

PIGGYBACK PROGRAM



Program Document and Summary Program Description

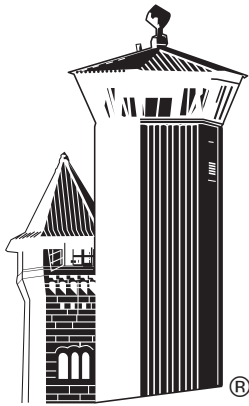
CCPOA

Benefit Trust Fund

**Supplemental Dental, Vision and
Hearing Aid Program**



Effective January 1, 2024



PIGGYBACK PROGRAM

**of the
California Correctional
Peace Officers Association
Benefit Trust Fund**

SUMMARY PROGRAM DESCRIPTION AND PROGRAM DOCUMENT

Updated:
January 1, 2024

TO THOSE WHO WALK THE TOUGHEST BEAT IN THE STATE:

This booklet describes your CCPOA Supplemental Dental/Vision/Hearing Aid Program, known as the Piggyback Program. This booklet provides a description of the Program and answers to commonly asked questions. It is intended only to highlight the Program. Keep this Summary Program Description for future reference.

The formal text of the Program Document controls eligibility, benefit payments, participation and administration of the Program. If you have any questions about the Program or desire any further information, please contact the CCPOA Benefit Trust Fund Office at 916-779-6300 or 800-IN-UNIT-6.

Sincerely,

The CCPOA BTF Board

CONTACT

Contact information for CCPOA Benefit Trust Board Members, Providers, Staff, and current Documents can be found at our website: www.ccpoabt.org

IMPORTANT NOTE TO COVERED PARTICIPANTS

You have a limited amount of time from the date covered expenses are incurred to submit claims to the CCPOA Benefit Trust Fund for payment. Detailed information concerning these time limits as well as your rights to appeal denied claims can be found in Sections 7-9. Your eligibility for certain dental benefits is subject to waiting periods, which are described in Section 2. Please review these sections carefully and contact the Trust Fund Office if you have any questions.

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SECTION 1 TYPE OF PROGRAM

(a) Piggyback Dental Program

This part of the Supplemental Program pays a portion of the fees the dentist of your choice charges, after benefits have been paid by your primary dental plan provided to you and your Dependents because of your employment by the State of California (hereafter referred to as “Primary Dental Plan”) or after benefits have been paid by any other primary dental plan.

(b) Vision Care Program

This part of the Supplemental Program provides reimbursement of the deductible and excess frame charges required by your state-paid Primary Vision Plan or the Retired “Standard” Vision Plan through Vision Service Plan. For retirees not enrolled in VSP, the Program provides reimbursement of vision services on fee-for-service basis.

(c) Hearing Aid Program

This part of the Supplemental Program is designed to reimburse you for a portion of the charges for a hearing exam and hearing aid on a fee-for-service basis.

SECTION 2 PARTICIPATION

Eligible Employees And Dependents

To be a Participant and eligible for benefits under this Program, a person must be an active member in good standing of CCPOA and employed by the State of California; a retired member in good standing of CCPOA and receiving benefits through the Department of Personnel Administration or the Public Employees Retirement System of the State of California; an employee of CCPOA or the CCPOA Benefit Trust Fund; a dependent of an eligible member in good standing of CCPOA; or a dependent of an eligible employee of CCPOA or the CCPOA Benefit Trust Fund.

- A. Additionally, those CCPOA members who are active employees of the State of California must maintain their eligibility to receive a State contribution towards payment of a premium for dental or vision program.

B. Active employees of CCPOA and the CCPOA Benefit Trust Fund must meet the eligibility requirements of their respective Employee Handbook or Employee Manual.

C. The eligibility requirements for dependents or widowed spouses will be the same as for the CCPOA-sponsored dental programs as found in the Program Documents describing those programs. Coverage for dependents and widowed spouses exists only if any additional premiums required for such coverage are currently paid in full. Participants must indicate on their application for enrollment that they wish to enroll their dependents and pay the additional premium for them.

D. If a Participant terminates his/her coverage under this Program, there is a one (1) year waiting period for reinstatement.

E. In addition, CCPOA members who were qualified for benefits immediately preceding a suspension, termination or medical demotion or termination may continue their enrollment in the Program by demonstrating to the Trust Fund that they are actively challenging the employment action and by self-paying the required contribution at least fifteen (15) days prior to the date eligibility would otherwise cease. Coverage under such circumstances will terminate when the suspension, termination or demotion ceases to be challenged, or thirty-six (36) months after such coverage commenced, whichever is earlier, or on the last day of the month for which contributions were received.

Under the Omnibus Budget Reconciliation Act of 1993, the Program must recognize any Qualified Medical Child Support Order (QMCSO) and enroll as directed by such Order any child of a Program Participant specified therein. A qualified Medical Child Support Order is any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court which:

(a) Provides the child of a Program Participant with child support or directs the Participant to provide the child with coverage under a health benefits plan or,

(b). Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the employee parent does not enroll the child, then the non-employee parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify for all of the following:

1. The name and last known mailing address of the Participant and the name and mailing address of each child covered by the order.
2. A reasonable description of the type of coverage to be provided by the Program to each such child.
3. The period of coverage to which the order applies.
4. The name of each program to which the order applies.

A Medical Child Support Order will not qualify if it would require the Program to provide any type or form of benefit or any option not otherwise provided under this Program, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of benefits by the Program under a QMCSO to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian, or as assigned to the provider of services.

No eligible Participant's child covered by a QMCSO will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's Federal income tax return or does not reside with the parent.

Effective Date Of Eligibility For Benefit Coverage

You and your eligible dependents will become covered for benefits under the Program on the first day of the calendar month immediately following the date payroll deduction commences.

Certain benefits for new enrollees covered under the Piggyback Dental Program are subject to the following waiting periods.

Orthodontic care services (New Programs) will be considered covered under this program only if the initial banding occurred after the participant has been enrolled in the Piggyback program for twelve (12) months.

Termination Of Eligibility For Benefits Coverage

Benefits under this Program will cease under each of the following circumstances:

1. When the Participant retires, unless the retiree reapplies as a dues-paying member of CCPOA Retired Chapter; or
2. When the Participant is no longer a member in good standing of CCPOA or the Participant or dependent otherwise ceases to be eligible under the provisions of this Program; or
3. When the Trust fails to receive the required contribution for that month; or
4. When written notification has been received by the Trust Fund Office that the Participant no longer wishes to participate in the Program; or

When the Program terminates.

Benefit coverage for an eligible dependent spouse and/or children shall cease coincident with the date the Participant's coverage is terminated.

An Eligible Spouse shall cease to be covered on the date of legal separation or divorce from the Participant unless premiums are paid pursuant to COBRA, discussed on the following pages

SECTION 3 COVERAGE CONTINUATION – COBRA SELF PAYMENTS AND FMLA LEAVE OF ABSENCE

If you or your Dependent would otherwise cease to be eligible for dental benefits, self-payments may be made to the Trust through the Trust Fund Office, under certain circumstances, described below. Enrollment applications for continued coverage are available and should be initiated through the Trust Fund Office.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), you, your spouse or eligible dependent child(ren) can individually elect to continue coverage under COBRA for a limited time by making monthly payments to the Trust. Such COBRA coverage is available for a limited period of time following election.

If one of the following events (known as a Qualifying Event) occurs, you and your eligible dependents have the right to continue coverage that was in effect at the time of the Qualifying Event.

The following are Qualifying Events:

Failure to maintain eligibility to receive a State contribution toward payment of a premium for a dental or vision program (e.g. failure to work at half-time or more for over six (6) months as a permanent employee; or failure to work a minimum of 480 or more hours in any control period for a Permanent Intermittent Employee);

- Termination of employment through resignation layoff, discharge (other than for gross misconduct), strike, lockout, or retirement;
- For your spouse or Dependent child, in the event of your divorce or legal separation (if you stop paying premiums for your spouse in anticipation of a divorce, your spouse will be treated as losing coverage at the time of the subsequent divorce or legal separation);
- For your spouse or Dependent child, in the event of your death;
- The loss of status as a Dependent child.

If less than the minimum work hours were reported for a month on your behalf (Item 1 above) or your employment terminates (Item 2 above), you and your Dependents are entitled to an additional eighteen (18) months of COBRA coverage under the

Program calculated from the date of the Qualifying Event. Each of the other above listed items (Items 3 through 5) entitles your Dependents to thirty-six (36) months of coverage from the date of the Qualifying Event. The eighteen (18) month period may be extended to 36 months if a second event (divorce, legal separation, death or Medicare entitlement, but not termination of employment) occurs during the eighteen (18) month period.

If you are a Participant entitled to Medicare and have a Qualifying Event because insufficient hours are reported for the month or your employment is terminated, your Dependents will be allowed to continue their coverage until the later of:

- Eighteen (18) months, or twenty-nine (29) months if there is a disability extension as described on page 9, from the date you did not work the required minimum work hours or your employment terminated; or
- Thirty-six (36) months from the date you became entitled to Medicare. For example, if you turn sixty-five (65) and become entitled to Medicare and twelve (12) months later lose coverage under the Program due to retirement, your Dependents will be entitled to twenty-four (24) months of COBRA coverage.
- “Entitled to Medicare” means enrollment in Medicare Part A or B, whichever is earlier.

Self-Payment for Continuation Coverage

The payment for COBRA coverage is borne entirely by you and your covered Dependents. The Trust makes no contributions on your behalf. If you or your Eligible Dependents elect to continue coverage, you will be obligated to pay the full premium for such coverage plus a two percent (2%) administrative fee.

HOW TO OBTAIN COBRA COVERAGE

Under COBRA, you or your family members have the responsibility to inform the Trust Fund Office within sixty (60) days of one of these events:

- a divorce or legal separation; or
- a child losing Dependent status (Dependent status is defined as under age twenty-six (26), or unmarried and incapable of self-support because of either physical or mental disability regardless of age) under the Program.

You will be notified of your rights to choose continuation coverage within fourteen (14) days of the date the Trust Fund Office receives notice of your Qualifying Event. COBRA rights will be forfeited if the Trust Fund Office is not notified of the

Qualifying Event within the sixty (60) day time period.

The State of California Department of Personnel Administration has the responsibility to notify the Trust Fund Office within thirty (30) days of the date coverage would otherwise be lost for one of the following reasons:

- your death; or
- termination of employment or you worked less than the minimum required work hours.

However, you or your dependents should advise the Trust Fund Office of these events as well. The Trust Fund Office has fourteen (14) days following receipt of notice of such an event within which to notify you of your rights to continue coverage. Such notice will be sent to the address of record maintained by the Trust Fund Office. It is your responsibility to keep the Trust Fund Office informed of your current mailing address.

The Trust Fund Office will send you a notice whenever the State of California Department of Personnel Administration reports less than the minimum required work hours or your employment is terminated. **You must sign and return the form to the Trust Fund Office electing coverage within sixty (60) days or you will not be eligible for COBRA continuation coverage.** You do not have to show that you are insurable to choose COBRA coverage. COBRA rights will be forfeited if you or your Eligible Dependents do not file the COBRA election forms within this sixty (60) day period.

If you do not choose COBRA coverage, your coverage will end. However, your spouse and/or your eligible dependents may elect COBRA coverage, independent of your decision, but they must also make their election within sixty (60) days of receiving the COBRA election forms.

Your initial COBRA coverage will be identical to coverage provided to similarly situated employees under the Program. It may be modified if coverage changes for other Participants or family members. All dependents covered at the time of a Qualifying Event are eligible to continue coverage hereunder. In addition, if you elect COBRA coverage, you may add dependents as needed, but these dependents will not be given the same rights as Dependents covered at the time of the initial Qualifying Event. You may add a dependent child born to you or placed for adoption with you while you have COBRA continuation coverage by notifying the Trust Fund Office within sixty (60) days of the birth or placement. A newly-born dependent child or adopted child added while you are COBRA

Continuation coverage will be given the same rights as any other dependent who was covered at the time of the initial Qualifying Event.

Extended COBRA Coverage Due to Disability

If you or your dependents are determined by Social Security to have been totally disabled at the time of your termination or reduction of hours or during the first sixty (60) days of COBRA Continuation coverage, COBRA coverage for you and your dependents may be extended for eleven (11) months beyond the original eighteen (18) months, for a total of twenty-nine (29) months. To qualify for these additional eleven (11) months, such an individual must report the Social Security determination to the Trust Fund Office before the original eighteen (18) month period expires and within sixty (60) days after the date of the determination. Further, the Trust Fund Office must be notified within thirty (30) days of the final determination that the qualified beneficiary is no longer totally disabled. Please note the premium for the additional eleven (11) months will be approximately fifty percent (50%) higher than the COBRA premium for the first eighteen (18) months if the continuation coverage includes the disabled individual and the continuation coverage would not be available in the absence of a disability.

TERMINATION OF COBRA COVERAGE

COBRA coverage will terminate earlier than the eighteen (18), twenty-nine (29) or thirty-six (36) month coverage periods upon occurrence of any one of the events listed below:

1. The first day of a coverage month in which you or your dependents fail to remit the required premium payments in full and on time (within forty-five (45) days following the submission of the initial COBRA election form and which payment must include the cost of coverage retroactive to the first day your coverage would have otherwise terminated, or within thirty (30) days following the due date established by the Trust Fund Office for subsequent periodic payments); or
2. You or your dependents have continued coverage for additional months due to a disability and there has been a final determination by Social Security that you or your dependent is no longer disabled. Coverage will terminate thirty (30) days following the date the Social Security determination is made; or
3. The date the Program terminates; or
4. The first day of the month following the date you or your dependents become covered under another plan which does not contain a limitation or exclusion for any pre-existing condition that is applicable to you or your dependents under HIPAA or other applicable law; or
5. The date the person receiving COBRA coverage enrolls in Medicare Part A or B, if the person becomes entitled to Medicare after he or she elected COBRA coverage.

If your marital status has changed, or if you acquire new Dependents while on COBRA Continuation coverage or you or your spouse have moved, please contact the Trust Fund Office. Please let the Trust Fund Office know of any Qualifying Event even if the State of California Department of Personnel Administration is otherwise required to give notice to the Trust Fund Office.

COBRA COVERAGE QUICK REFERENCE CHART

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
(1) Reduction in your minimum required work hours	You, your spouse and dependent children	18 months after date of qualifying event*
(2) Termination of your employment	You, your spouse and dependent children	18 months after date of qualifying event*
(3) Your death	Your spouse and dependent children	36 months after date of qualifying event
(4) Your divorce or legal separation	Your spouse	36 months after date of qualifying event
(5) Your dependent child's loss of that status under Program	Affected dependent child if covered under Program	36 months after date of qualifying event
(6) Your entitlement to Medicare after a qualifying event described in (1) or (2).	Your spouse and dependent children	36 months after date of initial qualifying event
(7) Your entitlement to Medicare before a qualifying event described in (1) or (2).	You, your spouse and dependent children	For you, 18 months after the date of the initial qualifying event. For your spouse and dependent children, later of 18 months from the qualifying event or 36 months from the date of your Medicare entitlement
<p><i>*The eighteen (18) month period may be extended due to disability or a second qualifying event, as discussed on the preceding pages.</i></p>		

COVERAGE DURING A FMLA LEAVE OF ABSENCE

If you, an Active Participant, are taking an approved leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you and your eligible dependents will continue to be covered under this Program provided you were eligible when the leave began and you make the required contributions during your leave. Coverage will be continued while you are absent from work on an FMLA leave as if there were no interruption of active employment and as if you were continuing to work the number of hours required for coverage. Coverage will continue until the earlier of the expiration of the FMLA leave or the date you give notice to the State of California Department of Personnel Administration that you do not intend to return to work at the end of the FMLA leave. If you do not return to work at the end of an FMLA leave, the end of the leave will be treated as a Qualifying Event for purposes of COBRA continuation coverage for you and for your dependents who were covered under this Program immediately before the leave began.

SECTION 4 PIGGYBACK DENTAL PROGRAM

(a) Variations in Primary Dental Insurance

In the event that the Participant has no Primary Dental coverage or has coverage with benefits less than those provided to the Primary Dental Plans' Participants, benefits under this Program will not exceed the amounts this Program provides Participants who have primary coverage with the Primary Dental Plans. In the absence of such other dental insurance, covered charges will be based on allowances under the Unit 6 State "CCPOA Primary Dental Program."

Exhaustion of benefits under a Participant's Primary Dental Plan will not affect the maximum liability of this Program.

(b) Piggyback Dental Benefits for Active Participants and Dependents

Your Primary Dental Plan will determine the customary and reasonable charges for covered expenses. Thereafter, the "Piggyback" Dental Program will pay benefits at the following levels, calculated upon that customary and reasonable charge for the service:

Fifty percent (50%) of the Covered Expense determined by your Primary Dental Plan for:

- Partial or full dentures.
- Fixed bridge work.

Twenty percent (20%) of the Covered Expense determined by your Primary Dental Plan for:

- Inlays.
- Crowns, including cast restorations
- Gold fillings.

Ten percent (10%) of the Covered Expense determined by your Primary Dental Plan for:

- All examinations other than the first examination each calendar year.
- Oral Surgery.
- Restoration, but not cast restorations.
- Emergency services.
- Periodontic treatment.
- Endodontic treatment.
- General anesthetic.

Additional Piggyback Dental Benefits for Participants and their Dependents.

Orthodontic Care Benefits: The Piggyback Dental Program will pay a fifty percent (50%) benefit for Orthodontic care with a family lifetime maximum of one thousand dollars (**\$1,000.00**). *Orthodontic care benefits will only be provided for orthodontic treatment programs which commence after the expiration of the one (1) year eligibility waiting period. Any treatment which begins prior to the completion of the waiting period, regardless of whether it continues after such period expires, will be excluded from coverage.*

In no event will payment under the Piggyback Dental Program exceed the amount the Participant is required to pay. In addition, in cases where alternative courses of treatment or services are available, payment will be based on the least expensive, professionally adequate alternative.

MAXIMUM PIGGYBACK DENTAL BENEFIT:

Two Thousand Dollars (\$2,000) per family, per calendar year.

(c) Piggyback Dental Benefits for

Retired Participants and Dependents Retired Participants

Your Primary Dental Plan will determine the customary and reasonable charges for covered expenses. Thereafter, the Piggyback Dental Program will pay benefits at the following levels, calculated upon that customary and reasonable charge for the service:

Fifty percent (50%) of the Covered Expense determined by your Primary Dental Plan for:

- Partial or full dentures.
- Fixed bridgework.

Twenty percent (20%) of the Covered Expense determined by your Primary Dental Plan for:

- Inlays
- Crowns, including cast restorations.
- Gold fillings.

Ten percent (10%) of the Covered Expense determined by your Primary Dental Plan for:

- Oral Surgery.
- Restoration, but not cast restorations.
- Emergency services.
- Periodontic treatment.
- Endodontic treatment.
- General anesthetic.

Dependents Of Retired Participants

Your Primary Dental Plan will determine the customary and reasonable charges for covered expenses. Thereafter, the Piggyback Dental Program will pay benefits at the following levels, calculated upon that customary and reasonable charge for the service:

Fifty percent (50%) of the covered expense determined by your Primary Dental Plan for:

- Partial or full dentures
- Fixed bridgework
- Inlays
- Crowns
- Gold fillings

Twenty percent (20%) of the Covered Expense determined by your Primary Dental Plan for:

- Oral Surgery.
- Restorations, but not cast restorations
- Emergency services
- Periodontic treatment
- Endodontic treatment
- General anesthetic

Orthodontic Care Benefit: The Piggyback Dental Program will pay a fifty percent (50%) benefit for Orthodontic care with a family lifetime maximum of one thousand dollars (**\$1,000.00**). Orthodontic care benefits will only be provided for orthodontic treatment programs which commence after the expiration of the one (1) year eligibility waiting period. Any treatment which begins prior to the completion of the waiting period, regardless of whether it continues after such period expires, will be excluded from coverage.

In no event will payment under the Piggyback Dental Program exceed the amount the Participant is required to pay. In addition, in cases where alternative courses of treatment or services are available, payment will be based on the least expensive, professionally adequate alternative.

MAXIMUM PIGGYBACK DENTAL BENEFIT:

Two Thousand Dollars (\$2,000) per family, per calendar year.

(d) Exclusions and Limitations of the Piggyback Dental Program

1. Deductibles are not reimbursed by this Program.
2. Charges in excess of the Primary Dental Plan's covered allowances are not covered.
3. Dental services not covered by the Primary Dental Plan are also not covered under this Program.
4. No benefits are payable if the underlying dental condition is the result of an on-the-job injury.
5. Orthodontic care limitation
6. Participants must be enrolled in the Piggyback Dental Program for one (1) year prior to becoming eligible for Orthodontic care benefits. Orthodontic care benefits will not be provided for Orthodontic treatment programs

which commence prior to the expiration of the one (1) year eligibility period.

7. Payment under this Program will not exceed the Participant's out-of-pocket expenses.
8. No benefits are payable for dental procedures requiring a nine (9) month waiting period until such waiting period has expired. Treatment begun prior to the conclusion of the waiting period, which continues after the waiting period has ended, is not eligible for payment.
9. Piggyback claims received by the CCPOA Benefit Trust Fund office more than one (1) year from the date the Primary Plan or carrier paid the original claim are not covered.
10. Benefits payable are only assignable if you are enrolled in the CCPOA Primary Dental Program or if the provider submits the claim directly to the Trust and has an assignment of benefits on file. The Piggyback Program is designed to reimburse you for out-of-pocket expenses, and such payments may not be paid by the Trust Fund office directly to your dental provider without an assignment of benefits signed by you, with the exception of payments made under Qualified Medical Child Support Orders.
11. If benefits have been exhausted under your primary carrier's plan, the maximum liability of the Program is no greater than the maximum covered under the Piggyback Dental Program.

SECTION 5 VISION CARE PROGRAM BENEFITS

(a) Vision Benefits for Active or Retired Participants and their Dependents

If you are enrolled in either the State-paid Primary Vision Plan or the Retired "Standard" Vision Plan through Vision Service Plan, Piggyback Vision Care Program will provide supplemental benefits as follows:

1. Reimbursement of a participant's or eligible dependent's Primary Vision Plan deductible, to a maximum of six (6) deductibles per family, per calendar year, up to three hundred dollars (\$300.00).

2. Reimbursement of up to fifteen dollars (\$15.00) for frames, if the frame expense exceeds the Primary Vision Plan allowance, to a maximum of six frames per family, per calendar year up to ninety (\$90.00) dollars.

Notwithstanding the foregoing, a family's annual maximum benefit will not exceed three hundred dollars (\$300.00).

(b) Vision Benefits for Retired Participants (not enrolled in a "Standard" Vision Plan through Vision Service Plan) and their Dependents

Upon receipt of due notice and proof that a Retired Participant or dependent has incurred expenses for covered vision services, such expenses will be reimbursed up to the following annual maximum amounts:

Professional fees:

Vision examination\$35.00
(limited to one visit per person)

Materials (lenses):

Single vision.....\$30.00/pair
Bifocals \$40.00/pair
Trifocals.....\$50.00/pair
Lenticular\$100.00/pair
Frames \$45.00/pair
Contact lenses are not covered

Notwithstanding the foregoing, a family's annual maximum benefit will not exceed three hundred dollars (\$300.00). Reimbursement for exams and glasses is limited to two (2) per person, per calendar year."

SECTION 6 HEARING AID PROGRAM BENEFIT

If a Participant or a Participant's eligible dependents undergo a medical examination by a licensed provider (M.D. or audiologist) and a hearing device(s) is prescribed, the Program will reimburse fifty percent (50%) of the expenses incurred for the examination and fifty percent (50%) of the expenses incurred for the hearing device(s) once every thirty-six (36) months, with a family maximum of Five Hundred Dollars (\$500.00). To qualify for these benefits, the hearing device(s)

must be purchased within ninety (90) days from the date of the hearing exam at which the hearing device was prescribed.

Benefits are not paid for battery replacements, repairs, and maintenance of hearing device(s).

A copy of the prescription ordering the hearing device(s) must be submitted with the itemized bill.

SECTION 7 APPLICATION FOR BENEFITS — HOW TO FILE A CLAIM

A Participant who believes he or she is entitled to benefits must submit a claim to the Program Administrator at the CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, California 95833-4235. The claim must be filed with the Trust Fund Office within sixty (60) days from the date of service and in no event later than one (1) year after the date the primary carrier paid the original claim. **IF YOU DO NOT SUBMIT THE CLAIM WITHIN THE ONE (1) YEAR PERIOD, YOUR CLAIM WILL BE DENIED.** If the Trust requires any additional information, the Participant must provide it before he/she will receive benefits. Failure to provide information or falsifying information in the application for enrollment or in a claim form shall be sufficient cause to deny, suspend or discontinue benefits.

The Trustees have the right to recover and reimburse the Trust for any benefits paid improperly, and may deduct overpayments from future payments due under this Program, including any expenses and attorneys' fee incurred in effecting said recovery. The specific claim procedure for each benefit is as follows:

(a) Piggyback Dental Program

Determine your State-paid Primary Dental Plan for your job class. (See item 1A on page 2).

When dental services are required, obtain a claim form from your Primary Dental Plan, or your dentist's office.

Ask your dentist to complete the claim form, listing services and charges. You should review this form to assure that all performed services were listed. Then ask your dentist to mail the claim form to your primary dental plan for payment. If you are enrolled in the CCPOA Primary Dental Program, the Trust Fund will process both your Primary Dental Benefit as well as

Supplemental Piggyback Benefit. For this reason, you no longer need to submit your dental explanation of benefits.

If you are covered by Delta Dental, please mail Delta's "Notice of Payment" to the Trust. If you are covered by any other dental program, please send an itemization of your out-of-pocket copays to the CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, California 95833-4235. The Trust will determine your benefits and issue a payment to you or your assigned dental provider for the covered charges and services.

(b) Vision Care Program

For Participants Covered Under A Vision Service Plan (Vsp) Program: When you are ready to obtain vision care services, call your VSP participating doctor. If you need to locate a VSP participating doctor, call Vision Service Plan at (800) 877-7195 or visit their web site at www.vsp.com. Your provider will indicate the deductibles you paid and give you a copy of the benefits form or an itemized bill. Mail this copy to CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, California 95833-4235.

The Trust Fund Office will determine your benefits and issue a check to you for benefits covered under this Program.

For Retired Participants Not Enrolled In A Vision Service Plan Program: Retired Participants must mail an itemized statement to the Trust Fund Office. The Trust Fund Office will determine your benefits and issue a check to you for covered benefits. Although not required, a claim form for vision services can be obtained on the CCPOA Benefit Trust Fund website, www.ccpoabtf.org or by calling the Trust at 1-800 IN UNIT 6.

(c) Hearing Aid Program

Have the attending physician or audiologist ordering the hearing device(s) and the provider who dispenses the device(s) submit a copy of the prescription ordering the hearing aid device and an itemized statement to the CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, California 95833-4235, containing the following information: Participant's name, patient's name, Participant's Social Security Number, date of service, services rendered, and charges for each service. The Trust Fund office will determine your benefits and issue a check to you for covered services.

SECTION 8 ALL OR PART OF A CLAIM MAY BE DENIED

It is not unusual that some charges submitted for a particular claim may be denied.

Common reasons for denial include:

- The service was provided prior to enrollment in the program or prior to the conclusion of the required waiting period.
- The denied portion of the claim is for charges exceeding the Primary Dental Plan's "customary and reasonable" allowance.
- A portion of the charges were denied by the Primary Dental Plan because the treatment was not the least expensive, professionally adequate alternative means of treating that particular condition.
- The expenses were incurred as the result of an on-the-job injury.
- The claim was submitted more than one (1) year from the date the primary plan carrier paid the original claim.

SECTION 9 CLAIMS APPEALS AND DISPUTES

The Piggyback Dental/Vision/Hearing Aid Program contains a claim and appeals procedure which a Participant must follow. The purpose of the procedure is to make it possible for claims and disputes to be resolved fairly and efficiently, with consistent application of the expressed rules. Failure to strictly adhere to this procedure shall be cause for denial of any appeal.

You will receive a written explanation of the benefits decision on each claim you submit. If you submit a claim and it is denied, you have the right to have the Board of Trustees review your claim. To have your claim reviewed, you must notify the Trust Fund Office in writing of your disagreement within 180 days after the date on the notice of the decision denying the claim. You must state the reasons why you believe the denial of your claim was in error. You have the right to representation throughout the review procedure at your own expense, but it is not required. The failure to file a request for review within the 180 day period shall constitute a waiver of your rights to have your claim reviewed.

You may request a hearing on your appeal. The Board of Trustees may request you to appear at a hearing. It is solely within the discretion of the Trustees whether, in any given instance, a hearing shall be conducted. The Board of Trustees will review the appeal by no later than the date of the meeting of the Board of Trustees which immediately follows the Program's receipt of your request for review. If the request is made within thirty (30) days of the date of such meeting, a decision may be made by no later than the date of the second meeting following the Program's receipt of the request for review. If special circumstances require a further extension of time for processing, written notice of such extension shall be furnished to you. The decision on review shall be rendered not later than the third meeting of the Board of Trustees following receipt of the request for review. The Board of Trustees' decision will be provided in writing and will include the specific reasons for the decision. The decision of the Board of Trustees is final, subject to judicial review in accordance with federal law. The provisions of this section shall apply to and include any and every claim for benefits under the Program, regardless of when the act or omission upon which the claim is based occurred and regardless of whether or not the claimant is a Participant in the Program within the meaning of those terms as defined under ERISA.

The Trust, at its own expense, shall have the right and opportunity, as often as it may reasonably require during the pendency of the claim hereunder, to examine the person of the covered beneficiary.

SECTION 10

QUESTIONS AND ANSWERS

Who is covered under the Program?

This Program applies only to full-time, permanent employees, permanent intermittent employees, and retired employees receiving benefits through the Department of Personnel Administration and the Public Employees Retirement System for Unit 6 of the State of California, who are also members in good standing of CCPOA, their eligible dependents, and employees of CCPOA and CCPOA Benefit Trust Fund. Eligibility requirements for dependents will be the same as the requirements for the State Primary Dental Plans which currently indicate the following as “eligible dependents”:

1. Your lawful spouse;
2. Unmarried children from birth to age twenty-six (26). Children include stepchildren and adopted children provided such children are dependent upon the employee for support and maintenance.
3. Your child age twenty-six (26) or over who has never been married and who is incapable of self-support because of physical or mental disability which existed continuously prior to age twenty-six (26).

NOTE: Parents, grandparents, common-law spouses, life partners, divorced spouses (except under COBRA), roommates, children under twenty-six (26) who marry and subsequently divorce, dependents who are married to your children, and relatives other than those listed above are not eligible dependents.

Can I borrow from the Program or give my benefits to someone else?

No. Your right to benefits cannot be transferred but may be used as part of court-ordered child or spousal support obligations but only to the extent covered by the Program.

Who runs my Program?

The Board of Trustees of the CCPOA Benefit Trust Fund, who are CCPOA members.

Where can I get information about the Program?

This Summary Program Description is only a brief description of the Program. Copies of the Program and Trust documents, reports filed with government agencies and annual audit reports

are available for your inspection at the Trust Fund Office during normal business hours. You may obtain copies of these documents with a written request and after payment of reasonable copying costs.

Can I continue benefits upon termination of employment?

Yes. A Participant who would otherwise cease to be eligible for benefits provided by this Program may, under certain circumstances described in this booklet, make self payments to the Trust for a specified period of time. (See page 6, Coverage Continuation – COBRA Self Payments.)

Can I maintain my benefits into retirement?

Yes. By enrolling in the CCPOA Retiree Chapter and maintaining your dues, you will be eligible to enroll in the Piggyback Dental/Vision/Hearing Aid Program for the Retiree Chapter. To enroll, you must also complete the Retiree Chapter application for the Piggyback Program.

What do I need to do now?

Inform the Trust of your address and the names of your dependents and any changes that occur.

SECTION 11

YOUR RIGHTS UNDER ERISA

The federal Employee Retirement Income Security Act of 1974 (“ERISA”) protects employees’ rights to their health and welfare benefits. The CCPOA Benefit Trust Fund organized this Program under ERISA in 1987 in order to assure the protection of CCPOA members’ rights to their health and welfare benefits.

As a Participant in the Piggyback Dental/Vision/Hearing Aid Program, you are entitled to certain rights and protection under ERISA. ERISA provides that all Participants shall be entitled to:

- Examine, at the Program Administrator’s office and at other specified locations without charge, all program documents, including insurance contracts, and copies of all documents the Program filed with the U.S. Department of Labor, such as detailed annual reports and Program descriptions.
- Obtain copies of all Program documents and other Program information upon written request to the Program Administrator. The Program Administrator may charge the Participant a reasonable fee for the copies.
- Receive a summary of the Program’s annual financial report. The Program Administrator is required by law to furnish each Participant with a copy of this summary annual report.

In addition to creating rights for Program Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Program, called “fiduciaries” of the Program, have a duty to do so prudently and in the interest of you and other Program 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 for exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Trustees of the Program review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you require materials from the Program and do not receive them in thirty (30) days, you may file suit in federal court. In such a case, the court may require the Program Administrator to provide materials and pay you up to one hundred dollars (\$100) per day until you receive the materials, unless the materials were not sent because of reasons beyond the Administrator’s control.

If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the Program's appeal procedures, ERISA allows you to file suit. The Trustees may require you to submit your claim to arbitration. If it should happen that the Program fiduciaries misuse the Program's money or other assets, 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 will pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay your costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

If you have any questions about your Program, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Pension and Welfare Benefit Administration ("PWBA"), Department of Labor listed in your telephone directory. The San Francisco Regional Office is located at 71 Stevenson St., Suite 915, P.O. Box 190250, San Francisco, CA 94119-3212 (phone (415) 975-4600) and the Los Angeles Regional Office is located at 790 E. Colorado Blvd., Suite 514, Pasadena, CA 91101 (phone (626) 583-7862). You may also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

SECTION 12

ADDITIONAL PROGRAM INFORMATION

Governing Law

This Program Trust is an employee welfare plan governed by the Internal Revenue Code and ERISA. If there is any conflict of interpretation with any law of the State of California, the Program shall be governed under ERISA and other applicable federal law. The Board of Trustees of the CCPOA Benefit Trust Fund reserve the right to amend, delete or add to the terms of this program at any time and to terminate this program at any time. The Board of Trustees is vested with the power to interpret this program, and any interpretation shall be final and binding.

Program Name

The name of this Program is the CCPOA Supplemental Dental/Vision/Hearing Aid Program, commonly known as the Piggyback Program, which is a part of the CCPOA Benefit Trust Fund Health and Welfare Plan, EIN #94-6459649. The three-digit number the Administration has assigned to this Program is 501.

Program Administration

The Program (and the Trust) is administered by the Board of Trustees. There are five (5) Trustees. Three (3) Trustees are elected at the CCPOA annual convention and serve three (3) year terms. Two (2) Trustees are appointed by the CCPOA President and serve two (2) year terms.

Funding and Administration

The benefits under the program are administered in accordance with the provisions of the CCPOA Benefit Trust Fund Agreement and Declaration of Trust. The Program is self-funded.

No person has a vested right to any benefit under the Program. The Board of Trustees has the discretion to change the amount, form, manner, duration or existence of any benefit. The Program exists only so long as there are sufficient funds to enable the Trustees to pay benefits and Program expenses.

Service of legal process may be made upon the Program Administrator, at the CCPOA Benefit Trust Fund Office: 2515 Venture Oaks Way, Suite 200, Sacramento, California 95833-4235.

Contribution

The contributions necessary to finance the Program are made solely by the Participants. The contributions are calculated actuarially.

Program Year/Fiscal Year

The Program Year and Fiscal Year commence on April 1 and end on the following March 31. The Claim Determination Period is based on a calendar year, which is a twelve (12) month period starting January 1 at 12:01 a.m. Pacific Standard Time.

Termination of Program

The Trustees have the right to discontinue or terminate the Trust and Program in whole or in part. There is no guarantee that the Program will last forever. In the event of termination or partial termination of the Program, the assets then remaining, after providing for the expenses of the Program and for the payment of any benefit theretofore approved, could be distributed among the Participants or transferred to another plan providing similar benefits. Neither the U.S. Government Pension Benefit Guaranty Corporation nor any other government agency insures the Program benefits.

Limitation Upon Reliance on Booklets and Statements

The explanation in this booklet is a brief and general summary. It is not intended to cover all the details of the Program. Under the Program, you are not entitled to rely on oral statements of the Trust Fund Office, any individual Trustee, any Union official, any employer, or this Summary Program Description. The provisions of this Summary Program Description are subject to and controlled by the Program Document. In the event of any conflict between the provisions of the Program Document and this Summary Program Description, the Program Document shall prevail.

Number and Gender of Words

Whenever appropriate, words used herein in the singular may include the plural, the plural may be read as the singular, and the masculine may include the feminine.

Review the Program to fully determine your rights. If you wish an official interpretation of the program on which you can rely, send your questions in writing to the Trust.

We've Got You Covered.

(916) 779-6300

1-800-468-6486



**CCPOA
Benefit Trust Fund**

2515 Venture Oaks Way, Suite 200
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