EMPLOYEE

DENTAL & VISON HANDBOOK

2021

Schools Self-Insurance
of Contra Costa County

Dental & Vision Benefits Guide

General Information

Benefits Offered

Miscellaneous

Dental Benefits:

Vision Benefits:

For Benefits information, please contact your district benefits staff.

The information in this brochure is a general outline of the benefits offered under the Schools Self-Insurance of Contra Costa County benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Introduction & Eligibility

Flexible Solutions For Your Benefits Needs

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our district, we are committed to providing you with a competitive dental and/or vision plans.

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference. If you are well-informed, you will be better able to make the benefit choices that best meet your needs.

Thank you.

Who's Eligible?

Employees

All employees working at least 20 hours per week are eligible for employee benefits. Some benefits are offered to all employees regardless of the number of hours worked. Benefits will be effective the first of the month following employment for all new eligible employees.

Eligible Dependents

Your eligible dependents include your legally married spouse, domestic partner, and children (including stepchildren and adopted children) up to age 26. However, for other plans, age limits may apply. Requests to add coverage for dependent newborns must be submitted within 60 days.

Please discuss with your district benefits department any specific questions you may have.

When You Can Enroll

New Hires/Newly Eligible for Benefits

When you are first hired or become eligible for benefits, you have 30 days to enroll. If you do not enroll within that time period, you will not be eligible to enroll unless you have a qualifying change in status.

Qualifying Change in Status

If you have a qualifying change in status, you may be able to change your benefits. You must notify Human Resources within 60 days of the change.* If you meet the deadline, changes will be effective on the first of the month following the request for change(s).

* **Qualifying change in status events include:**

- Change in marital or domestic partner status
- Change in the number of dependents
- Change in benefits eligibility for you, your spouse or dependent
- Change in employment for you, your spouse or dependent
- Change in work schedule for you or your spouse
- Gaining other coverage through your spouse
- Dependent Children may be added at the beginning of the plan year up to age four (4), including the plan year immediately following their fourth (4th) birthday.
- Loss of other coverage for your dependent
- Change in residence causing loss of coverage
- Federal and state family medical leave, if qualified
- Medicare or Medicaid entitlement for you, your spouse or dependent
- Qualified Medical Child Support Order (QMCSO)
- A significant change in benefit or cost of coverage for you and your spouse/domestic partner

Common Definitions

Dental Definitions

Certain words that you will see in this booklet have specific meanings. These definitions should make your dental plan easier to understand.

BENEFITS those dental services available under the Contract and which are described in the Evidence of Coverage booklet.

CONTRACT the written agreement between your employer or sponsoring group and Delta Dental to provide dental Benefits. The Contract, together with this booklet, forms the terms and conditions of the Benefits you are provided.

COVERED SERVICES those dental services to which Delta Dental will apply Benefit payments, according to the Contract.

DELTA DENTAL DENTIST a Dentist who has signed an agreement with Delta Dental or a Participating Plan, agreeing to provide services under the terms and conditions established by Delta Dental or the Participating Plan.

DELTA DENTAL PPO DENTIST a Dentist with whom Delta Dental has a written agreement to provide services at the in-network level for Enrollees in this Delta Dental PPO Plan.

DEPENDENT a Primary Enrollee's Dependent who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

PREMIUMS the money paid each month for you and your Dependents' dental coverage.

EFFECTIVE DATE the date this plan starts.

ENROLLEE A Primary Enrollee or Dependent enrolled to receive Benefits or a person who chooses to pay for OPTIONAL CONTINUATION OF COVERAGE.

MAXIMUM the greatest dollar amount Delta Dental will pay for covered procedures in any calendar year.

PARTICIPATING PLAN Delta Dental and any other member of the Delta Dental Plans Association with whom Delta Dental contracts for assistance in administering your Benefits.

PRIMARY ENROLLEE any group member or retiree who is eligible to enroll for Benefits in accordance with the conditions of eligibility outlined in this booklet.

SINGLE PROCEDURE a dental procedure to which a separate Procedure Number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

USUAL, CUSTOMARY AND REASONABLE (UCR)

A Usual fee is the amount which an individual dentist regularly charges and receives for a given service or the fee actually charged, whichever is less.

A Customary fee is within the range of usual fees charged and received for a particular service by dentists of similar training in the same geographic area.

A Reasonable fee schedule is reasonable if it is Usual and Customary. Additionally, a specific fee to a specific Enrollee is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty, of the case in question.

Common Definitions (continued)

Vision Definitions

ANISOMETROPIA A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

BENEFITS those vision services available under the Contract and which are described in the Evidence of Coverage booklet.

BENEFIT AUTHORIZATION Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.

COPAYMENTS Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.

COVERED PERSON An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.

ELIGIBLE DEPENDENT Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group.

EMERGENCY CONDITION A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

ENROLLEE An employee or member who meets the criteria for eligibility defined by the district.

ELIGIBILITY FOR COVERAGE of the Group Plan document maintained by your Group Administrator.

EXPERIMENTAL NATURE Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.

GROUP An employer or other entity which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

KERATOCONUS A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

MEMBER DOCTOR An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

NON-MEMBER PROVIDER Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

PLAN BENEFITS The vision care services and materials which a Covered Person is entitled to receive under this plan.

PREMIUMS The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

RENEWAL DATE The date on which this plan shall renew or terminate if proper notice is given.

SCHEDULE OF BENEFITS The document, attached as Exhibit A to the Group Plan document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this plan.

Frequency Asked Questions

Dental and/Or Vision Eligibility

1) Are all employees' eligible for dental and/or vision coverage?

All full-time employees who are benefit eligible based on the district criteria are allowed to enroll onto the plan. This includes, but is not limited to, classified, certificated, administration, and confidential. Superintendents and retirees may also be allowed to enroll into the plan provided that their contracts allow for this coverage. This may be different between JPA Districts. Benefit eligible part-time employees may also be allowed to enroll onto the plans provided that your plan specifically outlines the hours required to be considered "benefit eligible". The hours that determine a benefit eligible part-time employee may be different between JPA Districts.

2) Are Board Members allowed on the plans?

Board members and former Board members may be allowed enrollment onto the plan provided that their contracts allow for this coverage. This may be different between JPA Districts.

3) Are Domestic Partners allowed?

Yes. The SSICCC JPA allows for Domestic Partners of the employee as defined by California. California requires domestic partners to file a Declaration of Domestic Partnership with the Secretary of State. The Family Code 297 requires that both persons are members of the same sex unless the employee is age 62 or over. If age 62 or over the domestic partners may be of opposite sex. You should request a copy of the Declaration of Domestic Partnership as confirmation for your records.

4) Are all eligible employees required to be enrolled into the dental and/or vision plans?

Yes. All benefit eligible employees are required to enroll into the plan upon hire or when they become eligible.

5) Is verification of a physical handicap or mental incapacity required?

Yes. If you have a dependent who is physically handicapped or mentally incapacitated, you will need to provide verification to the district. Providing verification is your responsibility and can be requested from your dependent's physician. The dependent's coverage will be terminated once the maximum age limit is reached unless noted as disabled.

6) Can married couples, both employed by the same district, have dual coverage?

Yes. Married employees within the same district have the option to be covered individually or one spouse to be covered as a dependent.

7) To what age are dependents allowed to remain on the dental and/or vision plan?

All dependents are allowed to remain on the plan to age 26. A dependent includes legally adopted children from the moment of placement for adoption with the employee or a child placed into the employees care by a court of law. It is the JPA Districts responsibility to request the necessary documentation for adoption and guardianship to confirm the dependents eligibility.

8) At what date are employees/dependents required to enroll in the plan?

The benefit eligible employee should be enrolled into the dental and/or vision plans when they become eligible or as outlined by the JPA District criteria. The effective date of eligibility may be different between JPA Districts. Dependents should be enrolled into the plan at the same time that the employee is enrolled, but no later than within 60 days of the dependent becoming eligible. If the dependents chose not to enroll at that time, they will be allowed to enroll onto the plan at a later date due to the qualifying event of loss of coverage. If enrolling due to loss of coverage, the dependent must enroll within 60 days from the date the loss of coverage occurred. It is the JPA Districts responsibility to request confirmation of loss of coverage, e.g. notification from previous employer, continuation of coverage document from previous carrier.

Frequency Asked Questions (continued)

9) Can dependent children be enrolled at any time?

Dependent children should be enrolled at the same time the employee is enrolled or as outlined by the JPA District criteria, but no later than within 60 days of becoming eligible. However, children to age four (4) can be enrolled at the beginning of the plan year (January 1st) any time prior to their fourth (4th) birthday or the beginning of the plan year immediately following their fourth (4th) birthday. If the dependent is not enrolled by the plan year immediately following the fourth (4th) birthday, they may only be enrolled thereafter due to a loss of coverage qualifying event.

10) Can dependents be enrolled for a qualifying event?

Yes. Dependents can be enrolled for the following qualifying events: Marriage, birth, adoption, guardianship and loss coverage. Enrollment into the plan must be within 60 days from the date the qualifying event took place.

11) What happens if a dependent terminates from the plan?

Once a dependent is terminated from the plan, they may be allowed enrollment back onto the plan for a qualifying event. Enrollment into the plan must be within 60 days from the date the qualifying event took place.

12) Can we offer open enrollment to the dental and/or vision plans?

No. There is no open enrollment on the SSICCC JPA plans. Please refer to questions #4 #8 and #9 above for enrollment requirements.

13) When does eligibility end if an employee resigns or is terminated?

Eligibility ends on the last day of the month in which the termination or resignation occurs or as otherwise defined by the JPA District's collective bargaining agreements.

14) Can a periodic audit be completed to ensure enrollments are appropriate?

Yes. Districts have the option to perform a dependent audit once every five (5) years, beginning in 2015 and occurring in years ending in 0 or 5. The Dependent Enrollment Audit may be completed during the open enrollment period for years ending in 0 or 5. For example, the open enrollment period in 2019 for the effective date of 1/1/2020.

OR

The Dependent Enrollment Audit may be completed during the year ending in 0 or 5 for the effective date of the year ending in 1 or 6 (the following year). For example, during the year 2020 for an effective date of 1/1/2021.

**For further information please contact your Benefits Department.

Dental Tools and Resources

DELTA DENTAL®

Healthier Smiles

For California school district employees

Delta Dental's incentive plan for California school district employees is designed to encourage the regular dentist visits that keep your smile healthy and bright. If you visit any licensed dentist for a cleaning and exam at least one time during your plan year, your benefits will increase each consecutive year until your plan covers 100% of your coinsurance (amount you pay for covered services) for preventive services.[1]

No visit? No worries

If you miss your cleaning and exam one year, your benefits continue at the same level. (For example, if your plan pays 80% your second year and you don't visit the dentist that year, your plan will still pay 80% your third year.) You won't receive an incentive increase that year, but you aren't penalized either.

Lapses in coverage

If there's a break in your coverage, your benefits revert to the first year's coverage level (70% in the chart). Breaks in coverage usually happen if you opt out of dental insurance for a period of time. If you're transferring to another school district with an incentive plan, you won't have a break in coverage when termination and enrollment are on consecutive days.

Lower your out-of-pocket costs

Consecutive years you are covered by the incentive plan	First year	Second year	Third year	Fourth year
Your plan pays	70%	80%	90%	100%
Your coinsurance	30%	20%	10%	None[2]

This example assumes you visit a licensed dentist for diagnostic or preventive care at least once per plan year. For illustrative purposes only.

[1] Some plans may also extend the incentive to diagnostic benefits and other services. If your plan includes orthodontics or prosthodontics, these services are typically not part of the incentive plan. Other benefits may also be excluded. Refer to your plan booklet for a full list of services covered by your incentive plan. You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[2] In this illustrative example, you would have no coinsurance at a Delta Dental dentist. Since non-Delta Dental dentists have no restrictions on what they can charge, you may have to pay the difference between the plan allowance and their submitted fee, which is known as "balance billing."

We keep you smiling®

Dental Tools and Resources (continued)

5 easy ways to get more value from your plan

Already on track to get the most from your incentive plan? Learn more easy ways to save:

1 **Choose a network dentist**

Maximize your savings by choosing a Delta Dental network dentist. Delta Dental dentists agree to charge reduced fees for covered services and won't "balance bill" you for amounts not covered by your dental plan. Delta Dental dentists are carefully screened for quality and they will agree to complete and submit all claim forms for you. Find a network dentist near you at **deltadentalins.com**.

2 **Try a pre-treatment estimate**

You can ask your dentist to obtain a free estimate from us before you begin treatment.[3] Called a "pre-treatment estimate," this service is especially helpful when you:

- Expect dental work to exceed $300 (like for a crown, wisdom tooth extraction, bridge, dentures or periodontal surgery)
- Aren't sure if a procedure is covered by your plan
- Worry that a procedure might exceed your annual plan maximum
- Need to budget for your payment

3 **Set up an online account**

Create a free, secure online account at **deltadentalins.com** to get plan information online anytime. Access benefits, eligibility, claims status, average procedure costs and more. Plus, view or print your ID card.

4 **Coordinate your benefits**

Are you also covered under another dental plan? Ask your dentist to include information about both plans with your claim, and we'll handle the rest.[4]

5 **Check out our wellness resources**

Visit **mysmileway.com** to access a variety of oral health resources for all members of your family. And, subscribe to *Grin!*, our fun, free dental health e-magazine at **deltadentalins.com/grin.**

[3] A pre-treatment estimate is not a guarantee of Delta Dental's final payment. When the treatment is complete and we receive a claim for payment, we will calculate payment based on your current eligibility, amount remaining in your annual maximum and any deductible requirements or dual coverage. Please review your plan booklet for specific details about your coverage.

[4] Group-specific exceptions may apply. Please review your plan booklet for details about your plan's coordination of benefits, including rules for determining primary and secondary coverage.

Contact us

Online assistance:

For quick and easy online assistance, go to **deltadentalins.com** > **Contact Us** > **Delta Dental of California** > **Delta Dental Premier and Delta Dental PPO Inquiries.**

Telephone assistance:

California School District Employees: **866-499-3001**

Delta Dental PPO™ and Delta Dental Premier® are underwritten in California by Delta Dental of California.

DELTA DENTAL®

Where's My ID Card?

If you've been looking for your dental plan ID card, we have good news for you: **You don't need one!**

Just tell your dental office that you're covered by Delta Dental and provide your **name**, your **date of birth**, your **enrollee ID number** (or social security number) and the **name of your employer**.

Got dependents on your plan? Tell them to provide your details.

Want an ID card anyway?

Print one from your computer

- Go to **deltadentalins.com**
- Log in to Online Services > Click on **My ID card** > Print

Pull it up on your smartphone

- Go to **deltadentalins.com** or download our app (**Delta Dental** by Delta Dental Plans Association from the App Store or Google Play)
- Log in to your Online Services account > Select **My ID card**

Delta Dental of California, Delta Dental of New York, Inc., Delta Dental of Pennsylvania, Delta Dental Insurance Company and our affiliated companies form one of the nation's largest dental benefits delivery systems, covering 34.5 million enrollees. All of our companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to 73 million people in the U.S.

We keep you smiling®
deltadentalins.com/enrollees

Dental Tools and Resources (continued)

DELTA DENTAL

Delta Dental PPO™
Delta Dental Premier®

Best of Both

Coordinate two plans with dual coverage

Are you or your family members covered under two dental plans? Dual coverage doesn't mean your benefits are doubled, but it can mean added savings on dental costs.

As soon as you're covered under two dental carriers, let your dental office know. Delta Dental will coordinate with your other carrier to share the cost of your treatment.

Basic concepts

- When you're covered under two plans, one plan is considered your **primary carrier**. This carrier will pay a larger portion of your benefits, leaving a smaller amount to your **secondary carrier**. You can find out how to identify your primary carrier on the back of this flyer.
- Check the plan booklet for your secondary carrier to see if you have a **non-duplication of benefits clause**. If you do, your benefit will be slightly less than standard dual coverage.

How does dual coverage help me save?

How much you save depends on whether your secondary carrier has a non-duplication of benefits clause.[1]

Type of coverage	Primary carrier covers	Secondary carrier covers	Your coverage pays
No dual coverage	50%	N/A	**50%**
Standard dual coverage	50%	80%	**100%**
Dual coverage with non-duplication of benefits	50%	80%	**80%**

[1] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan. If your primary or secondary carrier is an HMO-type plan, please contact Customer Service for details.

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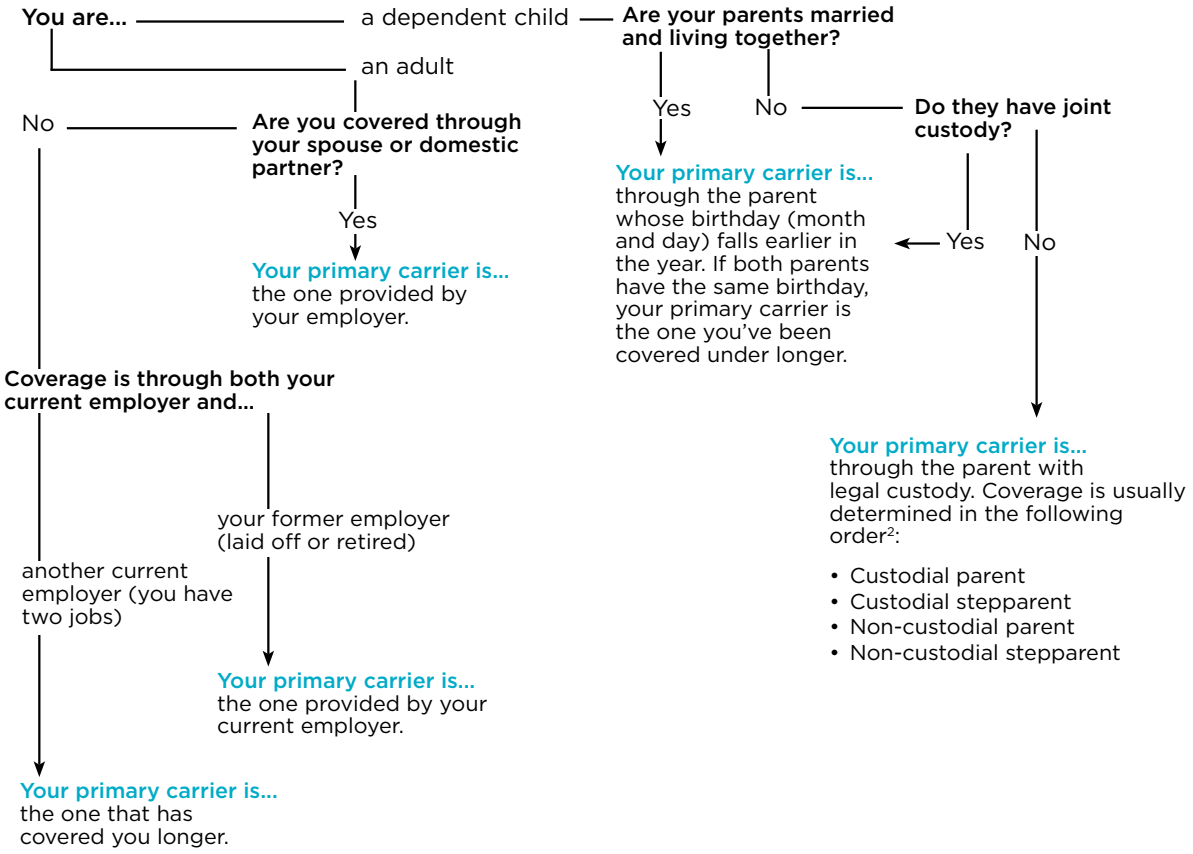
Dental Tools and Resources (continued)

Which is my primary carrier?



If you have any questions about how your employer-sponsored or Marketplace plan coordinates benefits with another plan, please call Customer Service.

[2] If a court decree establishes a different order of benefits for a dependent child's coverage, that decision applies instead.

Contact us

Delta Dental of California: **888-335-8227**
California School District Employees: **866-499-3001**

Delta Dental of Delaware; Delta Dental of the District of Columbia; Delta Dental of New York; Delta Dental of Pennsylvania (and Maryland); Delta Dental of West Virginia: **800-932-0783**

Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah): **800-521-2651**

Delta Dental PPO and Delta Dental Premier are underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV, TX and UT and by not-for-profit dental service companies in these states: CA – Delta Dental of California; PA, MD – Delta Dental of Pennsylvania; NY – Delta Dental of New York, Inc.; DE – Delta Dental of Delaware, Inc.; WV – Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

EF9 #121175F (rev. 5/19)

DELTA DENTAL

Estimate Your Costs

Looking to budget your dental costs? Try the Cost Estimator. This feature of Delta Dental's online account gives you a personalized estimate of how much you'll pay for your next dentist visit.

Whether you're getting braces or need a cavity filled, you'll choose from the most common dental services, described in everyday language. The Cost Estimator organizes information logically, so you don't need to be concerned whether your treatment involves multiple procedure codes or visits.

Advantages

- **Easy to use.** Questions guide you through the process, letting you add services to your visit, like getting x-rays or a cleaning alongside your dental exam.
- **Based on real data.** Your cost estimate is calculated from actual claims Delta Dental has processed, updated daily.
- **Personalized.** You'll get a customized cost based on your actual benefits, taking into account any maximums and remaining deductible.
- **Available on desktop and mobile.** Get an estimate on your computer, tablet or phone.

Features

- **Change your dentist.** Want to know if you'd save by switching to another dentist? Test it out by comparing up to five dentists.
- **Personalize your procedure.** Specify which tooth is being treated, the type of filling you need or whether you're going to a specialist. The price will be calculated accordingly.
- **Keep track of your benefits.** A handy sidebar shows the current status of any deductibles and annual and lifetime maximums.

deltadentalins.com/enrollees

Dental Tools and Resources (continued)

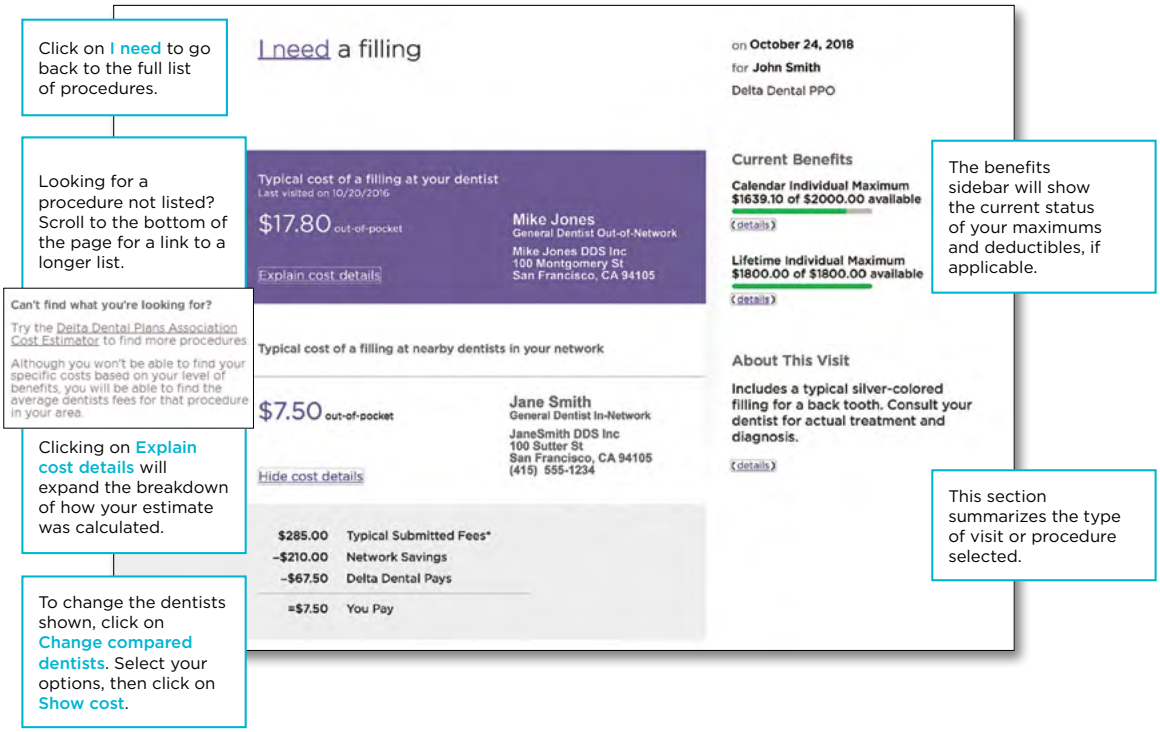
Try it out

Ready to get an estimate?

1. Log in to your account at **deltadentalins.com**. (If you don't have one yet, click on **Register**.)
2. Click on the **Cost Estimator** link by your name.

How to navigate

Start by selecting the service you need. As you explore, you can answer additional questions (like "Which tooth?" or "Are you a new patient?") to further customize your results. If you've been using your dental benefits, your current dentist will show up by default, but if you want to see other options, just click on **Select dentists to compare**. Whenever you're ready, click **See cost**.



Dental Tools and Resources (continued)

DELTA DENTAL®

Plan for a Healthy Smile

Get a pre-treatment estimate

Even if you're savvy about your dental benefits, you might like a bit of help clarifying the cost of a treatment. That's why Delta Dental offers free pre-treatment estimates. This is an easy way to help you predict your out-of-pocket cost for a specific procedure.[1]

You might benefit from a pre-treatment estimate if you are:

- Planning dental work that will likely exceed $300, like a crown, wisdom tooth extraction, bridge, dentures or periodontal surgery
- Wondering if a procedure is covered by your plan
- Worried a procedure might exceed your annual plan maximum
- On a budget and need to plan your payment in advance

The pre-treatment estimate includes:

- An overview of services covered by your dental plan, as well as those that are limited or excluded
- How your coinsurance, deductibles and maximums may affect your share of the cost

[1] Pre-treatment estimates are available if you are covered under a Delta Dental PPO™ or Delta Dental Premier® plan.

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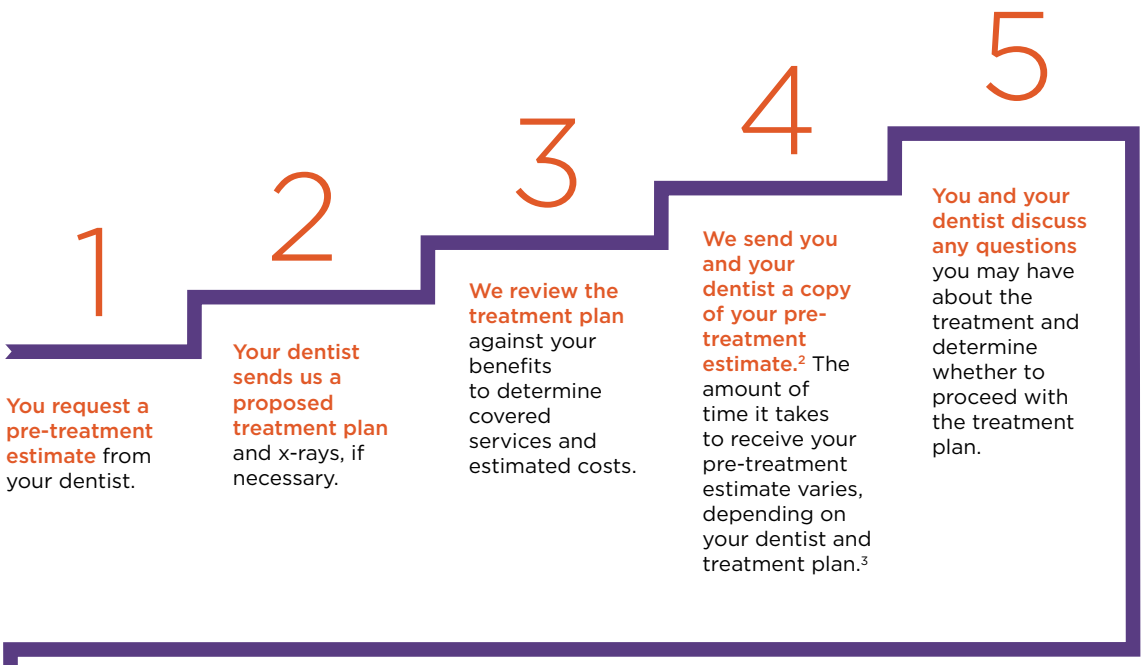
Dental Tools and Resources (continued)

Step by step

The pre-treatment estimate process



? Have more questions about your plan? Visit **Your Dental Plan Support Guide** at **deltadentalins.com/enrollees**.

[2] A pre-treatment estimate is not a guarantee of Delta Dental's final payment. When the treatment is complete and a claim is received for payment, Delta Dental will calculate its payment based on your current eligibility, amount remaining in your annual maximum and any deductible requirements or dual coverage. Please review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[3] Generally, pre-treatment estimates process in two to three weeks. However, dentists using our online tools may be able to provide your pre-treatment estimate while you are in the office.

Dental Tools and Resources (continued)

DELTA DENTAL

Stay Connected

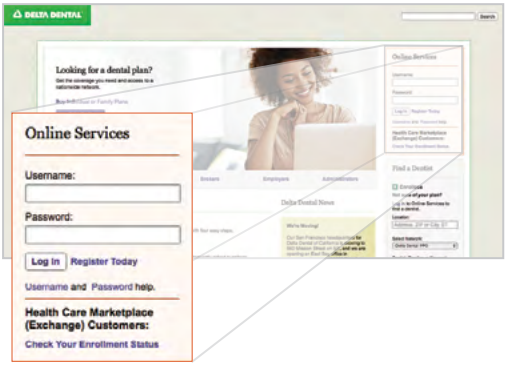
At **deltadentalins.com**, all the information you need is at your fingertips. You can check your plan details, find an in-network dentist and more.

Create an account

1. Go to **deltadentalins.com**.
2. Click on **Register Today** in the **Online Services** section.

With an online account, you can:

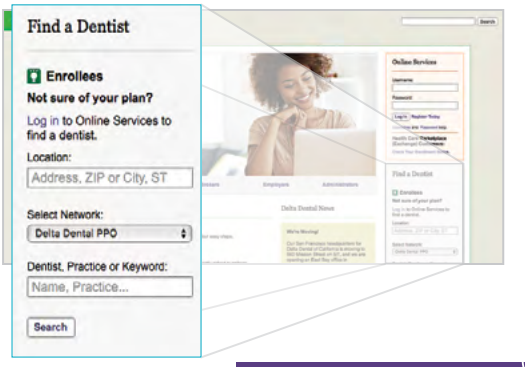
- Check your plan details and eligibility
- Review claim statements and plan documents
- View or print your ID card



Find a dentist

1. Go to **deltadentalins.com**.
2. In the **Find a Dentist** section, enter your address and select your network from the drop-down menu.
3. Click **Search**.

Browse Yelp reviews, check office hours and see the address on a map.



For more online resources, turn the page.

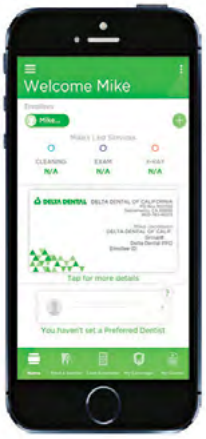
deltadentalins.com/enrollees

Dental Tools and Resources (continued)

Download the app

1. Open the **App Store** or **Google Play**.
2. Search for "**Delta Dental**."
3. Download the free app titled **Delta Dental** by Delta Dental Plans Association.

Review your plan details, pull up your ID card and try out the musical toothbrush timer.



Get answers

Got a question? We've got answers.

Learn how your dental plan works:

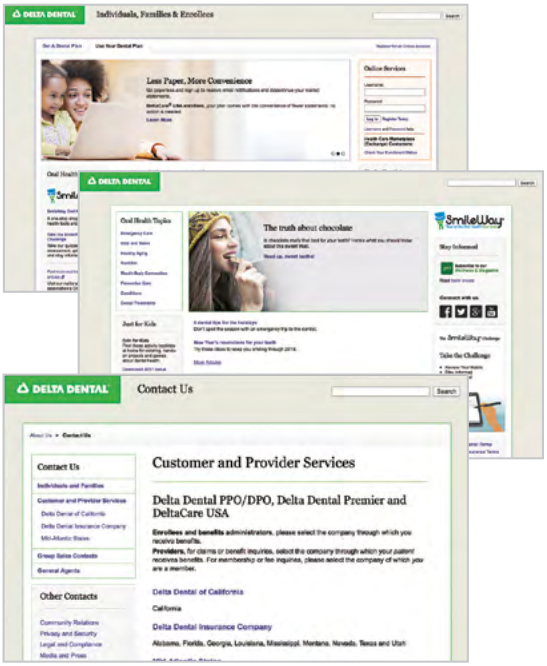
Visit **deltadentalins.com/enrollees** for the 101 on dental benefits.

Improve your dental health:

Check out **mysmileway.com** for the latest recipes, articles and videos.

Contact Customer Service:

Submit an online question at **deltadentalins.com/contact**.



Website available on desktop, mobile and tablet

Dental Tools and Resources (continued)

DELTA DENTAL® | amplifon Hearing Health Care

An offer to keep you smiling — from ear to ear

You now have access to discounts on hearing aids through Amplifon Hearing Health Care.[1] Delta Dental[2] selected Amplifon, a leader in hearing health care, to act as your personal concierge. They'll guide you through every step, from using your discounts to finding the right products and care to match your hearing needs.

Continued on back

Dental Tools and Resources (continued)

Have you heard? 48 million Americans have significant hearing loss.[3] Let Amplifon help.

The new program gives you:

Access to the best hearing aid prices, guaranteed.
There's no sign-up fee for the program, and you'll enjoy 62% average savings off retail pricing.[4] If you find a lower price at another local provider, Amplifon will not only match it, they'll beat it by 5%.[5] Plus, no interest financing is available.

Choice of top hearing aid brands.
Amplifon offers access to the nation's leading hearing aid brands featuring the latest technology. And, all products are backed by a 60-day no-risk trial.

Thousands of hearing care providers.[6]
With a broad network of hearing clinics across the nation, it's likely Amplifon has a provider near you.

Industry-leading support for your purchase.
The advantages of Amplifon don't stop right after you buy. You get one year of free follow-up care, two years of free batteries and a three-year product warranty for all hearing aid purchases.

Ready to get started? It's simple.

1

Call Amplifon at 1-888-779-1429. A Patient Care Advocate will help you find a hearing care provider near you.

2

Your advocate will explain the discount process, ask you a few simple questions, then help you make an appointment.

3

Sit back. Amplifon will send you and your selected provider the necessary information to activate your hearing aid discounts.

Take advantage of your value-added feature!
Visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429 to get started.

[1] Amplifon's hearing health care services are not insured benefits. Delta Dental makes the hearing health care services program available to enrollees to provide access to the preferred pricing for hearing aids and other hearing health services.

[2] Delta Dental of California, Delta Dental Insurance Company, Delta Dental of Pennsylvania, Delta Dental of New York, Inc. and our affiliated enterprise companies.

[3] Center for Hearing and Communication; http://chchearing.org/facts-about-hearing-loss/

[4] Amplifon Hearing Health Care utilization database, January-December 2018. Discounts or savings may vary by manufacturer and technology level of the hearing aid device.

[5] Amplifon offers a price match on most hearing devices; some exclusions apply. Not available where prohibited by law. Visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429 for more details.

[6] Amplifon Hearing Health Care provider file, February 2019

Dental Tools and Resources (continued)

DELTA DENTAL® | QualSight LASIK

Set your sights on even more value

Think you'd never be able to afford LASIK eye surgery? Now it may be within reach. Why? Because Delta Dental[1] has selected QualSight[2] to offer you access to discounts on LASIK services. Through QualSight, you can save 40-50% off the national average price of Traditional LASIK[3] along with big savings on Custom and Custom Bladeless LASIK procedures!

Continued on back ▶

Dental Tools and Resources (continued)

See it to believe it. QualSight can help you find the right vision solution.

Extra savings	Expert surgeons	Expansive choice
		
You get preferred pricing on LASIK through QualSight providers across the nation. Plus, pre- and postoperative visits are included, along with a one-year assurance plan.	There's no need to fear — QualSight's network is built with credentialed laser eye surgeons who have collectively performed more than 6.5 million procedures.[4]	With more than 1,000 LASIK locations[4], you can choose the physician with the experience, reputation and technology your vision correction requires.

Ready. Set. Save. It only takes three simple steps to take advantage of these savings.

1. Get ready.	2. Get set.	3. Save!
Give a QualSight care manager a call at 1-855-248-2020.	A care manager will explain the program and answer any questions.	Pick a physician and pay a discounted price for LASIK services.

To learn more about the LASIK discounts, visit www.qualsight.com/-delta-dental.

[1] Delta Dental of California, Delta Dental Insurance Company, Delta Dental of Pennsylvania, Delta Dental of New York, Inc. and our affiliated enterprise companies.

[2] The Vision Corrective Services are not an insured benefit. Delta Dental makes the Vision Corrective Services program available to enrollees to provide access to the preferred pricing for LASIK surgery.

[3] Refractive Quarterly Update, Market Scope LLC, November 2018. Discounts or savings may vary by provider.

[4] QualSight provider file, February 2019

Delta Dental is a registered trademark of Delta Dental Plans Association.

EF74 #120020B (rev. 3/19)

Vision Tools and Resources

You have access to **vsp.com** with easy navigation and a personalized dashboard to get exactly what you need, when you need it!

VSP Vision Care

QUICK VIEW OF YOUR BENEFIT INFORMATION

Once logged in, My Dashboard is your homepage. You'll see personalized benefit information, including previous doctor visits, and more!

INTUITIVE BENEFITS SECTION

The My Benefits tab shows your benefits history and an explanation of how you and your dependents can use your benefits.

DOWNLOAD THE APP

The redesigned VSP® app is available for free in the Apple App store or Google Play store. Updated with a streamlined login process, easier navigation, and a personalized member dashboard to mirror the look and feel of your dashboard on **vsp.com**!

IMPROVED FIND A DOCTOR PAGE

The search capabilities are endless on the Find a Doctor page! You can view a map and use the drop-pin functionality to find the right eye doctor for you in your region.

$

GET ACCESS TO SAVINGS

up to $3,000 with VSP Exclusive Member Extras when you log in to **vsp.com**.

Create an account on vsp.com to get the most out of your vision benefits.

Coordination of Benefits

Overview

The purpose of coordination of benefit (COB) is to allow the patient to maximize coverage while preventing duplicate payment for the same benefit.

VSP allows coordination of benefits for patients eligible for coverage by more than one vision plan.

Primary and Secondary Plans

When coordinating benefits, it must be determined which plan is billed first.

- The plan that covers the member as an employee is “primary”.
- The plan that covers the member as a dependent is “secondary”.

If the patient is a dependent child and is covered under both parents’ plans, typically the parent whose birthdate falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, unless otherwise ordered by the court.

Primary Plan

The primary plan must pay or provide benefits as if the secondary plan does not exist.

Secondary Plan

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services.

Services from Non-VSP Providers

VSP will reimburse the patient according to each benefit’s out of network schedule of allowances, not to exceed the actual exam fee and the cost of corrective eyewear.

Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered-in-full. Member is responsible for any remaining expenses.

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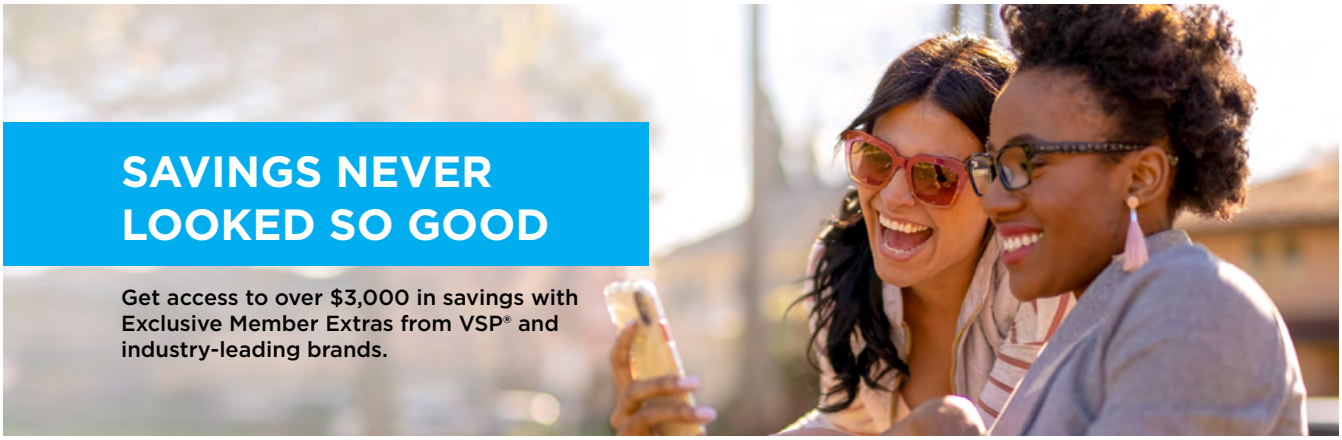
Vision Tools and Resources (continued)



DISCOVER YOUR SAVINGS

- Extra $20 on featured frame brands[1,3]
- Instant savings and satisfaction guarantees on popular lenses and enhancements[2,3]
- Savings on LASIK
- Mail-in rebates and free trials on popular contact lens brands
- Discounts on medical care, prescription drugs, lab work, as well as entertainment and theme park passes[4]
- Savings on digital hearing aids and replacement batteries[5]

VSP EXCLUSIVE MEMBER EXTRAS

PREMIER PROGRAM

BONUS OFFERS

Maximize your savings with Bonus Offers only available at Premier Program locations.

ENJOY BIG SAVINGS

from VSP and industry-leading brands.

LENSES AND FRAMES

EXTRA $20 TO SPEND · eyeconic · Eyezen+ · sunsync · techshield · Transitions · unity · ZEISS

CONTACTS

BAUSCH+LOMB See better. Live better. · CooperVision

LASIK

The LASIK Vision Institute · TLC Laser Eye Centers

FINANCING AND HEARING AIDS

CareCredit · TruHearing

HEALTH AND ENTERTAINMENT

VSP SIMPLE VALUES

View Bonus Offers at vsp.com/offers

Offers subject to change without notice. Some members may not be eligible for all offers. Visit **vsp.com/offers** for terms and conditions on specific offers.

1. Brands and promotions are subject to change. **2.** Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. **3.** Available to VSP members with applicable plan benefits. **4.** Some members may not be eligible for this program; visit **vsp.com/simplevalues** for terms and conditions. **5.** VSP is providing information to its members, but does not offer or provide any discount hearing program. The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly. TruHearing offers individuals the opportunity to purchase hearing aids at discounted prices, including individuals covered by self-funded health plans not subject to state insurance or health plan regulations. TruHearing is not insurance and not subject to state insurance regulations. TruHearing provides discounts to certain healthcare groups for hearing aid sales and services; TruHearing provides fitting, programming, and three adjustment visits at no cost; the member is obligated to pay for testing, and all post-fitting hearing care services, but will receive a discount from those healthcare providers who have contracted with TruHearing. Not available directly from VSP in the states of Washington and California.

Vision Tools and Resources (continued)

Browse with benefits.

See why Eyeconic® is the most seamless way to buy eyewear online.

Eyeconic connects your eyewear, your insurance coverage, and the VSP® doctor network.

Your vision and wellness come first with VSP. Now, your benefit includes **eyeconic.com**,® an eyewear store for VSP members.

When you choose Eyeconic, you'll enjoy:

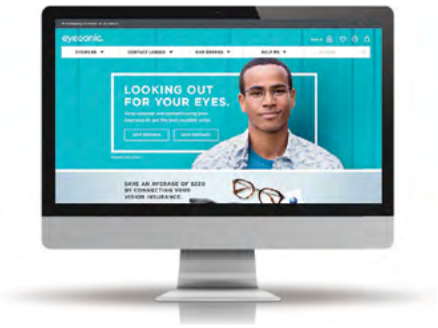
- Applying your benefit directly to your purchase.
- Browsing a huge selection of contact lenses and designer frames 24/7—and using the virtual try-on feature.
- Buying without risk—Eyeconic offers free shipping and returns. Plus, if you find the same merchandise at a lower price, we'll refund the difference.*
- Personal attention—Each qualifying purchase includes a complimentary frame adjustment or contact lens consultation.
- Peace of mind—Eyeconic will verify your prescriptions and perform a 25-point inspection.

You get exclusive savings year round.

Already used your benefits for the year? As a VSP member, you still receive 20% savings on glasses and sunglasses at Eyeconic.

It's easy to use your VSP benefit.

1. **Create an account at vsp.com**. Review your vision benefit and access your eligibility and coverage information, including how to apply your benefits at Eyeconic.
2. **Find superior eye care near you.** The decision is yours—choose a conveniently located VSP doctor or any out-of-network provider. Visit **vsp.com** or call **800.877.7195** to find the best provider for you.
3. **Check out Eyeconic and browse the frame brands you love.** You can connect to your VSP benefits, upload your prescription and order your glasses following your WellVision Exam.®



Just a few of the great brands you can choose from at Eyeconic!

Nine West
Nike
Lacoste
Flexon®
Calvin Klein
bebe®

Get started today.
It's more seamless.
More human.
More Eyeconic.

*Terms and conditions apply. Visit eyeconic.com/faqs for more details.

Vision Tools and Resources (continued)

With the VSP Laser VisionCare Program, you'll enjoy a safe and successful path to better vision. In addition to fully covered visits before and after your procedure to your VSP® doctor, you'll get special pricing on services from a VSP-contracted laser vision center.

Enjoy Discounted Pricing[1]

VSP offers special pricing with participating centers, which means up to hundreds of dollars in savings for you. Contact a center near you to learn more about their pricing.

How to Use Your Benefit

1. Visit **vsp.com** to learn what to expect during your procedure. If you don't already have a provider, you can also find a VSP Laser VisionCare doctor and confirm your eligibility.
2. Make an appointment with a participating VSP doctor to schedule a complimentary screening. If you're a candidate for laser surgery, your VSP doctor will provide pre-operative care, coordinate your procedure with a VSP-contracted laser vision center, and co-manage your treatment plan.[2]
3. After your procedure, be sure to return to your VSP doctor for post-operative care and ongoing management of the health of your eyes and vision. You may be able to use your VSP frame benefit for non-prescription sunglasses to protect your eyes from the sun. Ask your VSP doctor for details.

VSP® Vision care for life

VSP Laser VisionCare℠ Program

Get an average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. VSP members won't pay more than $1,500 per eye for PRK, $1,800 per eye for LASIK, and $2,300 per eye for Custom LASIK, Custom PRK, or Bladeless LASIK.

Learn more. **vsp.com | 800.877.7195**

1. The VSP Laser VisionCare Program is a discount plan only. Discounts only apply to services received from a VSP participating laser center. No monetary benefits are payable to members under this program. **2.** The laser vision correction screening and consultation with your VSP provider are complimentary. If you have a pre-operative exam and don't proceed with the procedure, your VSP provider may charge an exam fee up to $100.

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Vision Tools and Resources (continued)

Save Up to 60% on Brand-name Hearing Aids

TruHearing™

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,000, and few people have hearing aid insurance coverage.

TruHearing® makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too.

In addition to great pricing, TruHearing provides you with:

- Three provider visits for fitting and adjustments
- 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Plus, with TruHearing you'll get:

- Access to a national network of more than 5,500 hearing healthcare providers
- Straightforward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids
- Deep discounts on batteries shipped directly to your door

Best of all, if you already have a hearing aid benefit from your health plan or employer, you can combine it with TruHearing prices to reduce your out-of-pocket expense even more!

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

Here's how it works:

Contact TruHearing.
Call **877.396.7194**. You and your family members must mention VSP.

Schedule exam.
TruHearing will answer your questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Important Notices

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

Important Notices (continued)

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.