July 1st following the annual open enrollment period. If you become employed during the Plan Year and you elect coverage during a period other than the annual open enrollment period, your coverage will be effective the first of the month following 30 days of employment. If your effective date is January 1st or later, you will be considered a late entrant.

What Happens If I Don't Enroll When I First Become Eligible?

If you (or your dependents) do not enroll in a District dental plan when you (or your dependents) first become eligible to participate, you may enroll yourself (or your dependents) during the annual open enrollment period for the next Plan Year or a later Plan Year. If you (or your dependents) do not enroll in a District dental plan when you (or your dependents) first become eligible to participate, you (or your dependents) will be referred to as a "late entrant". (Late entrants are subject to reduced benefits under the Plan. See the question below entitled "What Amount Of Expenses Does The Plan Pay If I Am A Late Entrant?" beginning on page 6.)

Can I Change My Election During The Year?

Your election to receive coverage under the Plan will remain in effect for the Plan Year (July 1 – June 30). If you are a new employee and elected coverage during a period other than the annual open enrollment period, your initial election will remain in effect from the date your election became effective until the following June 30th. If you do not complete a new election form for dental coverage during the next annual open enrollment period, your election will automatically remain in effect for the next Plan Year.

You may change or revoke your election during the middle of a Plan Year only if you experience a "change in status", and the change in coverage is on account of and consistent with the change in status. Examples of changes in status include:

- 1) your marriage, divorce or legal separation;
- 2) the birth or adoption of a child;
- 3) the death of a dependent;
- 4) a dependent who either becomes eligible for coverage or is no longer eligible;
- 5) a change in your spouse's employment;
- 6) a significant change in your or your spouse's health coverage attributable to your spouse's employment;
- 7) the receipt of a qualified medical child support order;
- 8) a "special enrollment period," as required under the Internal Revenue Code; or
- 9) any other event deemed a change in status by the Plan Administrator, in accordance with applicable law.

You may change Plan options only during the annual open enrollment period.

What Dental Expenses Can I Get Reimbursed?

You will be reimbursed for all properly submitted dental expenses incurred by you or your covered dependents while you are covered under the Plan, except for those expenses discussed below that are not covered under the terms of the Plan. Covered expenses include treatment by any licensed provider.

Are There Any Dental Expenses Not Covered?

You will not be reimbursed for the following expenses:

- Expenses incurred for elective, cosmetic dentistry.
- Expenses incurred for services which are covered by a district-sponsored medical plan or other health or dental insurance.
- Expenses incurred for injuries or conditions which are payable through workers' compensation or through third party liability, such as an auto insurance carrier.
- Expenses incurred for services which are covered by a governmental agency.
- Expenses incurred for orthodontia treatment under the Low Option dental plan.

What Amount Of Dental Expenses Does The Plan Pay?

Each person covered by the Plan, other than a late entrant, is eligible to be reimbursed for the percentage of his or her expenses in the amount indicated below for that Plan option. The Plan Year in which the treatment was provided is the year used to determine the reimbursement.

The High Option will pay:

- 100% of the first \$200 of expenses, then
- 50% of the next \$3,600 of expenses.
- Maximum Annual Benefit of \$2,000 per person.
- Orthodontia is included.

The Low Option will pay:

- 100% of the first \$200 of expenses, then
- 50% of the next \$1,600 of expenses.
- Maximum Annual Benefit of \$1,000 per person.
- Orthodontia is Not included.

Are There Any Deductibles?

No, there are no deductibles to satisfy before dental expenses are reimbursed under the Plan. This means that there will be no amount of dental expenses that you must pay before you are entitled to be reimbursed for dental expenses.

What Amount Of Expenses Does The Plan Pay If I Am A Late Entrant?

If you (or your dependents) are late entrants, the amount of expenses that will be reimbursed is reduced for the first Plan Year in which you (or your dependents) participate in the Plan. After the first Plan Year during which you (or your dependents) participate as late entrants, you (or your dependents) will be eligible for standard Plan benefits, assuming you (or your dependents) continue to participate in the Plan. If you (or your dependents) subsequently drop dental coverage during an annual open enrollment period and then re-enroll during a following annual open enrollment period, the amount of dental expenses that will be reimbursed is again reduced for the first Plan Year in which you (or your dependents) resume participation in the Plan.

For each late entrant, the Plan will pay covered expenses incurred during the Plan Year as described below.

The High Option will pay:

- 100% of the first \$100 of expenses, then
- 50% of the next \$1,800 of expenses.
- Maximum Annual Benefit of \$1,000 per person.
- Orthodontia is included.

The Low Option will pay:

- 100% of the first \$100 of expenses, then
- 50% of the next \$800 of expenses.
- Maximum Annual Benefit of \$500 per person.
- Orthodontia is Not included.

How Do I Get Reimbursed For My Dental Expenses?

When you incur dental expenses, you should obtain a written statement from your provider that describes the dates of service, the type of treatment and the charge. If services are covered by another dental plan as described below, you will also need to include a statement showing the amount paid by the other plan as reimbursement under this Plan is based on the portion not covered by other insurance. A request for claim payment should be made on claim forms that are obtained from the District Website Intranet under Human Resources, Benefit Forms. Properly completed claim forms should be sent directly to the Claims Administrator (the address is on all claim forms and at the end of this Summary Plan Description) within a reasonable period following occurrence of the dental treatment or expense. Reimbursement for dental expenses may be made directly to you or to the provider of the service, if your provider allows you to assign your benefit reimbursement payments directly to the provider of the service.

All claims for dental expenses must be submitted no later than 3 months after the end of the Plan Year (July 1 – June 30) in which the expenses were incurred.

The District reserves the right to verify all reimbursement requests. A fraudulent claim is grounds for termination of benefits and may result in disciplinary action, including termination of employment, following District policy.

How are Orthodontic Claims Submitted And Reimbursed: (Covered under High Option Only)

Since orthodontic treatments are carried out over extended periods of time, the total cost of the orthodontic treatment will not be reimbursed at the onset of the procedure. Charges for orthodontic treatments should be submitted as an initial down payment, a series of monthly payments spread out over the anticipated

duration of the treatments, and the customary diagnostic records as prescribed by the dentist/orthodontist.

A maximum of 25% of the estimated total treatment charge will be considered for reimbursement as the down payment, then the remaining balance will be reimbursed as they are incurred on a monthly basis upon receipt of the claim form and itemized bill.

The one page “orthodontic questionnaire” must be completed by the orthodontist and submitted with the initial orthodontic charges. This form is available on the District website Intranet under Human Resources, Benefit Forms.

How Does The Plan Determine When A Service Is Incurred?

The charge for service, supply, or treatment is considered incurred on the date the service is provided, with the following exceptions:

- For dentures or fixed bridgework, the incurred date is the date the final impression is taken for the denture or bridge, not the date the prosthesis is inserted in the mouth.
- For crowns, the incurred date is the date the tooth is prepped (filed) for crowning, not the date the crown is cemented.
- For root canal therapy, the incurred date is the date the work begins on each individual tooth, regardless of the number of canals and the sequence of visits in their treatment.

How Does The Plan Handle Expenses For Treatment In Process When Coverage Begins?

We will exclude from coverage all procedures, which began prior to the effective date, with the exception of orthodontic care where we will allow expenses for monthly maintenance, incurred after the effective date.

How Are Dental Benefits Coordinated Under the Plan?

If you are covered by this Plan and another Plan, or your covered spouse or children are covered under two or more plans, the plans will coordinate benefits

when a claim is received. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

- 1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- 2) Plans with a coordination provision will pay their benefits up to the allowable charge:
 - a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) are determined before those of the plan which covers the person as a dependent.
 - b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - c) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
 - i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
 - e) When a child's parents are divorced or legally separated, these rules will apply:
 - i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

- ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
- iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
- iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.
- v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

What Do I Do If My Claims Are Denied?

If your claim is denied (all or in part), you will be informed of the reason(s) for denial, and you may initiate a review of the claim by contacting the Plan Administrator for further instructions. Under the review procedure, you or your duly authorized representative have the right to:

- 1) request the review by making written application to the Plan Administrator, no later than 60 days after the claim denial;
- 2) review pertinent Plan documents; and
- 3) submit issues and comments in writing in support of the claim.

You will be notified in writing of the results of the claim review and the reason for any denial no later than 60 days following receipt of the properly completed request for review, unless it is necessary to seek additional information, in which case the determination will be made within 120 days. Any requests for review not responded to within this period shall be deemed denied.

When Does My Coverage End?

Your coverage, as well as that of your dependents, ends on the earliest of the following dates, subject to your right to elect COBRA coverage:

- The date this Plan terminates or is amended to exclude you or your dependents from the class of employees or dependents, as applicable, eligible for coverage;
- The date you are no longer in an eligible class of employees or, with respect to a dependent's coverage, the date the dependent is no longer an eligible dependent;
- The end of the month in which you terminate your employment or your employment is terminated;
- The end of the month in which you complete a form to end your enrollment;
- The date of your death; or
- The date you fail to timely pay employee-required contributions.

Any expenses that you incur during your period of coverage will be eligible for reimbursement, subject to the terms of the Plan.

Note: If you take a leave of absence pursuant to the Family and Medical Leave Act, your elected coverage will be continued by the District for the authorized period of leave. You will have the option of continuing to pay for your portion of the premium for coverage while on leave or upon return to active employment. However, if you do not continue to pay for your portion of the premium for coverage while on an unpaid leave (other than under the Family and Medical Leave Act), you will be subject to the same benefits eligibility requirements and waiting period as a newly eligible employee. If you take an unpaid leave of absence, your elected coverage will be continued by the District for the authorized period of the leave, however, you will be responsible for paying the full premium for coverage while on leave.

What Are My Rights Under COBRA?

COBRA continuation of benefits under the Plan is available to those individuals who, for a variety of reasons, would normally lose coverage. Individuals who wish to continue coverage must elect to do so within certain time limits and must pay the entire cost of coverage plus an administrative charge on a regular timely basis. Further information with respect to COBRA continuation is included in the COBRA Initial Notice & Notice to Employer of Qualifying Event Form, the Littleton Public Schools Group Insurance Plan located in the new employee Benefits booklet, and the District website.

How Protected Health Information About You May Be Used And Disclosed And How You Can Obtain Access To This Information?

Detailed information regarding your protected health information and your rights under the Health Insurance Portability and Accountability Act of 1996 are included in the LPS Group Healthplans Privacy Notice, the Littleton Public Schools Group Insurance Plan located in the new employee Benefits booklet, and the District website.

You may also contact Wells Fargo Third Party Administrators, Inc., Privacy Officer, Cassie Gross, at 1-888-745-3274.

PLAN INFORMATION

PLAN DOCUMENT:

This Summary Plan Description also constitutes the plan document for Littleton Public Schools Dental Direct Reimbursement Plan.

NAME OF PLAN:

Littleton Public Schools Dental Direct Reimbursement Plan

TYPE OF PLAN:

Welfare Benefit Plan

PLAN YEAR:

July 1-June 30

PLAN NUMBER:

501

PLAN SPONSOR/PLAN ADMINISTRATOR:

Littleton Public Schools is the Plan Sponsor that maintains the Plan and is also the Plan Administrator.

Littleton Public Schools
Attn: Human Resources Department
5776 So. Crocker St.
Littleton, CO 80120
(303) 347-3366
(303) 347-3384 Fax

The Plan Administrator has the exclusive power and discretionary authority to interpret the Plan.

EMPLOYER IDENTIFICATION NUMBER:

84-6000862

PLAN FUNDING:

District and Employee contributions cover the cost of the Plan. District contributions and any Employee pre-tax or after-tax contributions are held by the District and used to pay Plan benefits. The amount of all such contributions are actuarially determined.

AGENT FOR RECEIVING SERVICE OF LEGAL DOCUMENTS:

In the event of legal action involving the Plan, legal papers may be served upon Littleton Public Schools at the address shown above.

CLAIMS ADMINISTRATOR:

Claims for benefits under the Plan will be processed by Wells Fargo Third Party Administrators, Inc. The Claims Administrator's address is:

Wells Fargo Third Party Administrators, Inc.
P.O. Box 71549
Newnan, GA 30271
678-762-8842