Smile. We've Got You Covered.

DENTAL PLAN

Powered by the
Benefit Trust Fund

Partnered with:

United Concordia dental®

SUMMARY PROGRAM DESCRIPTION
AND
PROGRAM DOCUMENT

CCPOA Benefit Trust Fund

Effective: January 1, 2026

DEAR PARTICIPANT:

The Board of Trustees of the CCPOA Benefit Trust Fund is pleased to provide the CCPOA Dental Program (the "Program") to you. This booklet contains a description of the dental benefits available under the Program. Together with the CCPOA Benefit Trust Fund Summary Plan Description and Plan Document, this booklet acts as the plan document and summary plan description for these benefits. KEEP A COPY OF THIS BOOKLET FOR YOUR REFERENCE.

If you have any questions about the Program or desire any further information, please contact the Administration of claims and Customer Service at:

United Concordia Dental
Dental Claims
PO Box 69421
Harrisburg, PA 17106-9421
Customer Service: 1-844-789-1713

Partnered with:

CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235
Telephone: (916) 779-6300 (Sacramento)
Toll-free: (800) IN UNIT 6 or (800) 468-6486

Sincerely,
Board of Trustees, CCPOA Benefit Trust Fund

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.

CCPOA DENTAL PROGRAM

of the

CALIFORNIA CORRECTIONAL PEACE OFFICERS ASSOCIATION BENEFIT TRUST FUND

SUMMARY PROGRAM DESCRIPTION AND PROGRAM DOCUMENT

Updated:
January 1, 2026

United Concordia dental®

IMPORTANT NOTE TO COVERED PARTICIPANTS:

Time Limit
If you or your dependent anticipates receiving treatment for dental services that is expected to cost $300 or more, you are encouraged to have your provider submit a treatment plan to the Trust Fund Administrator for review before the treatment starts so that you can obtain a written estimate of the benefit payable, if any, under this Program. Also, you have a limited amount of time from the date Covered Expenses are incurred to submit claims to United Concordia Dental for payment. Detailed information about these time limits as well as your right to appeal denied claims can be found in Sections 9 & 10.

Contact
United Concordia Dental
PO Box 69421
Harrisburg, PA 17106-9421
1-844-789-1713 if you have any questions about claims.

Trust Attorney
Trucker Huss
One Embarcadero Center
12th Floor
San Francisco, CA 94111-3628

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.

CONTENTS

SECTION 1
TYPE OF PROGRAM

In 1987, the California Correctional Peace Officers Association established a trust (the "Trust Fund") for the purpose of providing health and welfare benefit plans to employees of State of California Bargaining Unit 6 and their supervisors and managers, and granted administration of the Trust Fund to the Board of Trustees of the Trust Fund ("Board of Trustees") pursuant to a Trust Fund Agreement and Declaration of Trust Fund (the "Trust Fund Agreement").

The Board of Trustees established the CCPOA Dental Program ("Program") as part of the health and welfare plan funded by the Trust Fund. The Program is funded by contributions from the State of California and Program Participants. The benefits provided under the Program are described in this "Program Document". This "Program Document" was previously amended and restated as of April 1, 1998. The Board of Trustees is now amending and restating the Program in its entirety effective January 1, 2026.

The Program is intended to pay a portion of the fees your Dentist or Registered Dental Hygienist in Alternative Practice (RDHAP), charges for Covered Dental Services and Supplies. To qualify for Program benefits, you and your Dependents must be eligible for Program benefits as defined below when dental services are rendered. (Hereinafter, all references to "Dentist" include Registered Dental Hygienists in Alternative Practice.)

The Trustees have entered into an agreement with United Concordia Dental (UCD) to provide an Elite Plus network of preferred Dentists for the Program. All Dentists participating in the network agree to charge you no more than the amount negotiated by the Trust Fund with UCD. Please refer to Section 4.4 for additional information about how to access care through the UCD network.

SECTION 2
PARTICIPATION

2.1 Eligibility

Full-time permanent employees and Permanent Intermittent Employees of the State of California Bargaining Unit 6 and their Eligible Dependents (whom the Participant enrolls and pays any required premiums), become eligible to enroll for coverage on the first day the employee is Actively at Work for the State of California Department of Corrections and Rehabilitations or their successors. Membership in Good Standing in the CCPOA is also required to enroll in and maintain coverage under the Program. To enroll, you must submit a completed enrollment application to your Personnel Office. Enrollment applications are available at the Personnel Office of your correctional facility or institution. To help ensure that your coverage commences as soon as the Program provides, submit your completed enrollment application as soon as you become eligible.

Employees of CCPOA and CCPOA Benefit Trust Fund and their Eligible Dependents (whom the Participant enrolls and for whom the Participant pays any required premiums), become eligible to enroll in coverage on the first day the employee is Actively at Work for the CCPOA or the CCPOA Benefit Trust Fund, as applicable. To enroll, you must submit a completed enrollment application to the HR specialist for the CCPOA or CCPOA BTF, as applicable. Enrollment applications are available at the Trust Fund Office. To help ensure that your coverage commences as soon as the Program provides, submit your completed enrollment application as soon as you become eligible. CCPOA members who were qualified for benefits immediately preceding a suspension, termination or medical demotion while in Unit 6 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 actively 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, if earlier.

Dependent Eligibility:

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.

Important Information:
Married State Employees may not "split" Dependent coverage; all Dependent children must be enrolled by only one State Employee. If an Eligible Dependent enrolls as a State Employee, coverage as a Dependent will be terminated as of the date that employee-coverage becomes effective. There is no dual coverage allowed. Employees and Dependents may not have dual coverage under any dental plan which is funded in any amount by the State of California.

The Program must recognize any Qualified Medical Child Support Order (QMCSO), as defined in the federal Omnibus Budget Reconciliation Act of 1993, and enroll 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) which:

1. 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
2. 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:

a. The name and last known mailing address of the Participant and the name and mailing address of each child covered by the order,
b. A reasonable description of the type of coverage to be provided by the Program to each such child,
c. The period of coverage to which the order applies, and
d. 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 Medical Child Support Order to reimburse expenses claimed by a child or the custodial parent or legal guardian shall be made to the child or the custodial parent or legal guardian.

No eligible Participant's child covered by a Qualified Medical Child Support Order 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.

2.2 Effective Date of Coverage

When you file an enrollment application after becoming eligible, payroll deductions should commence the following month. You and your Eligible Dependents will become covered for Program benefits on the first day of the calendar month immediately following the date payroll deductions commence. That is your Effective Date of coverage. You must also be Actively at Work in order for coverage to start, otherwise, coverage will be delayed until you return to Active Work status.

2.3 Deferred Effective Date of Coverage

If you are already enrolled in the Program and want to add new Dependents, you may do so by completing an enrollment application with the Personnel Office at your correctional facility or institution. A new spouse must be enrolled within sixty (60) days of the date of marriage. A new child must be enrolled within sixty (60) days of acquiring the child.

Provided the Dependent is properly enrolled and appropriate premium payments have been received by the Trust Fund, coverage for your new spouse will commence on the first day of the month following the date of marriage and coverage for your newly acquired Dependent child, other than a newborn, will commence on the first day of the month after acquiring the child. A newborn child will be covered from the date of the birth provided that a properly completed enrollment application is filed with your Personnel Office within sixty (60) days from the newborn child's date of birth.

2.4 Late Enrollment

If you do not enroll yourself or your Dependents within the time frames required under the Program, you and your Dependents may file an application to enroll for dental coverage at the next

annual open enrollment period held each fall. Coverage will become effective on the following January 1 provided that the premium deductions required are made and you are Actively at Work on that day(or upon your return to Active Work, if still eligible).

2.5 Annual Option to Change Dental Programs

Once each year, you are provided the opportunity to change dental programs. The Effective Date of coverage for any changes made during the open enrollment period in the fall will be January 1. If enrollment is not completed during the open enrollment period for a January 1st Effective Date, no change will be allowed until the next open enrollment period.

2.6 Termination of Eligibility

Eligibility for benefits under the Program will cease upon the earliest to occur of the following:

a. The first day of the month following the date that you retire;

b. The first day of the month following the date you stop self payment contributions to the Program;

c. The first day of the month following receipt of written notice from you of your intent to voluntarily withdraw from the Program;

d. The first day of the month following receipt of written notice from you of your intent to voluntarily withdraw your membership in CCPOA;

e. The first day of the month in which you are no longer eligible under the terms of the Program;

f. The date CCPOA Benefit Trust Fund no longer provides coverage for a class of employees to which you belong; or

g. When the Program terminates.

Eligibility for benefits for your Dependents will cease at the same time your eligibility terminates, except Dependent coverage will cease earlier under any of the following circumstances:

a. The date the Dependent no longer qualifies as an Eligible Dependent under the Program;

b. The first day of the month for which you discontinue self payment contributions to the Program for Dependent coverage; or

c. The date that Dependent coverage ceases to be available under the Program.

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

If you or your Dependent ceases to be eligible for dental benefits, you or your Dependent may continue Program coverage under certain circumstances, as described below, by making self-payments to the Trust Fund. Enrollment applications for continued coverage are available and should be initiated through your Personnel Office.

In accordance with the Public Health Services Act, you, your spouse or Eligible Dependent child(ren) may individually elect to continue coverage under COBRA following the occurrence of a "qualifying event" (see below) for a limited time by making monthly payments to the Trust Fund. Such COBRA coverage is available for a limited period of time following election of such coverage.

If one of the following events (known as the 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:

1. Reduction in work hours below the level of thirty (30) hours per week for full time employees and for Permanent Intermittent Employees, the loss of sufficient hours/work schedule to maintain PIE status.
2. Termination of employment through resignation, layoff, discharge (other than for gross mis- conduct), strike, lockout, or retirement;
3. 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);
4. For your spouse or Dependent child, in the event of your death;
5. The loss of a child's status as a Dependent child.

A person who is entitled to elect COBRA coverage because of a loss of coverage due to one of the events described above is a Qualified Beneficiary under COBRA.

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	Your spouse and dependent children
(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, 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.		

If Program coverage is terminated because less than the minimum work hours were reported for you for a month (Item 1 above) or your employment terminates (Item 2 above), you and your Dependents are entitled to eighteen (18) months of COBRA coverage under the Program calculated from the date of the Qualifying Event. This eighteen (18) month period may be extended to 36 months for your Dependents if a second event (divorce, legal separation, your death or Medicare entitlement, but not termination of employment) occurs during the eighteen (18) month period.

Each of the other qualified events listed above (numbered 3 through 5) entitles your Dependents to thirty-six (36) months of coverage from the date of the Qualifying Event. 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:

a. Eighteen (18) months or twenty nine (29) months, if there is a disability extension as described on page 18) from the date you did not work the required minimum work hours or your employment terminated; or

b. 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.

Note: "Entitled to Medicare" means enrollment in Medicare Part A or B, whichever is earlier.

3.1 Self Payment for Continuation Coverage

You and your Eligible Dependents are responsible for making all payments for COBRA coverage. The Trust Fund 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. [Note: 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.]

3.2 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 the occurrence of one of these COBRA "qualifying events":

a. A divorce or legal separation; or

b. A child losing Dependent status 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 (60) day time period.

The State of California Department of Personnel Administration is responsible for notifying the Trust Fund Office within thirty (30) days of the date you would otherwise lose coverage for any one of the following COBRA "qualifying events":

a. Your death; or
b. Termination of your employment or if you worked less than the minimum required work hours for coverage.

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 your last 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 COBRA notice whenever the State of California Department of Personnel Administration reports less than the minimum required work hours for you or if 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 with the Trust Fund Office within the sixty (60) day period.

If you or your Dependents do not choose COBRA coverage, your respective coverage will end. You and your Dependent have independent rights to elect COBRA coverage. Such coverage must be elected 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 during an open enrollment period, but these Dependents will not be given the same rights as Dependents covered at the time of the initial Qualifying Event as they will not be considered "Qualified Beneficiaries" under the Public Health Service Act. However, newly born or adopted Dependent children will be given the same rights as any other Dependent who was covered at the time of the initial Qualifying Event if they are enrolled with the Trust Fund Office within sixty (60) days of the birth or adoption placement.

3.2 Extended COBRA Coverage Due to Disability

If you or your Dependents are determined by the Social Security Administration to have been totally disabled at the time of your termination of employment 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 of coverage, such an individual must report the Social Security Administration's 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. If such individual ceases to be disabled, 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 that 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.

3.3 Termination of COBRA Coverage

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

a. 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 - such payment must include the cost of coverage retroactive to the first day of your COBRA coverage - or within thirty (30) days following the due date established by the Trust Fund Office for subsequent periodic COBRA payments); or

b. You or your Dependents have continued cover- age for additional months due to a disability and there has been a final determination by the Social Security Administration that you or your Dependent is no longer disabled. Coverage will terminate thirty (30) days following the date the Social Security Administration's determination is made; or

c. The date the Program terminates; or

d. 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

e. 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.

f. Any event that would terminate coverage of a Participant not on COBRA (e.g., fraud).

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.

3.4 Coverage During an FMLA Leave of Absence

If you are an Active Participant and are taking an approved leave under the terms of the Family and Medical Leave Act of 1993, you and your eligible Dependents will continue to be covered under the 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 the 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
HOW THE CCPOA DENTAL PLAN WORKS

4.1 Deductible
The Program pays a portion of the fees your Dentist charges for Covered Dental Services and Supplies after satisfaction of the Program's per person fifty dollar ($50.00) Calendar Year deductible. This deductible applies to out-of-network providers only and must be satisfied by you and each of your Dependents before benefits are payable under the Program. The deductible amount will not apply toward diagnostic or preventive dental services. The maximum deductible per family each Calendar Year is one hundred fifty dollars ($150.00). If three members of an enrolled family each meet their separate deductibles during a Calendar Year, then the Calendar Year deductible for all family members is considered to have been met and no further deductible will be applied for the remainder of the Calendar Year. Only charges incurred for Covered Dental Services and Supplies may be used to satisfy your deductible amount and any charges submitted which exceed the Program's Allowable Charge for a Covered Dental Service or Supply will not be applied to your deductible amount.

Any charges applied to the deductible during the last quarter of any Calendar Year and applied toward the Calendar Year deductible amount for that year, also counts toward the Calendar Year deductible for the following Calendar Year.

The deductible is waived on all covered services rendered by an in-network provider.

The deductible for out-of-network providers will be waived for all covered services incurred in between January 1, 2026 and December 31, 2026.

4.2 Authorization
While preauthorization is not required, you are encouraged to have your Dentist submit a treatment program for dental services that are expected to exceed three-hundred dollars ($300.00) to the Administrator before treatment starts. The Administrator will review the treatment plan and will provide a written estimate of the benefits payable, if any, under the Program.

4.3 Maximum Benefits
The annual maximum benefit payable for Covered Services and Supplies incurred by you and each of your Dependents is two thousand dollars ($2,000.00). Benefit payments for Orthodontic Services are limited to a lifetime maximum of one thousand dollars ($1,000.00) for you and each of your Dependents.

4.4 Preferred Dental Providers
The Trust Fund has contracted with United Concordia (UCD) to provide Trust Fund members with an Elite Plus network of Dentists, who have agreed to provide dental care at negotiated rates. So, before you visit a Dentist, check to see if your provider is a participating Dentist within the Elite Plus network with UCD. UCD contracts with dental providers throughout California. You are free to choose any UCD Elite Plus network Dentist.

The following is a list of some common questions and answers about accessing the United Concordia:

How do I find a United Concordia Dentist?

- Visit the United Concordia website at: https://www.unitedconcordia.com/ccpoa
- Call United Concordia at: 1-844-789-1713 for Dentist information and customized referrals.

What if I need to see a specialist?
The United Concordia Dental Elite Plus network includes both general care Dentists and specialists. In most areas you will have a selection of in-network specialists to choose from. All participating specialists have agreed to charge fees at negotiated rates.

What if my Dentist is not a United Concordia Dentist?
You may wish to nominate your Dentist to join United Concordia's network.
Simply call United Concordia at 1-844-789-1713 or use their website:
https://www.unitedconcordia.com/contact-us/nominate.xhtml to submit your Dentist's name It is not a requirement of the Program that you use in-network providers. The same level of benefits are payable for out-of-network providers, though claims will be paid using the out-of-network fee schedule.

SECTION 5
WHAT THE PLAN PAYS

5.1 Covered Expenses
If you or your Dependent, while eligible for benefits, incur expenses for Covered Dental Services or Supplies, the Program will pay the following percentage of Covered Expenses (following page), subject to any deductible, or other limitations and exclusions provided in Section 6 and any other provisions of the Program.

COVERED SERVICES

Non-Contracted Provider:
Calendar year maximum: $2000/ per person
Combined Dental & Orthodontic Deductible: *Per calendar year:*
Individual: $50 / Family: $150
Deductible is waived on Preventive/Diagnostic Services
Reimbursement is based on the schedule of maximum allowable charges (MACs).

UCCI Elite Plus In-Network Providers:
Calendar year maximum: $2000/per person
Deductible: None
Reimbursement is based on United Concordia's schedule of maximum allowable charges (MACs).

Preventive/Diagnostic Services: 100%

Prophy: Three times in the calendar year (anytime)
Fluoride: Unlimited for dependents 14 and under.
Sealants: No age limit, on permanent unrestored posterior molars only - Once every 36 months
Bitewing: Unlimited, unless done with Panographic or 10 PA's.
Panographic/FMX: Once every 36 months

Exams: Unlimited. First exam of the calendar year is payable at 100%, ALL exams after will be at 90% with no deductible. (Including D9310 & D9430)
Consultations: One per provider per 12 months
Space Maintainers: Unlimited for dependents 18 and under.
Emergency Palliative Treatment: Two per 12 months.

Basic Services: 90%

Restorative Services: Posterior Composite & Amalgam Fillings Covered - Once every 6 months per tooth
Endodontic Services: Root canal Therapy
Periodontal Services: Root Planing & Scaling: Once every 24 months
Periodontal cleanings: Two per Calendar Year
Oral Surgery: Extraction of teeth & minor oral surgery. (Medical does not have to be billed first)
General Anesthesia: With a qualified covered procedure not to exceed 60 minutes per session.

Singles Crowns, Inlays, Onlays & Build-ups: 80%

One per tooth per 5 years

Prosthodontic (Major) Services: 50%

Implants: One per tooth per lifetime over age 18
Partial or Complete Dentures: One per 5 years. Missing tooth penalty does not apply.

Orthodontic Services: No Age Limit

50% to lifetime benefit $1,000 including adjustments & retainers

Services Not Covered

TMJ
Occlusal guards/Night guards
Analgesia/Nitrous oxide
Arestin

Coordination of Benefits: Standard

Additional Information
Pre-determination is suggested over $300, but not required.
Dependant children may be covered up to age 26 regardless of student status

SECTION 6
EXCLUSIONS AND LIMITATIONS

6.1 Limitations

The following limitations will apply to any Covered Dental Service or Supply. Please read these carefully as they affect the benefits payable to you and your Dependents under the Program.

a. If there is a professionally acceptable treatment plan which is less expensive, the Program will pay for the least expensive professionally adequate treatment plan as determined by the Administrator and/or Utilization Review Program. This need not change the plan of treatment you choose, but it establishes a benefit allowance for services the Program will pay.

b. Covered Expenses will include only those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are considered optional and are not covered.

c. Teeth cleaning is limited to three (3) cleanings during a Calendar Year. Charges for sealants will be considered Covered Expenses with no age limit. The Program will limit payment to one sealant per tooth in any thirty-six (36) month period and only if the sealant is provided on a permanent posterior molar which does not contain any filling material.

d. Scaling and root planing , entire mouth or quadrant, are limited to once every twenty four(24) months. Charges for periodontal cleanings that are in conjunction with an active periodontal disease will be limited to two cleanings per Year and only for the eighteen (18) month period following treatment of the periodontal disease. Osseous Surgery will be limited to one (1) treatment in a thirty-six (36) month period.

e. Endodontic Treatment. Covered Expenses will include the initial root canal treatment of once per tooth per lifetime.

f. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, and a more elaborate or precision appliance is elected, the Program will limit coverage to a cast chrome or acrylic partial denture. Tissue conditioning is limited to two times in a twelve (12) month period. Charges for Relines or Rebase following six (6) months from the original appliance placement are limited to once in a twelve (12) month period.

g. If a placement of or addition to existing dentures or bridgework is required, it will be covered only if one of the following conditions is met:
    1. The placement or addition is required to replace one or more teeth extracted after the existing denture or bridgework was installed.
    2. The existing denture or bridgework cannot be repaired, duplicated or made serviceable and at least five (5) years have elapsed since it was installed. If the existing denture or bridgework can be repaired, duplicated or made serviceable and you choose to replace it, the Program will cover only those services which would be necessary to render the appliance serviceable.
    3. The existing denture is an immediate temporary denture and placement by a permanent denture is required and takes place within twelve (12) months from the installation of the immediate temporary denture.

h. Benefits are payable for orthodontic treatment program expenses incurred while eligible for Program coverage and may include treatment programs started prior to your or your Eligible Dependent's Effective Date. The Program will limit benefits for orthodontic treatment to the earlier of twenty-four (24) months from the date the orthodontic treatment program com- menced or the date treatment ends.

i. Benefits are payable in accordance with UCD guidelines.

6.2 Exclusions

In addition to the limitations stated in Section 6.1 above, no payment will be made under the Program for expenses incurred for or in connection with any of the following:

1. Prophylaxis treatments exceeding three (3) treatments in a Calendar Year.
2. A set of full mouth x-rays or its equivalent exceeding one set in a thirty six (36) month period.
3. Any services or supplies which in the opinion of the administrator or dental consultant are not Medically Necessary.
4. Procedures which have been unbundled and for which the Dentist charges separately for two (2) or more procedures that are normally included under one procedure code.
5. Cosmetic dentistry unless services are performed for correction of functional disorders or as a result of

an accidental injury occurring while a Participant or Eligible Dependent was covered under the Program.

6. Any work related conditions, if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise under any workers' compensation, employer's liability law or occupational disease law, even if a claim is not made for those benefits.
7. Services provided by, or payment made by, any local, state, county or federal government agency (including Medicare) including any foreign government.
8. Services for which no charge is made or for which no charge would be made in the absence of insurance coverage.
9. Disease contracted or injuries sustained as a result of declared or undeclared war, or from exposure to nuclear energy, whether or not the result of war.
10. Services for treatment of malignancies and neoplasms.
11. Diagnosis or treatment by any method of any condition related to the jaw joint or associated musculature, nerves and other tissues.
12. Services to correct a congenital or developmental malformation including but not limited to, cleft palate, maxillary and mandibular malformation, enamel hypoplasia and fluorosis.
13. Replacement of existing full or partial dentures or prosthetic appliances which have been lost or stolen.
14. Repairs, adjustments or relines of full or partial dentures or other prosthesis during the first six (6) months following initial placement if such prosthesis were paid for under the Program.
15. Repairs, lost, stolen, ill-fitting or replacement to orthodontic appliances..
16. Fixed bridges, removable cast partials, cast crowns, with or without veneers, and inlays and onlays are payable on permanent teeth only. Stainless steel crowns will be the only allowance for deciduous teeth.
17. Procedures requiring appliances or restorations (other than those for replacement of structure loss due to dental decay) that are necessary to alter, restore or maintain occlusion. These include but are not limited to:
    a. changing the vertical dimension
    b. replacing or stabilizing lost tooth structure by attrition, abrasion or erosion
    c. realignment of teeth

d. gnathological recording
e. occlusal equilibration
f. periodontal splinting

20. Placement of fixed or removable prosthesis if placement occurs within five (5) years of the original placement, unless the denture is a stay plate used during the healing of recently extracted anterior teeth, or if the denture while in the oral cavity has been damaged beyond repair as a result of an injury occurring while covered under the Program.
21. Placement of crowns and cast restorations, including porcelain crowns and inlays and onlays if placement occurs within five (5) years of the original placement; provided, however, that if the Trust Fund dental consultant determines that tooth decay exists under a crown which would result in further decay or the need for additional dental procedures, the exclusion will be waived during the last three (3) months of the five (5) year exclusion period.
22. Hospital costs and any additional charges by a Physician for hospital treatment.
23. Services not included as a Covered Service or Supply unless they are similar in nature to an included procedure. Payments under the Program are based on the most comparable service.
24. Experimental or Investigational Procedures.
25. Treatment by an unlicensed dentist.
26. Charges for more than one Dentist for the same dental procedure.
27. Any prescribed drugs, pre-medication, medicaments or analgesia.
28. Oral hygiene instruction.
29. Disposable dental supplies used during any procedure.
30. Any illness, injury, or condition for which a third party may be liable or legally responsible by reason of negligence, or an intentional act or breach of any legal obligation on the part of such third party, is not covered; however, see below.

6.3 Trust Fund Right to Reimbursement

The CCPOA Benefit Trust Fund will provide the benefit payments in a third party situation described in Exclusion No. 30 in previous section subject to the following:

a. The CCPOA Benefit Trust Fund is entitled to enforce its right to full reimbursement in any manner allowed

by law in the event you do not reimburse the Trust Fund in accordance with this Section 6.3, including but not limited to, the deduction of amounts from future benefits payable to you (or on your behalf) under the Program or any other benefit program of the CCPOA Benefit Trust Fund and seeking appropriate equitable or legal relief. The CCPOA Benefit Trust Fund's right of reimbursement shall not be reduced by any fees or costs you may incur in connection with your pursuit of any of the benefits described in Exclusion No. 30 in previous section or by any state law doctrines that would reduce the amount the Program may be entitled to recover.

b. At the time the Program pays benefits which may be subject to the Program's right of reimbursement, you shall at that time grant to the Program (as a condition of such payment) a lien (legal, equitable, equitable lien by contract or other any other permissible lien) to the extent of benefits provided, upon any recovery, whether by settlement, judgment, or otherwise, that you or your Eligible Dependent receives from the third party, the third party's insurer, or the third party's guarantor. This lien will be made without regard to the identity of the property's source or holder at any particular time; or whether the property at the time the property exists, is segregated, or whether you have any rights to it.

Until the time such lien is completely satisfied, you shall take or regain possession of any property subject to the Program's lien in your name, place it in a segregated account within your control at least in the amount of the lien and not alienate it or otherwise take any action so that such property is not in your possession prior to the satisfaction of such lien. You shall hold such property as the Program's constructive trustee. As the Program's constructive trustee, you shall immediately deliver such property to the Program upon the direction of the Program to satisfy the lien.

You or your Eligible Dependent must advise the Administrator in writing within sixty (60) days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as the Administrator may require facilitating enforcement of the CCPOA Benefit Trust Fund's rights. You or your Eligible Dependents must not take action which may prejudice the rights or interests of the CCPOA Benefit Trust Fund. Failure to give such notice to the Administrator, or actions by you or your Eligible Dependent that prejudice the rights or interests of the CCPOA Benefit Trust Fund, will be a material breach of the Program and will result in you being personally responsible for reimbursing the CCPOA Benefit Trust Fund.

SECTION 7
EXTENSION OF BENEFITS

The benefits payable under the Program will cease when eligibility for you or your Eligible Dependents terminates except under the following circumstances:

1. If you or your Eligible Dependent have denture, bridgework or crown work in progress at the time benefits cease, coverage will be provided for the following dental services rendered after termination of coverage:
   a. For dentures, if impressions have been taken prior to the termination of coverage; or
   b. For fixed bridgework and crowns, if the teeth which will serve as retainers or support, or the teeth which are being restored, have been fully prepared to receive the appliance and impressions have been taken for its preparation prior to the termination of coverage.

However, in no event will the Program pay for any denture, fixed bridgework or crowns which are installed more than sixty (60) days after termination of eligibility.

2. If you or your Eligible Dependent is Totally Disabled by a dental condition and are under the treatment of a Dentist on the day coverage terminates, benefits will be continued for treatment of that condition. You must apply for this extension of benefits within ninety (90) days of the date coverage ends and include a written certification of Total Disability from your Dentist.

   This extension will be continued until the earliest of:

   a. Recovery from the Total Disability.
   b. The maximum benefits available under the Program are paid.
   c. Coverage is provided under another group health plan that provides benefits without limitations of the disabling dental condition.
   d. A period of twelve (12) consecutive months from commencement of this extension of benefits.

3. If you or your Eligible Dependent is entitled to continuation of coverage as described under Section 3.

SECTION 8
COORDINATION OF BENEFITS

All benefits under the Program are subject to coordination. Benefits otherwise payable under this Program for all Allowable Expenses incurred in a calendar year will be reduced by the total benefits payable under all "other plans" that cover you or your Eligible Dependents for the same expenses. This means that, for each eligible expense, the Program will only pay benefits to make up any difference between the amount payable under the other plan(s) and the amount this Program would pay in the absence of other coverage. When the Program is determined under its coordination rules to be the secondary carrier, it will coordinate benefits up to 100% of billed charges for actual covered services.

THE FOLLOWING DEFINITIONS WILL APPLY TO THE COORDINATION OF BENEFITS PROVISION OF THE PROGRAM:

"Allowable Expense" is any necessary, customary and reasonable item of Covered Expense which is at least partially covered under at least one of the plans covering the Participant or Eligible Dependent.

"Claim Determination Period" is one Calendar Year – January 1 through December 31.

"Covered Expense" as used herein, is the amount incurred for covered services, but not more than the Allowable Charge of this Program as determined by the Administrator. If this Program is not the principal plan and the other plan covering the Participant has negotiated lower charges with certain providers of service, the Covered Expense will be limited to the lower charges negotiated by the other plan with those providers of service.

"Other Plan" is any of the following which provides full or partial benefits or services for surgical, dental or medical care:

a. group, blanket or franchise insurance coverage.
b. group service plan contract, group practice, group individual practice and other group prepayment coverages.
c. group coverage under labor management trusteed plans, union benefit organization plans, employer

organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term Other Plan refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of any such agreement, policy, contract, or other arrangement which reserves the right to take the services or benefits or other plans into consideration in determining its benefits.

"Principal Plan" is that plan, with respect to any two or more plans that covers the Participant or his/her Eligible Dependent, under which benefits will be determined first.

"This Program" is that portion of this Program which provides the benefits which are subject to this provision.

When this Program is the Principal Plan, its benefits will be determined first without taking into account the benefits or services available under any other plan. When this Program is not the Principal Plan, then its benefits may be reduced so that all of the benefits and services available under all the plans covering the Participant or Dependent during each Claim Determination Period will not exceed the Covered Expense incurred. In no event will the Program pay benefits to a Participant or Dependent which exceed the total amount of benefits available under the Program to such participant or Dependent. Moreover, in no event will this Program's liability exceed the Participant's or Eligible Dependent's out-of-pocket expense.

The following rules determine the order in which benefits are coordinated and payable by all plans:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers the Participant or Eligible Dependent as an employee pays before a plan which covers the person as a Dependent.
3. For a Dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. However, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

For a Dependent child of parents who are divorced or legally separated, the following will apply in lieu of the above:

a. If the parent with custody of that Dependent child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a Dependent pays first.

b. If the parent with custody of that Dependent child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

    i. The plan which covers that child as a Dependent of the parent with custody.

    ii. The plan which covers that child as a Dependent of the stepparent (married to the parent with custody).

    iii. The plan which covers that child as a Dependent of the parent without custody.

    iv. The plan which covers that child as a Dependent of the stepparent (married to the parent without custody).

c. Regardless of (a) and (b) above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, the plan which covers that child as a Dependent of that parent pays first.

4. The plan covering the person as a laid-off or retired employee or as a Dependent of a laid-off or retired employee pays after a plan covering the person as other than laid-off or retired employee or the Dependent of such a person; however, if either plan does not have a provision regarding laid-off or retired employees, provision (5) below applies.

5. When the above rules do not establish the order of payment, the plan under which the person has been covered the longest pays first unless two of the plans have the same effective date. In this case, the Covered Expense is split equally between the two plans.

The CCPOA Benefit Trust Fund is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

When another plan provides benefits in the form of services rather than cash payments, the reasonable cash value of services provided will be considered to be an expense incurred by you or your Eligible Dependent. The reasonable cash value of any service provided to you or your Eligible Dependent by any organization furnishing benefits in that way also will

be considered a benefit paid, and the liability of the CCPOA Benefit Trust Fund will be reduced accordingly.

When payments which should have been made under the Program have been made under any other plan, the Administrator will have the right to pay to that other plan any amount it determines to be warranted to satisfy the intent of this provision. Any amount paid will be considered to be a benefit under the Program, and with that payment the CCPOA Benefit Trust Fund will have fully satisfied its liability under this provision.

Whenever payments for covered benefits have been made by the Administrator and those payments are more than the maximum payment necessary to satisfy the intent of this provision, regardless of who was paid, the CCPOA Benefit Trust Fund will have the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan or any other organization or persons, or to deduct the excess amount from any future amount due to you or your Eligible Dependent under the Program for such overpayment.

SECTION 9
CLAIM PROCEDURES

To make a claim for benefits, ask the selected Dentist to submit the claim on the "Universal" dental claim form, or obtain a dental claim form from United Concordia Dental website at https://www.unitedconcordia.com/CCPOA .

The completed claim form must be submitted to United Concordia Dental (UCD) within ninety (90) days of the date the service or supply is provided. If it is not reasonable to submit the claim within that time frame, an extension of up to nine (9) months will be allowed. You are responsible for making sure all claims are timely submitted to the UCD .

If the UCD needs additional information, you must provide it before you will receive any benefits. Failure to provide information within the deadline provided by UCD (45 days or the longer period specified in the notice provided by UCD), or falsification of information in the application for enrollment or in the claim form, will be sufficient cause for the Trustees to deny, suspend, or discontinue benefits. United

Concordia Dental , at its own expense, shall have the right and opportunity, as often as it may reasonably require during the pendency of a claim, to examine the Participant or Dependent receiving benefits. If you or your Dependent refuse to undergo an examination reasonably required by UCD , no benefits will be payable to you under the Program.

The Trustees may recover any benefits improperly paid and may deduct overpayments from future benefit payments payable to a Participant from this or another program of the Trust Fund, including any expenses and attorneys' fees incurred in effecting said recovery.

9.1 All or Part of a Claim May Be Denied
It is not unusual that a particular claim may be denied entirely or in part.

Common reasons for denial are:

a. The dental services were provided before you or your Eligible Dependent became covered under the Program or prior to the conclusion of the required waiting period for certain dental procedures.
b. The denied portion of the claim is for charges exceeding the Program's Allowable Charge.
c. The dental services rendered were reviewed and determined not to be Medically Necessary.
d. The dental services provided were excluded or limited under the Program.
e. A portion of the charges were denied because the treatment was not the least expensive, professionally adequate alternative means of treating a particular dental condition.

If United Concordia Dental (UCD) denies your claim in whole or in part, UCD will provide you with written notice of UCD's benefit determination within thirty (30) days of UCD's receipt of your claim, unless circumstances beyond the control of the UCD require an extension of time. If an extension is required, you will be provided with a written notice of the extension prior to the termination of the initial thirty (30) day period specifying the circumstances requiring the extension and the date by which the UCD expects to render its decision. The extension will not exceed fifteen (15) days from the end of the initial period. In the event that an extension is necessary because you failed to submit information necessary to decide your claim (including the report of any required medical examination), your written notice of the extension will specifically describe the required information. The time period for making a benefit decision will

also be suspended until the earlier of UCD's receipt of all the requested information or the date provided by the UCD for furnishing the information (forty-five (45) days or the longer period specified in UCD's notice of extension).

A decision will be made on your claim within fifteen (15) days after you respond to the request for additional information, or within fifteen (15) days after the end of the deadline given to provide additional information, whichever is earlier.

In the event that you are unable to file a claim or an appeal pursuant to the provisions of this section on your own behalf or if you desire to have someone else act on your behalf with respect to such claim or appeal, you may authorize another individual including, but not limited to, your spouse, association official, or attorney, to act as your authorized representative. Such representative must comply with the claims and appeals procedures described in this section. To designate someone as your authorized representative, please contact UCD to obtain an Authorization of Representative form. UCD will not treat anyone as your authorized representative unless such form has been completed and filed with UCD.

9.2 Notice of Claim Denial

If your claim for dental benefits is denied in whole or in part, the Trust Fund Office will provide you with a notice of the denial that includes the following information:

1. the specific reason or reasons for the adverse determination;
2. reference to the specific plan provision(s) on which the determination is based;
3. a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
4. a description of the Trust Fund's appeal procedure and the time limits applicable to such procedures;
5. a statement regarding your right to bring a civil action under ERISA §502(a) following an adverse benefit determination on appeal;
6. 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

7. 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 plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

SECTION 10
CLAIMS APPEALS AND DISPUTES

The Program contains a claims and appeals procedure which must be followed. This procedure has been designed to facilitate the fair and efficient resolution of claims disputes with consistent application of the rules. Failure to strictly adhere to the rules shall be cause for denial of any appeal.

The provisions of this section will 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 the Claimant is a Participant in the Program within the meaning of those terms as defined under ERISA.

10.1 Filing an Appeal
If you disagree with the Trust Fund's determination of your claim, you may appeal the determination to the Board of Trustees. You may request such a review by sending a letter to the Trust Fund Office which explains the basis of your appeal within one-hundred eighty (180) days of receiving the denial notice.

10.2 Rights on Appeal

a. If you file an appeal, you may submit written comments, documents, records, and other information relating to your claim to the Board of Trustees. You will also be entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits. The Board of Trustees will take

into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination. The Board of Trustees will make its determination independent of the initial benefit decision.

b. If you submit an appeal, you have the right to request that the Board of Trustees hold a hearing wherein you may present the merits of your appeal. The Board of Trustees may request that you appear at such a hearing. The Board of Trustees has sole discretion to decide whether, in any given instance, a hearing shall be conducted.

c. If the initial claim denial is based in whole or in part on a medical judgment, including determinations with, regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Board of Trustees will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. If a health care professional is consulted, such professional shall neither be the individual consulted in connection with the initial denial nor the subordinate of such individual. You may request the identification of any medical or vocational experts whose advice was obtained on behalf of the Trust Fund.

10.3 Timing of Benefit Determination on Appeal

If you submitted an appeal of a denied claim, the Board of Trustees will notify you of its determination on appeal as soon as possible, but not later than five (5) days after the next regularly scheduled Board of Trustees meeting, unless the appeal is filed less than thirty (30) days before the next meeting. In such case, the Board of Trustees will notify you no later than five (5) days after the second Board of Trustees meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, the Board of Trustees will notify you of its determination no later than five (5) days after the third meeting of the Board of Trustees following the Plan's receipt of the request for review. The Board of Trustees will provide you with a written notice of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension.

10.4 Notice of Denial on Appeal

If the Board of Trustees denies your appeal, 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. a statement of your right to bring an action under ERISA § 502(a);
5. 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
6. 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.

10.5 Action on Appeal
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 11
YOUR RIGHTS UNDER ERISA AND ADDITIONAL INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) provides protection of employees' rights to their health and welfare benefits. The CCPOA Benefit Trust Fund organized itself and the Program under ERISA to protect the benefits of CCPOA members.

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

b. Examine, without charge, at the Administrator's office and at other specified locations such as worksites, all Program documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

c. Obtain upon written request to the Administrator, copies of documents governing the operation of the Program including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may charge a reasonable fee for the copies you request.

d. Receive a summary of the Program's annual financial report. The Administrator is required by law to furnish each Participant with a copy of this summary annual report.

e. Continue dental coverage for yourself and your Dependents if there is a loss of coverage under the Program as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Program on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Program Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit program. 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 benefit is denied in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request material from the Program and do not receive it in thirty (30) days, you may

file suit in Federal court. In such a case the court may require the Administrator to provide the material and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored in whole or in part you may file suit in a state or Federal court. In addition, if you disagree with the Program's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that the Program's 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 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 the 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 Employee Benefits Security Administration (EBSA), U.S. Department of Labor listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

11.1 Governing Law
The Plan of which the program is a part is an employee welfare plan within the meaning of ERISA and is governed by ERISA and other applicable federal law.

11.2 Plan Name
The name of the plan of which this Program is a part is the CCPOA Benefit Trust Fund Health and Welfare Plan (the "Plan").

11.3 Sponsoring Organization
The Plan of which this Program is a part is sponsored and maintained by the CCPOA BTF Board of Trustees. Its address is as follows:

Board of Trustees of the CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

11.4 Type of Plan
The Plan of which this Program is a part is a welfare benefit plan. The Program is a dental program.

11.5 Plan Administrator
The Plan Administrator of the Plan of which this Program is a part is the Board of Trustees of the CCPOA Benefit Trust Fund. The Board of Trustees is vested with the exclusive authority and discretion to interpret this Program and resolve any ambiguities, and its interpretations are final and binding. Its address and phone number are as follows:

Board of Trustees of the CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235
Telephone: (800) IN UNIT 6 or (916) 779-6300

11.6 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 the functions necessary to carry out the orders and policies of the Board of Trustees with respect to the day-to-day administration of the Trust Fund with respect to this Program, including making initial claim determinations.

All administrative inquiries, claims, appeals and related information, and general information should be directed to the Trust Fund Office, care of the Trust Fund's Administrator:

Trust Fund's Administrator CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235
Telephone: (916) 779-6300 (Sacramento)
Toll-free: (800) IN UNIT 6

The name of the current Trust Fund's Administrator is set forth in Appendix A.

11.7 Names and Addresses of the Trustees
The names and business addresses of the Trustees are set forth in Appendix A.

11.8 E.I.N. and Plan Number
The E.I.N. of the Trust Fund is 94-6459649. The three- digit number assigned to the Plan of which this Program is a part is 501.

11.9 Plan Year
The Plan year is April 1 to March 31. The Claim Determination Period, however, is based on a Calendar Year defined in Section 12.6

11.10 Service of Legal Process
Service of legal process may be made upon the Trust Fund's Administrator, any Trustee, or the Plan Administrator at the Trust Office:

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

11.11 Contributions
The contributions necessary to finance the Program are made by the State of California and by Participants in the Program. Contributions are actuarially calculated, and changed, as necessary by the Trustees at any time in their sole discretion, to cover expected benefit payments and for defraying administrative expenses.

11.12 Funding
Contributions are received and held by the Board of Trustees of the California Correctional Peace Officers Association Benefit Trust Fund ("CCPOA Benefit Trust Fund"). The Board of Trustees pays the benefits and administrative expenses of the Plan (of which the Program is a part) directly from the CCPOA Benefit Trust Fund. The Program's benefits are self-funded and are not provided pursuant to any insurance policy or contract. The Trust Fund is financially responsible for all benefits under the Program. The benefits under the Program are administered in accordance with the provisions of the CCPOA Benefit Trust Fund Agreement and Declaration of Trust Fund, the Plan document and this Program document. No person has a vested right to any benefit under the Plan, including the Program. The Plan (including the Program) exists only as long as sufficient funds exist to enable the Trustees to pay Plan benefits and expenses.

11.13 Amendment and Termination of Program
The Board of Trustees has the discretion to terminate or change the amount, form, manner, or duration of any benefit. The Trustees have the right to amend, discontinue or terminate the Trust Fund and/or Program in whole or in part at any time. There is no guarantee that the Program will be permanent. 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 benefits previously approved, could be distributed among the Participants or transferred to a plan providing similar benefits. Program benefits are not insured by the U.S. Government Pension Benefit Guaranty Corporation or any other government agency.

11.14 Limitation Upon Reliance on Booklet and Statements
You are not entitled to rely on any oral statements made by the Trust Fund Office's 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.

11.15 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.

SECTION 12
DEFINITIONS

There are certain terms used in describing the Program. The following definitions will be helpful to you in understanding the Program:

12.1 "Actively at Work" or "Active Work" means that you are performing with reasonable continuity all the usual and customary duties of your employment for your Employer at your regular work location or other approved work location. You will be considered to be Actively at Work or in "Active Work" on any regularly scheduled days off, holidays, or vacation days, so long as you are capable of performing all of the usual and customary duties of your employment with reasonable continuity at your regular work location or other approved work location on those days.

12.2 "Administrator" or "Trust Fund's Administrator" means the Administrative Office of the CCPOA Benefit Trust Fund and the person appointed by the Board of Trustees.

12.3 "Allowable Charge(s)" means the maximum amount the Program will pay for Covered Dental Services or Supplies, as set by the Board of Trustees from time to time, but in no event will the "Allowable Charge" exceed the actual charge incurred by the Participant or Eligible Dependent. With regard to charges submitted by Preferred Dental Providers, the term means the fee negotiated between the provider and the Preferred Provider Organization.

12.4 "Association" means the California Correctional Peace Officers Association.

12.5 "Board of Trustees" or "Board" means the Board of Trustees created by the Trust Fund Agreement of the CCPOA Benefit Trust Fund.

12.6 "Calendar Year" or "Year" is a twelve (12) month period starting January 1 at 12:01 a.m. Pacific Standard Time.

12.7 "CCPOA" means the California Correctional Peace Officers Association.

12.8 "Covered Dental Service or Supply" or "Covered Dental Services or Supplies" means those services or supplies set forth in the American Dental Association's "Uniform Code of Dental Procedures", and included in the list of services and supplies covered by the Program, and when performed or provided by a Dentist of Physician or surgeon, or dental hygienist working under the direction of a licensed Dentist, for treatment of dental disease, defect or injury which are Medically Necessary and which are rendered for the care and treatment of a non-occupational accident or condition.

12.9 "Covered Expense(s)" means only those charges for a Covered Dental Service or Supply incurred by a Participant or Eligible Dependent while eligible for benefits. In no event will a Covered Expense exceed one hundred percent (100%) of Allowable Charges.

12.10 "Dentist" means a doctor of dentistry who is currently licensed to practice dentistry by the California Department of Consumer Affairs Board of Dental Examiners or an equivalent governmental agency having jurisdiction over the licensing and practice of dentistry outside of the State of California. The term

"Dentist" shall not include the Participant, or the Participant's spouse, child, brother, sister, or parent.

12.11 "Doctor" or "Physician" means a doctor of medicine (M.D.). The term "Doctor" or "Physician" shall not include the Participant or the Participant's spouse, child, brother, sister or parent.

12.12 "Effective Date" means the date coverage commences under the Program.

12.13 "Eligible Dependent(s)" or "Dependent(s)" as defined in the Program, are the lawful spouse of the Participant and the Participant's unmarried children from birth to age twenty-six (26). Children include step- children and adopted children provided such children are Dependent upon the Participant for support and maintenance. Eligible Dependent also includes any 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 prior to age twenty-six (26) and any child of a Participant required to be enrolled under a Qualified Medical Child Support Order.

Notwithstanding anything else herein contained, a Participant's spouse shall cease to be a Dependent when the Participant and spouse become legally separated or divorced.

12.14 "Emergency Services" are services provided in connection with the initial treatment of an emergency, which is defined as services required for alleviation of severe pain or bleeding, and/or immediate diagnosis and treatment of an unforeseen condition. Emergency services do not include charges incurred for continuing any treatment plan currently in process, unless it has been authorized by the Administrator. Determination as to whether services were rendered in connection with an emergency will rest with the Administrator, subject to the appeal process described within the Program.

12.15 "Enrollment" means that a Participant has elected to authorize a payroll deduction from his/her pay warrant to pay a monthly premium to the Program.

12.16 "ERISA" means the Employment Retirement Income Security Act of 1974, as amended, and any regulations adopted pursuant thereto.

12.17 "Experimental Procedures" are those procedures that are mainly limited to laboratory and/or animal research.

12.18 "Investigational Procedures" are those procedures that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized dental community.

12.19 "Medically Necessary" means dental services and supplies that are determined to be:

a. appropriate and necessary for the diagnosis or treatment of the dental condition, and;
b. within standards of good dental practice within the organized dental community, and;
c. not primarily for the convenience of the Participant or Eligible Dependent, the Dentist or another provider.

12.20 "Participant" means any full-time, permanent employee, or Permanent Intermittent Employee of the State of California Bargaining Unit 6 ("Unit 6") who is a member in good standing of CCPOA, or an employee of CCPOA or CCPOA Benefit Trust Fund who has completed Enrollment in the CCPOA Program and elected to pay in advance the required monthly premium therefore in order to qualify for benefits.

12.21 "Permanent Intermittent Employee" means a rank and file employee who works at a position or appointment in which the employee is to work periodically or for a fluctuating portion of the full-time work schedule.

12.22 "Preferred Dental Provider" means a provider who has an agreement with the Preferred Provider Organization to provide Participants with dental care at negotiated rates. All other providers are considered Non- Preferred Dental Providers.

12.23 "Preferred Provider Organization" means the company which has a contract with the Trust Fund to provide a network of Preferred Dental Providers under the Program.

12.24 "Program" means the "CCPOA Benefit Trust Fund Program," a program of the CCPOA Benefit Trust Fund Health and Welfare Plan.

12.25 "Registered Dental Hygienist in Alternative Practice" ("RDHAP") means someone who is recognized as a Registered Dental Hygienist in Alternative Practice by the Dental Board of California under the terms of Section 1774 of the CA Business and Professions Code and who performs services subject to the restrictions set forth in Section 1775 of the CA Business and Professions Code. This includes the requirement of a written

prescription for services provided by a Dentist or Medical Doctor as set out in Section 1775(h) therein. Treatment by an RDHAP and any coverage under the Program will be limited to the following procedures:

1. Any function that may be performed by a dental assistant or a registered dental assistant;
2. Dental hygiene assessment, development, planning, and implementation of a dental hygiene care plan;
3. Preventive and therapeutic interventions, including oral prophylaxis, scaling, and root planing; and
4. Application of topical, therapeutic, and subgingival agents used for the control of caries and periodontal disease.

The Board of Trustees may require an RDHAP to submit documentation for any services for which a claim for benefits is presented to the CCPOA Benefit Trust Fund, including the required prescription from a Dentist or Medical Doctor, upon request by the Board of Trustees. Any RDHAP who seeks payment for services provided under the Program must sign a statement agreeing to these terms and certifying, among other things, that he or she is a practicing RDHAP in accordance with California law in order to become eligible for payment as a provider under the Program.

12.26 "Total Disability" or "Totally Disabled" means a dental illness or injury that either:

a. causes a Participant to be unemployed and unable to work for income in any job for which he or she is qualified or for which he or she becomes qualified by training or experience; or
b. causes an Eligible Dependent to be unable to perform all activities usual for a person of that age.

12.27 "Trust Fund," "Benefit Trust Fund" or "Trust Fund" means the CCPOA Benefit Trust Fund.

12.28 "Trust Fund Agreement" means the Agreement and Declaration of Trust Fund entered into as of April 12, 1987, establishing the CCPOA Benefit Trust Fund and any modification, amendment, extension or renewal thereof.

12.29 "Utilization Review Organization" means the company which has a contract with the Trust Fund to perform prospective and retrospective review of the Medical Necessity of claims submitted by Preferred Dental Providers and Non-Preferred Dental Providers.

APPENDIX A

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

We've Got You Covered.

(916) 779-6300

1-800-468-6486

CCPOA
Benefit Trust Fund

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