Offset the Out-of-Pocket Expenses

PB

Piggyback

Supplemental Dental, Vision & Hearing Aid Program

Powered by the
Benefit Trust Fund

SUMMARY PROGRAM DESCRIPTION
AND
PROGRAM DOCUMENT

CCPOA
Benefit Trust Fund

Effective: January 1, 2026

PIGGYBACK PROGRAM

of the

CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATION BENEFIT TRUST FUND

SUMMARY PROGRAM DESCRIPTION AND PROGRAM DOCUMENT

Updated:
January 1, 2026

This Benefit Trust Fund program is governed by the BTF Welfare Benefit Plan 501. A copy of this plan may be downloaded from our website: ccpoabtf.org.

You can ask for a paper copy of the Trust's plans or programs at any time, even if you have agreed to receive the notice electronically. The Trust Administrator will provide you with a paper copy promptly.

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 United Concordia Dental for dental claims at 1-844-789-1713 and contact the CCPOA Benefit Trust Fund Office for vision and hearing aid claims at 916-779-6300 or 800-IN-UNIT-6.

Sincerely,

The CCPOA BTF Board of Trustees

IMPORTANT NOTE TO COVERED PARTICIPANTS

You have a limited amount of time from the date covered expenses are incurred to submit dental claims to United Concordia Dental ("UCD") for payment or vision and hearing aid claims to submit to 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 UCD for dental and the Trust Fund office for vision and hearing aids if you have any questions.

A complete list of the Trust Administration, Board Members and Legal Contacts can be found on our website: www.ccpoabtf.org

Contact the Trust Fund Office if you have any questions.

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FRAUD NOTICE – ***For your protection California law requires the following to appear on this form:*** Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

SECTION 1
TYPE OF PROGRAM

(a) Piggyback Dental Program
This part of the Supplemental Program pays a portion of the covered charges for which the dentist of your choice charges, after benefits have been paid by your primary dental coverage provided to you and your Dependents because of your employment by the State of California (hereafter referred to as "CCPOA Dental Plan") or after benefits have been paid by any other dental plans.

(b) Vision Care Program
This part of the Supplemental Program provides reimbursement of the deductible and a portion of the 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 programs.

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. Your Eligible Dependents include your lawful spouse or your registered domestic partner (as provided in California Family Code Section 297), and unmarried children from birth to age twenty-six (26). Children include stepchildren and adopted children, provided such children are dependent upon you (the employee) for support and maintenance. Such children may continue coverage under the Program beyond the age of twenty-six if the child is incapable of self-support because of a physical or mental disability which existed prior to the child attaining age twenty-six (26) and remains unmarried. If you wish to enroll your Dependents, you must add all such Dependents on your enrollment application and pay the additional premium, if any, 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 Treatment Plans) 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 on the same 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 to the Eligible Spouse elects 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.

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);

1. Termination of employment through resignation layoff, discharge (other than for gross misconduct), strike, lockout, or retirement;
2. 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);
3. For your spouse or Dependent child, in the event of your death;
4. 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 (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. The COBRA premium is 150% of the full premium for coverage for months 19-29 for Qualified Beneficiaries whose COBRA is extended due to disability.

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) days 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 and your eligible Dependents will lose your right to elect COBRA if you or your Eligible Dependents do not file the COBRA election forms within this sixty (60) day period.

If you do not choose to elect COBRA coverage, your coverage under this Program will end. 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 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
*The eighteen (18) month period may be extended due to disability or a second qualifying event, as discussed on the preceding pages.		

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.

3.5 Continuation Coverage During Military Leave
If you are on an approved military leave of absence subject to the Uniformed Services Employment and Reemployment Rights Act ("USERRA") for less than 31 days, coverage for you and your eligible Dependents will continue as though there was no interruption of active employment. However, if you fail to return to work at the end of such leave, your Qualifying Event occurs on the first day after you fail to return to work at the end of your leave.

If you take a leave of absence because of voluntary or involuntary covered service in the uniformed services for a period greater than thirty (30) days and such leave is subject to USERRA, you may elect to continue this Program's coverage for yourself and your eligible Dependents for up to twenty-four (24) months (eighteen[18] months for elections made prior to December 10, 2004) or for the period ending on the day after the date you fail to apply for or return to employment with your employer as determined under § 4312(e) of USERRA, whichever is earlier.

You may elect continuation coverage pursuant to USERRA for yourself and your eligible Dependents by following the election procedure for COBRA coverage and electing COBRA coverage. This is because a right to elect continuation coverage under USERRA and COBRA are triggered at the same time. Your period of continuation coverage available under

USERRA will run concurrently with COBRA coverage to the extent your rights under both laws overlap. If you fail to timely elect COBRA coverage, you will lose the right to continue coverage under both COBRA and USERRA. (Note: Your eligible family members do not have an independent right to elect continuation coverage under USERRA, but do have an independent right to elect COBRA coverage).

Continuation coverage under both COBRA and USERRA are available to Qualified Beneficiaries who are covered by the Program on the day before the event that qualifies them for COBRA and USERRA. Continuation coverage will be identical to the coverage provided under the Program to similarly situated employees or family members.

You will be required to pay 102% of the cost of coverage for the duration of your continuation of coverage period. The payment policies and procedures applicable to COBRA coverage also apply to USERRA coverage.

To continue coverage under USERRA, you must have provided your employer with advance notice of your military service. If you fail to provide advance notice to your employer, you will lose your right to continue coverage pursuant to USERRA unless the requirement to provide advance notice has been excused in accordance with USERRA because such notice was impossible or unreasonable under all circumstances or was precluded by military necessity. If your requirement to provide advance notice has been properly excused, your Program coverage will be reinstated retroactive to the date that your coverage was terminated upon your election to continue coverage and your payment of all unpaid premium payments to the CCPOA BTF.

3.6 Termination of USERRA Continuation Coverage

Continuation coverage pursuant to USERRA ends on the earliest to occur of the following:

- The date you fail to return from protected military service or apply for a position of employment as provided under USERRA;
- The end of the 24-month period beginning the date your military leave of absence began;
- Your failure to make a timely payment for your COBRA/USERRA coverage;
- The date you are discharged from military service under other than honorable conditions or if you are dismissed or dropped from military rolls under conditions that result in a loss of reemployment rights under USERRA;

- Any event that would terminate coverage of a Participant not on COBRA/USERRA (e.g., fraud); or
- CCPOA Benefit Trust Fund's termination of the Program.

SECTION 4
PIGGYBACK DENTAL PROGRAM

(a) Variations in Primary Dental Insurance
In the event that the Participant is not enrolled in the CCPOA Dental Program and that dental coverage has coverage with benefits less than those under the CCPOA Dental Program's' Participants, benefits under this Piggyback Dental Program will not exceed the amounts this Program provides Participants who have primary coverage with the CCPOA Dental Program. If a Participant is not enrolled in a Primary Dental plan, then this Piggyback Dental Program will not pay anything.If the Participant is covered under more than one dental program, the Piggyback Dental Program will always pay last.

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 their Dependents
Your primary dental plan will determine the customary and reasonable charges for covered expenses (including if you are enrolled in the CCPOA Dental Program). 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 example:
- Partial or full dentures.
- Fixed bridge work.
- Implants and Implant crowns.

Twenty percent (20%) of the Covered Expense determined by your primary dental plan for example:
- Inlays/Onlays
- Crowns, including cast restorations
- Gold fillings.

Ten percent (10%) of the Covered Expense determined by your primary dental plan for example:

- Examinations not paid at 100%..
- Oral Surgery.
- Restorations, Fillings.
- Emergency services.
- Periodontic treatment.
- Endodontic treatment.
- General anesthesia

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 out of pocket under their primary dental plan. 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 ACTIVE AND RETIRED PIGGYBACK DENTAL BENEFIT:

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

(c) Piggyback Dental Benefits for Retired Participants and Dependents Retired Participants and their 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 example:

- Partial or full dentures.
- Fixed bridgework.
- Implants and Implant crowns

Twenty percent (20%) of the Covered Expense determined by your primary dental plan for example:

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

Ten percent (10%) of the Covered Expense determined by your primary dental plan for example:

- Oral Surgery.
- Restoration, 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 RETIRED PIGGYBACK DENTAL BENEFIT:
Two Thousand Dollars ($2,000) per family, per calendar year.

(d) Exclusions and Limitations of the Piggyback Dental Program For Active and Retired Participants

1. Deductibles are not reimbursed by this Program.
2. Charges in excess of your primary dental plan's covered allowances are not covered.
3. Dental services not covered by your 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. Charges in excess of the Orthodontic care limitation. 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.
6. Payment under this Program will not exceed the Participant's total out-of-pocket expenses under their primary dental plan.
7. Piggyback claims received more than one year from the date the primary dental plan paid the original claim are not covered.
8. Benefits payable are only assignable if you are enrolled in the CCPOA Dental Program or if the provider submits the claim directly to United Concordia Dental and has an assignment of benefits on file. The Piggyback Dental Program is designed to reimburse you for out-of-pocket expenses, and such payments may not be paid by the United Concordia Dental 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.
9. 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 as indicated in Section 4, Items (b) and (c).

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 Vision Plan or the Retired Vision Plan through Vision Service Plan (VSP), the Piggyback Vision Care Program will provide supplemental benefits as follows:

1. Reimbursement of a participant's or eligible dependent's Vision Plan copays, to a maximum of six (6) copays 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 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 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 1 year (365 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 for dental to:

United Concordia Dental
PO Box 69421
Harrisburg, PA 17106-9421

and submit claims for vision or hearing aids to:

CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, California 95833-4235

The claim must be filed with the appropriate claims administrator 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 THE CLAIM IS NOT RECEIVED WITHIN THIS ONE YEAR PERIOD, YOUR CLAIM WILL BE DENIED. If any additional information is required, 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 to Participants or their Dependents 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

If you are an Active Employee, Determine your State-paid primary dental coverage for your job class. It may be

the CCPOA Dental Program (Administration by United Concordia) or it may be Delta Dental.

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 Dental Program, United Concordia Dental will process both your dental benefit under the CCPOA Dental Program as well as benefit under the Piggyback Dental Benefit. For this reason, you do not need to submit your dental explanation of benefits.

If you are covered by Delta Dental, please mail Delta's "Notice of Payment" to United Concordia Dental.. If you are covered by any other dental program, please send an itemization of how the claim was paid (an Explanation of Benefits [EOB]) to United Concordia Dental, PO Box 69421, Harrisburg, PA 17106-9421 .

The benefits will be determined 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 copays and overages you paid and give you a copy of the benefits form or an itemized statement. Please include the Participant's name, patient's name, last 4 of your social security number or your BTF ID number and/or Date of Birth.

Mail this copy to:
CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 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 (VSP) 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 1-800-468-6486.

(c) Hearing Aid Program
Have the attending physician or audiologist ordering the hearing device(s) and the provider who dispenses the device(s) provide you with a copy of the prescription ordering the hearing aid device and an itemized statement for the hearing aid and send to the CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, California 95833-4235. Please include the Participant's name, patient's name, Participant's last 4 of the Social Security Number or BTF ID number and/or Date of Birth. The itemized statement should include the date of service, services rendered, and charges for each service.

Mail this copy to:
CCPOA Benefit Trust Fund
2515 Venture Oaks Way Suite 200
Sacramento, CA 95833-4235
The Trust Fund office will determine your benefits and issue a check to you for covered services under this Program.

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 your 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 year from the date the primary dental plan 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.

Dental Claims and Appeals
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 appeal your dental claim to United Concordia Dental for a first level appeal or if you disagree with the UCD decision you have a right to appeal to the CCPOA BTF Board of Trustees for a second level appeal of your claim. To have your claim reviewed, you must notify UCD 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. The same information is required for the second level appeal. 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.

Vision or Hearing Aid Claims
To have your vision or hearing aid claim reviewed, you must notify CCPOA Benefit Trust Fund 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. There is no second level of review for vision or hearing aid claims.

You may request a hearing on your second level dental appeal or your vision or hearing aid 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.

If the Board of Trustees or UCD denies your appeal (depending on whether it is a dental or vision/hearing aid benefit), UCD or the Board of Trustees will provide you with a notice of the adverse determination that includes the following information:

1. the specific reason or reasons for the denial;
2. a reference to the specific Program provisions on which the denial is based;
3. a statement regarding your entitlement to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
5. If the denial is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to your medical circumstances, or a statement that, such explanation will be provided free of charge upon request.

6. If the denial is for the first level of appeal, a description of the procedures for filing a voluntary second level of appeal (if applicable).

The decision of the Board of Trustees is final, subject to judicial review. Such judicial review may not be pursued unless and until the claims and appeals procedures described in this section have been exhausted in accordance with such procedure.

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 or your registered domestic partner;
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 of mental disability which existed continuously prior to age twenty-six (26).

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 a 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 **SECTION 3**, 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 complete the Retiree Chapter application and the application for the Retired Piggyback Program.

SECTION 11
STATEMENT OF ERISA RIGHTS

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 ten dollars ($110) 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
(415) 975-4600

The Los Angeles Regional Office is located at:
790 E. Colorado Blvd., Suite 514,
Pasadena, CA 91101
(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 reserves 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 Management
The Program (and the Trust) is managed 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.

Program Administration
The Plan of which this Program is a part is administered by the Board of Trustees in accordance with the provisions of the Trust Fund Agreement. The Board of Trustees has appointed an administrator (the "Trust Fund's Administrator") to perform certain functions necessary to carry out the orders and policies of the Board of Trustees with respect to the administration of this Program. If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator shall be deemed to include reference to such delegate.

Certain administrative functions including the processing and payment of dental claims under this Program have been delegated by the Board of Trustees to a Claims Administrator. All administrative inquiries, claims, appeals and related information, and general information regarding dental claims should be directed to the Claims Administrator:
United Concordia Dental
Dental Claims
PO Box 69421
Harrisburg, PA 17106-9421
Customer Service: 1-844-789-1713

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 personnel, United Concordia Dental personnel, any individual Trustee, any Association official or any employer. If you wish an official interpretation of the Program, please communicate your questions to the Trust Fund in writing..

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.

We've Got You Covered.

(916) 779-6300

1-800-468-6486

CCPOA
Benefit Trust Fund

2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235
www.ccpoabtf.org

TRUST WEBSITE

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ACCEPT NO SUBSTITUTES