

SAN JOSE UNIFIED SCHOOL DISTRICT

PRESENTS

SELF-FUNDED DENTAL BENEFITS

FOR OUR EMPLOYEES
AND THEIR
ELIGIBLE DEPENDENTS

JULY 2008

ADMINISTERED BY:

*UNITED ADMINISTRATIVE SERVICES, INC.
1120 SOUTH BASCOM AVENUE
P.O. BOX 5057
SAN JOSE, CALIFORNIA 95150
TELEPHONE: (408) 288-4400*

**GROUP DENTAL BENEFITS
Self-Funded Dental Plan**

District Funded Dental Benefits for You and Your Eligible Dependents

San Jose Unified School District is pleased to provide the accompanying dental benefits to our employees and their eligible dependents.

Dental Expense Benefits

If you or your dependent incur Covered Dental Charges, this Plan will pay for the expenses actually incurred, but not to exceed the percentages of reasonable and customary covered charges as defined below for services, supplies and treatment itemized under Covered Dental Charges when performed by a legally qualified dentist for oral examinations and treatment of accidentally injured or diseased teeth and supporting bone or tissue.

REASONABLE AND CUSTOMARY COVERED CHARGES are those charges which do not exceed the customary fees charged by the dentists for the same services performed within the particular geographic area concerned, or those charges which can be justified by the special circumstances of the particular case.

Alternate Courses of Treatment

If alternate procedures, services or courses of treatment may be performed for the treatment of the injury or disease concerned or to accomplish the desired result, the amount included as Covered Dental Expense will not exceed the reasonable and customary charge for the least expensive procedure, service or course of treatment which, as determined by the Administrator, will produce a professionally adequate result.

The benefits payable are subject to the Definitions, Exclusions and Limitations in this booklet.

Covered Dental Charges

Covered charges Payable at 90%.

- Oral examinations, including scaling and cleaning of teeth (but not more than two in any period of 12 consecutive months).
- Topical application of sodium or stannous fluoride.
- Dental X-Rays.
- Extractions.
- Oral surgery, including excision of impacted teeth.

- Fillings.
- General anesthetics administered in connection with oral surgery or other covered dental services.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Endodontic treatment including root canal therapy.
- Space maintainers.
- Injection of antibiotic drugs by the attending dentist.
- The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures.
- Replacement of an existing partial or full removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Administrator is presented that:
 - a) The replacement or addition of teeth is required to replace one or more natural teeth extracted while insured under the Plan;
 - b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot be made serviceable; or
 - c) The existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within 12 months from the date of installation of the immediate temporary denture.
- Repair or recementing of crowns, inlays, bridgework or dentures, or relining of dentures.
- The replacement of a crown restoration, provided the original crown was installed more than five years prior to the replacement.
- Inlays, gold fillings, crowns (including precision attachments for dentures), and initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one or more natural teeth.

Covered Charges Payable at 50%

- Orthodontic care, treatment, services and supplies (except for missing primary teeth), including correction of malocclusion.

Maximum Benefits

Benefits are payable per person up to \$1,000 lifetime maximum for orthodontics and up to \$2,000* each calendar year for all other covered charges.

*Adopted January 1, 1998.

Coordination of Benefits

If you or an insured dependent are entitled to benefits under any other plan which will pay part or all of the expense incurred for necessary, reasonable and customary charges for treatment of a dental disease or injury, the amount of benefits payable under this Plan and 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 this Plan exceed the amount which would have been paid if there were no other plan involved.

Effective Date

The effective date of the Plan is July 1, 1977. Revised October 1, 1980, July 1, 1984, and July 1, 2008.

Eligibility

All active full-time certificated employees and full-time classified employees who work 40 hours or more each week, regular part-time certificated employees who instruct at least 15 hours per week and permanent part-time classified employees working at least 20 hours or more but less than 40 hours each week are eligible to participate in the District Dental Plan.

Employees who are on health, sabbatical, maternity or other approved leaves of absence may continue to be eligible to participate in the District Dental Plan in accordance to an agreed upon rate of District participation.

Retired employees receiving retirement benefits under the State Teachers Retirement System, Public Employees Retirement System or Federal Social Security Law and who have been employed by the San Jose Unified School District for a minimum of ten years at the time of retirement are also eligible.

At age 19 unmarried children may be included to age 25 if the child is attending school full-time at an accredited high school, trade school, college or university and primarily dependent upon the employee for support. If your dependent child(ren) loses eligibility between age 19 and 25 and subsequently becomes a full-time student as noted above, they will become eligible to re-enroll in the plan upon proof of full-time status. A Child is the Employee's child, stepchild, your adopted child from the moment of placement in your home, or a child under your legal guardianship, but only if this child depends on You for support and maintenance and if the child lives with You in a parent-child relationship. The term child does not include a foster child who is eligible for benefits provided by any governmental program or law, unless such inclusion is

required by the laws of state. Proof of full-time status will be required annually from the school, college or university. Coverage also extends beyond age 19 for children who are mentally or physically incapacitated and incapable of self-support.

How to File a Claim

- 1) Obtain a Claim Form from your employer.
- 2) Complete the employee portion of the claim form.
- 3) Have your dentist complete his/her portion of the claim form.
- 4) Upon completion of the claim form, attach itemized bills and return your claim form to:

San Jose Unified School District Dental Plan
P.O. Box 5057
San Jose, CA 95150

- 5) If you have a question regarding your claim, you may phone the Administrator at:

(408) 288-4400

- 6) Should you desire a personal consultation, please bring all forms and bills, if any, to:

1120 South Bascom Avenue
San Jose, CA 95128

Appointments are encouraged, and may be obtained by phoning the Administrator at:

(408) 288-4400

Effective Date of Coverage

You become covered on the date of eligibility.

Termination of Coverage

Your coverage under this Plan terminates at the end of the month you leave the employ of the District, or when you cease to be a member of the eligible group.

How Claims are Processed

Claim forms are available at the Personnel Office, as well as other locations as needed.

PRE-AUTHORIZATION of treatment is encouraged; X-Rays may be requested and reviewed by the UAS Dental Staff.

UAS and its dental consultant will review each claim for approval or adjustment. After the claim is reviewed and upon completion of the treatment, one of two actions will occur:

- 1) The employee will be reimbursed for the Plan's share of the cost, provided benefits weren't assigned; or
- 2) The dentist providing treatment will be reimbursed for the Plan's share of the cost.

Claim Disputes

If an insured employee and/or his or her dentist disagree with Plan benefits, the following system will be employed to provide satisfaction:

- 1) First, the claim and the method of computing benefits will be reviewed for correctness and suitability by dental consultants retained by the Plan.
- 2) If, after a thorough review of circumstances, a dispute still exists between an employee and the Plan, either:
 - a) The employer and the Plan will review, if a fee dispute, for a possible upward revision of UCR criteria; or
 - b) The claim may be submitted to peer review by the County Dental Association to determine suitability and/or necessity of treatment.

The Plan agrees to abide by the finding of a) or b) above, but if a dispute still exists, all parties shall agree to submit the claim to binding arbitration according to current California Civil Code.

Exclusions and Limitations

Exclusions:

- 1) Services for injuries or conditions which are compensable under Workers' Compensation or Employers Liability Laws; services which are provided the eligible patient by any Federal or State Government Agency or are provided without cost to the eligible patient by any municipality, county or other political subdivision.
- 2) Services with respect to congenital or developmental malformations or cosmetic reasons.
- 3) Prosthodontic services or devices (including crowns and bridges) or any single procedure started prior to the date the patient became eligible for such services under this or the previous Plan.
- 4) Expenses incurred after termination of insurance except for prosthetic devices (including bridges and crowns) which were fitted and ordered prior to termination and which are delivered to you or your insured dependent within thirty days after the date of termination.

- 5) Prescribed drugs.
- 6) Hospitalization.
- 7) Facings on pontics or crowns posterior to the second bicuspid.

Limitations:

The benefits as outlined are subject to the following limitations:

- 1) X-Rays: Complete mouth X-Rays are provided only once in a three-year period, unless special need is shown.
- 2) Prophylaxis: Prophylaxis (cleaning and scaling) including fluoride treatment for children is covered twice during any period of 12 consecutive months.
- 3) Prosthodontics: Replacements will be made of an existing prosthodontic only if it is unsatisfactory and cannot be made satisfactory. Prosthodontic appliances (including partial and complete dentures, crowns and bridges) will be replaced only after five years have elapsed following any prior provision of such appliances.
- 4) Optional: In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the Plan will pay the applicable percentage of the lesser fee. The patient is responsible for the remainder of the dentist's fee.
- 5) Implants (appliances inserted into bone of soft tissue in the jaw, usually to anchor a denture) are not covered by this Plan. However, if implants are provided along with a covered prosthodontic appliance, the Plan will allow the prosthodontic appliances when the prosthetic appliance is completed. The Plan will not pay for any replacement for five (5) years following the completion of the services.

COBRA BENEFITS (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985)

Federal law requires most employers sponsoring group health plans, to offer employees and their families the opportunity for a temporary extension of health coverage (called "Continuation

Coverage"), at group rates in certain instances where coverage under the plan would otherwise end, (e.g., dependent children beyond age 19 or full-time students at age 25). Employees and their dependents should read the COBRA section carefully.

Additional benefits for retirees and/or surviving spouses are detailed in the COBRA Section.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The FMLA law became effective August 5, 1993. One of the provisions of the FMLA states that Group Health Benefits must be continued by the employer while the employee is on an approved FMLA leave of absence. COBRA coverage is available after the end of the period that the district must continue coverage during a FMLA leave of absence. Please contact Human Resources for additional information.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

If an employee is absent from employment due to a qualifying military service under 38 U.S.C. 4301 et. seq., and notifies Human Resources of his or her entrance into such military service, then the employee has the right to continue coverage for himself or herself and his or her qualifying dependents for the periods stated under COBRA.

Coverage under the employer's coverage will be reinstated after discharge from active military duty if and when the employee returns to work for the employer, provided the employee returns within 90 days of discharge.

SOURCE OF RATE CONTRIBUTION

Information about your contribution to this program, if any, may be obtained from the District Payroll - Employee Benefits Office.

RELATIONSHIP BETWEEN PLAN AND HEALTH CARE PROVIDERS

No health care provider is an agent or representative of the Plan. The plan does not control or direct the provision of health care services and/or supplies to plan participants and beneficiaries by anyone. The plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the plan. The statement also applies to all entities (and their agents, employees and representatives) which contract with the plan to offer preferred provider networks, or health-related services or supplies to participants and beneficiaries.

Nothing in this plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

HIPAA PRIVACY RULE

Notice of Privacy Practices for Personal Health Information

This notice of Privacy Practices describes San Jose Unified School District Foundation Plan's practices for safeguarding personal health information. The terms of this Notice apply to members and their dependents with medical, dental or prescription drug coverage. This notice is effective April 14, 2003.

We are required by law to maintain the privacy of our Members' and their Dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. You have a right to request a copy of the Notice.

Uses and Disclosures of Your Personal Health Information

Authorization. Except as explained below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Privacy Officer, United Administrative Services, P.O. Box 5057, San Jose, CA 95150-5057.

Disclosures for Treatment. We may disclose your personal health information as necessary for your treatment. For instance, a doctor or health care facility involved in your care may request your personal health information in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your personal health information as necessary for payment purposes. For instance, we may use your personal health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform prospective reviews. We may also forward information to another health plan in order for it to process or pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary for health care operations. For instance, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting, or arranging for medical review or compliance. We may also disclose your personal health information to another health plan, health care facility or health care provider for activities such as quality assurance or case management. We may contact your health care providers concerning prescription drug treatment alternatives.

Other Health-Related Uses and Disclosures. We may also contact you to provide information about treatment alternatives; other health related programs, products or services that may be available to you.

Business Associate. Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your personal health information to these people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your personal health information.

Family, Friends and Personal Representatives. With your approval, we may disclose to family members, friends or another person you identify, your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your personal health information without your approval. We may also disclose your personal health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For compliance with workers' compensation programs.

We adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV – related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Your Rights. If you believe that your privacy rights have been violated, you may complain to the Plan in care of our Privacy Officer at United Administrative Services, P.O. Box 5057, San Jose, CA 95150-5057. There will be no retaliation for filing a complaint. You also may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have the right to request restrictions on how we use or disclose your personal health information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care of the paying of your care. To request a restriction, you must send a written request to our Privacy Office, listed above. You have the right to request communications regarding your personal health information from us by alternative means, or at alternate locations. We will accommodate reasonable requests.

CLAIMS PROCEDURES

The Dental Plan provides that treatment or service must be medically necessary and be covered by your program. United Administrative Services has responsibility for determining whether claims are payable. A practicing dental-consultant retained by the claims administrator must agree if the denial is based on lack of medical necessity. To be considered medically necessary the treatment must be one that cannot be avoided without adversely affecting the patient's condition. The mere fact that your dentist orders the treatment does not mean that it is medically necessary.

No benefits are payable for care, treatment, services and supplies to the extent that they are not reasonably necessary for treatment of an injury or disease or to the extent that the charges for care, treatment, services or supplies are unreasonable.

APPEALS

An appeal of an adverse benefit determination is considered filed when a Claimant, or an authorized representative, submits a written request for review to:

Plan Administrator
United Administrative Services
P.O. Box 5057
San Jose, California 95150-5057

A request for review will be treated as received by the Plan (a) on the date it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

The Claimant must file an appeal of an adverse benefit determination within 180 days following the Claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment, the Claimant must submit an appeal within thirty (30) days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan as outlined

above. This timing is without regard to whether all the necessary information accompanies the filing.

A Claimant may submit written comments, documents, records, and other information relating to the Claim. A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the benefit determination;
- (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional. The health care professional engaged to review an appeal should be an individual who was neither the person consulted in connection with the adverse determination nor the subordinate of any such individual. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

The Plan's decision on review is the plan's final decision, subject to a Claimant's option to elect to submit a benefit dispute to the voluntary level of appeal through arbitration described below.

A Claimant has the right to bring a civil action if the Claimant has filed an appeal and the Claimant's request for coverage or benefits is denied following review and/or voluntary arbitration.

Voluntary appeals through arbitration

A Claimant may elect arbitration when an adverse benefit determination is upheld as explained in the section above, entitled "Appeals."

The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary level of appeal through arbitration provided by the Plan.

During arbitration, any statute of limitations or other defense based on timeliness is suspended during the time the voluntary appeal through arbitration is pending.

The Plan will provide to the Claimant, at no cost and upon request, sufficient information about arbitration to enable the claimant to make an informed judgment about whether to submit a benefit dispute to arbitration. This information will include a statement that the decision will have no effect on the Claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the Claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the Claimant as part of the voluntary level of appeal, and the claimant will be told this.

Arbitration is not mandatory.