

# VISION & DENTAL BENEFITS



## SUMMARY OF VISION & DENTAL BENEFITS

VISALIA • HANFORD • TULARE

Sequoias Community  
College District



College of the Sequoias

**College of the Sequoias Dental and Vision Benefits**

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**\*It is important to note that collective bargaining agreements or employment agreements govern employee dental and vision benefits. While every effort will be made to keep this handbook accurate, this handbook is merely an attempt to provide *general* dental and vision benefit guidance. If inconsistencies, differences, questions and/or issues arise regarding dental and vision benefits, the appropriate collective bargaining agreement or employment agreement shall govern – not this handbook.**

**DENTAL BENEFITS**

**Payment**

Your plan pays up to a maximum of \$1,800 per person each calendar year for the listed services and supplies customarily performed by licensed dentists and oral surgeons for treatment of teeth, jaws, and their dependent tissues. Once the deductible has been satisfied, plan payments are made at the indicated percentage of the billed charge to dentists for the benefits of this plan, subject to the co-payment percentages indicated below.

**Reimbursement Provision**

All claims for reimbursements must be submitted to:

**Foundation for Medical Care  
3335 South Fairway  
Visalia, CA 93277  
(559) 734-1321, (800) 662-5502**

within six months after the month of service.

**Calendar Year Deductible \$25**

The deductible applies separately to each covered person each calendar year. It is the amount which you must pay out of pocket for charges that would otherwise be payable for dental care services and supplies. No more than \$75 per family per calendar year will be required.

**Incentive Level of Benefits**

The plan will pay 70% of the billed charge for covered diagnostic, preventive and basic services during the first year you are eligible. This percentage will increase 10% each year (to a maximum of 100%) for each enrollee provided that person visits the dentist at least once during the year. If an enrollee does not use the program during a calendar year, the percentage remains at the level reached the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

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### **Dental Benefits**

1. Services rendered for Diagnostic and Preventive Care are paid at the appropriate percentage level of the billed charge.
2. Services rendered for the procedures listed under Basic Services are paid at the appropriate percentage level of the billed charge.
3. Services rendered for the procedures listed under Major Services are paid at 60% of the billed charge. Subscribers are responsible for the remaining 40% balance of the billed charge.
4. Services rendered for Orthodontia are paid at 50% of billed charges. Subscribers are responsible for the remaining 50% of these charges.

The Foundation will pay for services rendered at the appropriate percentage level of the billed charge. It is suggested that you discuss fees beforehand with your dentist. Any difference between payment based on the percentage of billed charges and your dentist's charges are your responsibility.

### **Dental Care Benefits**

The following services and supplies are benefits when provided by a licensed dentist or oral surgeon and when necessary and customary as determined by the standards of generally accepted dental practice.

**Diagnostic and Preventive**  
Payable at the Appropriate Percentage Level of the Billed Charge  
Not Subject to the Deductible

**Clinical Oral Examinations** - Including consultations by a specialist (if diagnostic service is provided by dentist or physician other than practitioner providing treatment), not more than once in any period of six (6) consecutive months.

**Dental Prophylaxis** - Not more than once in any period of six (6) consecutive months. (Prophylaxes performed in conjunction with fluoridation or any other procedure and periodontal prophylaxes shall be considered as being a prophylaxis for the purpose of applying this limitation).

**Topical Application Of Fluoride** - Not more frequently than once in any period of twelve (12) consecutive months and only for eligible dependents under the age of 18.

**Periodontal prophylaxis** - (Recall or maintenance visit) not more than a combined total of one periodontal and/or regular prophylaxis per each period of six (6) consecutive months.

#### **X-rays**

**Bitewing Film** - Not more than once in any period of six (6) consecutive months. Full mouth series (includes 10 to 14 periapical x-rays and supplementary bitewing films) not more than once in any period of 24 consecutive months. In applying this 24-month limitation, a panoramic x-ray shall be considered a full mouth series.

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**X-rays** - Required to diagnose a specific condition that needs treatment are not subject to limitations stated above.

**Diagnostic Casts** - Not more than once in any period of twenty four (24) consecutive months. Working models taken in conjunction with a prosthetic or other appliance are not considered to be diagnostic casts.

<b>Basic Services</b>
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Payable at the Appropriate Percentage Level of the Billed Charge
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**Anesthesia** - General, only when provided in conjunction with a covered oral surgical procedure.

**Endodontics** - Pulp capping, therapeutic pulpotomy - deciduous teeth only (in addition to restoration; vital).

**Pulpotomy** - Deciduous teeth only; apexification; root canals on permanent teeth only, including pulpotomy or other palliative treatment and necessary x-rays and cultures, but excluding final restoration; root canal therapy; apicoectomy (including apical curettage).

**Oral Surgery** - Extractions; removal of impacted teeth, cysts and neoplasms; other surgical procedures; includes local anesthesia and routine pre and post-operative care.

**Palliative** - Emergency treatment for relief of pain.

**Periodontics** - Emergency treatment including but not limited to periodontal abscess and acute periodontitis; root planing (not prophylaxis); subgingival curettage, gingivectomy and osseous surgery (including post-surgical visits).

**Restorative Dentistry** - Amalgam restorations; synthetic restorations ( i.e. silicate cement filling, porcelain filling, plastic filling and composite filling); stainless steel crowns when the tooth cannot be restored with a filling material. Inlays, onlays, crowns (other than stainless steel); veneers and other laboratory produced restorations and bridges are excluded.

**Cast Restorations** - Cast or other laboratory prepared restorations and crowns are covered only when teeth cannot be restored with a filling material. Cast restorations (inlays, onlays, and other laboratory prepared restorations); crowns (acrylic, composite glass, porcelain and gold); veneers; post and cores; crown buildups (on vital or non-vital teeth when functionally necessary). Replacement of an existing crown, inlay or onlay, or other cast restoration which is more than five (5) years old and cannot be repaired. Repair or recementing of inlay, onlays and crowns, if after six (6) months of installation.

**Space Maintainers** - Includes all adjustments within 6 months after installation. Benefits for space maintainers are limited to eligible dependent children under age 16.

**Sealants** - One (1) treatment in any period of (24) consecutive months per each permanent molar and only for patients under age 18.

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### Major Services

Payable At 60% of the Billed Charge

**Prosthetics** - (After twelve months of continuous coverage under the plan) Bridges, dentures, partials and relining or rebasing dentures, adding teeth to partial denture to replace extracted teeth, full and partial denture repairs, stay plate, special tissue conditioning per denture (limited to one course of treatment per six (6) month period), and denture duplication (jump case). Fees for appliances include adjustments, repairs and relines for a six (6) month period following installation. An additional benefit for one reline per immediate denture is payable during the first six (6) months following installation. Replacement of an existing partial denture, full removable denture or fixed bridgework which is more than five (5) years old and cannot be repaired will normally be limited to a new partial denture; upgrading from a partial denture; upgrading from a partial denture to fixed bridgework will be payable only if acceptable documentation is presented which clearly demonstrates that the patient's arch cannot be adequately restored with a partial denture.

### Orthodontia

Payable at 50% of Billed Charges

Diagnosis and treatment by an orthodontist for the straightening of teeth, up to a lifetime maximum payment of \$1,500 per person. This payment is in addition to the maximum benefit provided for dental care.

## Dental Plan Limitations and Exclusions

### General Limitations

All benefits provided in this plan are subject to the following limitations:

**Implants** - Implants (artificial materials including synthetic bone grafting materials which are implanted into, onto or under bone or soft tissue) or the removal of implants (surgically or otherwise) are not benefits. However, if an implant procedure is performed, the plan pays the benefit available for any conventional restorative prosthetic procedure (if any) which could have been utilized to correct the subscriber's condition in a professionally satisfied manner. If the plan makes an allowance toward the cost of an implant procedure(s), benefits will not be available for any replacement prosthesis placed within the immediately following five (5) years.

**Crowns/Inlays** - Benefits are not provided for crowns, inlays or onlays, laminate veneers, or other cast or laboratory prepared restorations if the tooth can be restored with a filling material (e.g., amalgam, composite resin, or silicate cement).

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**General Anesthesia** - Benefits are not provided for general anesthesia except as administered by a licensed dentist in connection with a covered oral surgical procedure. Intravenous sedation is not general anesthesia for the purpose of this limitation and is therefore not covered.

### **General Exclusions**

Unless exceptions to the following general exclusions are specifically made elsewhere under this plan, this plan does not provide benefits with respect to:

1. Charges for services in connection with any treatment to the gums for tumors;
2. Charges for vestibuloplasty (i.e., surgical modification of the jaw, gums and adjacent tissues), and for any procedure, service, or supply including office visits, examination, and diagnosis provided directly or indirectly to treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular (jaw hinge) joint and its associated structures including but not limited to myofascial pain dysfunction syndrome;
3. Services or supplies provided in connection with a congenital anomaly (an abnormality present at birth) or developmental malformation (an abnormality which develops after birth). Congenital anomalies and developmental malformation include but are not limited to : cleft palate; cleft lip; upper or lower jaw malformations (e.g., prognathism); enamel hypoplasia (defective development); fluorosis (a type of enamel discoloration); treatment involving or required by supernumerary teeth; and anodontia (congenitally missing teeth);
4. Prescribed drugs, premedication, analgesia, local anesthetics, sedatives, or intravenous sedation;
5. Services, procedures, or supplies which are not reasonably necessary for the care of the person's dental condition according to broadly accepted standards of professional care or which are investigational in nature or which do not have uniform professional endorsement;
6. Appliances, restorations or services including but are not limited to equilibration required solely to change, maintain, or restore vertical dimension or occlusion or solely for the purpose of splinting (i.e., stabilizing loose teeth);
7. Services, procedures or supplies which are purely cosmetic in nature. Facings on crowns or pontics posterior to the second bicuspid and composite restorations on posterior teeth shall always be considered cosmetic;
8. The replacement of an appliance (i.e., a denture, partial denture, space maintainer, crown, inlay or onlay, etc.) which has been either lost or stolen;
9. Myofunctional therapy; biofeedback procedures; athletic mouthguards; precision or semi-precision attachments; denture duplication; oral hygiene instruction; treatment of jaw fractures; sealants; charges for acid etching;
10. Orthognathic surgery, including but not limited to, osteotomy, ostectomy, and other services or supplies to augment or reduce the upper or lower jaw;
11. Temporary dental services. Charges for temporary services are considered an integral part of the final dental service and will not be separately payable;
12. Extra-oral grafts (i.e., the grafting of tissues from outside the mouth to oral tissues);
13. Hospital costs and any additional fees charges by the dentist for hospital treatment;

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14. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by the Foundation and its dental consultants;
15. Any service, procedure, or supply which is received or started prior to the patient's effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have started is defined as follows:
  - For full dentures or partial dentures: on the date the final impression is taken;
  - For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
  - For root canal therapy: on the later of the date the pulp chamber opened or the date canals are explored to the apex;
  - For periodontal surgery: on the date the surgery is actually performed;
  - For all other services: on the date the service is performed.

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### VISION BENEFITS

Vision benefits are provided after each covered person pays a deductible amount of \$15 each calendar year. The deductible must be made up of charges covered by the plan.

The plan provides payments based on the amounts shown in the **Schedule of Allowances** for all providers.

One comprehensive eye examination in a 12-month period.

One pair of lenses in a 12-month period.

One frame in a 24-month period.

One pair of contact lenses for cosmetic reasons or for convenience, are provided in lieu of other eyewear once every 12 months.

Contact lenses when medically necessary following cataract surgery, when visual acuity cannot be corrected to 20/70 in the better eye, or when required for anisometropia or keratoconus.

**Reimbursement for lenses, frames, and contact lenses will only be paid when purchases in conjunction with a visual refraction obtained within ninety (90) days of the order of eyewear.**

### Reimbursement Provision

All claims for reimbursements must be submitted to:

**Foundation for Medical Care  
3335 South Fairway  
Visalia, CA 93277  
(559) 734-1321, (800) 662-5502**

within six months after the month of service.

### Schedule of Allowances

The following schedule includes pink or rose tint #1 or #2 in the allowance for lenses.

<u>Item Description (Eyeglasses)</u>	<u>Allowances (All eligible persons)</u>
Single vision lenses (glass or plastic)	\$100.00
Bifocal lenses (glass or plastic)	\$145.00
Trifocal lenses (glass or plastic)	\$155.00

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<b><u>Item Description (Eyeglasses)</u></b>	<b><u>Allowances (all eligible persons)</u></b>
7.25 diopter or more high-powered lenses	\$15.00
Verilux	\$105.00
Aphakic monofocal -- plastic/ aspheric	\$125.00
Aphakic multifocal - plastic/ aspheric	\$200.00
Lenticular (myodisc) monofocal	\$125.00
Lenticular (myodisc) multifocal	\$200.00
Prism 1 ½ to 4 diopters	\$14.00
Prism 4 ½ to 7 diopters	\$25.00
Prism 8 to 10 diopters	\$40.00
Slab off prism	\$75.00
Frame (*Note: If an expensive frame is selected, the subscriber is responsible for the additional costs)	\$130.00
Tint	\$12.00

<b><u>Item Description (Contact Lenses)</u></b>	<b><u>Allowances (all eligible persons)</u></b>
Contact lenses (hard) — medically necessary	\$200.00
Contact lenses (soft) — medically necessary	\$250.00
Contact lenses hard/soft) — convenience or cosmetic	\$120.00

Note: Allowance is in lieu of other eyewear. Any difference between the allowance and provider's charge is your responsibility.

Note: A routine follow-up visit is only payable after a twelve month interval following a comprehensive examination. Follow-up visits involving actual or suspected pathology or injury may be covered under the medical benefits of your health plan.

**Vision Plan Exclusions and Limitations**

In addition to the general exclusions of the plan, these benefits do not cover services or materials in connection with contact lenses, except as specifically provided; subnormal vision aids; vision training; non-prescription lenses, or glasses when no prescription change is indicated; coated lenses, no-line bifocal (blended type) lenses or oversized lenses exceeding the allowance for covered lenses; replacement or repair of lost or broken lenses or frames, except at the normal intervals; any eye examination required by the employer as a condition of employment; medical or surgical treatment of

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the eyes; or services incident to (a) any injury arising out of, or in the course of, any employment for salary, wage or profit; or (b) any disease covered with respect to such employment, by any workers' compensation law, occupational disease law or similar legislation. However, if the Foundation provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Foundation for the treatment of the injury or disease which was the basis of the person's claim under such workers' compensation law, occupational disease law or similar legislation.

Services for treatment directly related to any totally disabling condition, illness or injury for which an extension of benefits is provided under a plan or policy providing hospital, medical or surgical expense or service benefits that was in effect with the employer within sixty (60) days immediately before the effective date of this plan.

### **Exception for Other Coverage**

A provider may seek reimbursement from other third party payors for the balance of its reasonable charges for services rendered under this plan.

### **Exclusion for Duplicate Coverage**

In the event that you are covered under this plan and are also entitled to benefits under any of the conditions listed below, the Foundation's liability for services provided herein will be reduced by the amount of benefits paid, or the reasonable value of the services or supplies provided without any cost to you, because of your entitlement to such other benefits.

If you cease work because of retirement, disability, an approved leave of absence, temporary layoff or termination, see the Continuation of Coverage provisions described in this booklet for information on continuation of coverage.

If application is not made for a newborn or a newly adopted minor child within the 31 days following that dependent's effective date of coverage, benefits under this plan will be terminated at the end of such period.

When a benefit specifies a maximum allowance and the plan's maximum has been reached, the subscriber is responsible for any charges above the benefit maximum amounts.

## **Eligibility**

All employees as herein defined.

### **Eligible Employees:**

FULL-TIME FACULTY AND MANAGEMENT EMPLOYEES—on the date of hire.

CLASSIFIED EMPLOYEES—on the first of the month following their start date unless the employee's start date is less than five (5) business days from the end of the month. In this event, employees will be enrolled the following month (i.e. one month and five (5) business days from their start date.

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RETIREES—provided they were covered as an active participant prior to retirement and continued to elect coverage.

In addition, unless provided otherwise in an employment agreement, a retiree must have at least ten (10) years of service with the College and retire under the State Teacher's Retirement System, Public Employees' Retirement System or Federal Social Security law.

If a former employee is rehired, his/her period of service prior to termination of employment shall be included in the determination of his/her date of eligibility only if he/she has resumed active work within 6 months after his/her termination, or he/she has resumed active work within the time set by law for reinstatement of employment rights, if his/her previous employment was terminated due to entry into the armed forces, or he/she has resumed active work within one month after ceasing to be disabled if termination was due to his/her disability.

In all other cases a former employee shall be considered as an employee entering the employ of the contract holder on the date he/she resumed work and shall be eligible on the date he/she completes the period of service specified above.

If an employee transfers from an ineligible to an eligible class, he/she shall be considered as having entered the employ of the contract holder on the date of this transfer. His/her service in the ineligible class shall not be included in the determination of his/her eligibility.

### **Effective Date of Benefits**

Benefits become effective only after the employee completes the written request for all benefits for which he/she is eligible. Except as provided below, benefits shall become effective in accordance with the following:

1. The benefits of an employee who enrolls during the initial enrollment period shall become effective on the date of his/her eligibility.
2. If the employee declines enrollment during the initial enrollment period and subsequently requests enrollment for him/her and his/her new spouse as a result of marriage, the Employee and spouse will be effective on the first day of the month following receipt of the request for enrollment.
3. If an employee declines enrollment during the initial enrollment period and subsequently acquires a Dependent as a result of birth or placement for adoption, the employee and his/her dependents will be effective on the date of birth or in the case of placement for adoption, the date the employee or spouse has the right to control the child's health care.
4. The benefits of an employee who is a late enrollee shall become effective the earlier of, 12 months from the date the late enrollee requests enrollment at the employer's next open enrollment period.
5. The benefits of an employee who is not a late enrollee shall become effective on the date of loss of coverage under another employer dental plan. Provided enrollment is requested within 30 days of the loss of that other employer dental plan coverage. The employee must furnish written evidence of the loss of coverage.

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### **Termination of Benefits of an Employee**

The benefits of an employee shall cease on the first to occur of the following dates:

1. The date this contract is canceled.
2. The date this contract is amended to terminate the eligibility of any class of Employees of which the Employee is a member.
3. The end of the last period for which the employee has made his/her contribution, if he/she has notified the contract holder that his/her payroll deductible order is to be canceled, or otherwise failed to make his/her contribution when due.
4. The date the employee enters full-time military service.
5. The last day of the month in which the employee leaves voluntarily or is dismissed from the employ of the contract holder or otherwise ceases to be a member of a class of employees eligible for coverage, unless a different date on which the employee no longer meets the requirements for eligibility, except that:
  - a. If the employee ceases active work because of a disability due to illness or bodily injury, payment of dues with respect to that employee shall continue his/her coverage in force until the end of such disability or until employment is terminated by the contract holder, whichever is earlier, or
  - b. If the employee ceases active work because of an approved leave of absence (except for illness or bodily injury) or temporary layoff, payment of dues for that employee shall keep coverage in force for a period of three contract months commencing with the first contract month next following the date on which such approved leave of absence or temporary layoff began. If the contract holder is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave pursuant to such Acts, payment of dues for that employee shall keep coverage in force for the duration(s) prescribed by the Acts. The contract holder is solely responsible for notifying employees of the availability and duration of family leaves.

### **Eligibility of Employees for Dependent Benefits**

Spouse and children of employees are eligible to enroll in this plan. An eligible dependent means:

1. An employee's legally married spouse who is not covered for benefits as an employee, is not legally separated from the employee, and is not a member on active duty with the Armed Forces; or
2. An employee's unmarried child (including any stepchild, child placed for adoption or foster child), who is less than 26 years of age, is not covered for benefits as an employee, is not a member on active duty with the Armed Forces, and who is primarily dependent upon the employee for support and maintenance, or is dependent upon the employee for medical support pursuant to a court order; or

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3. An employee's sponsored dependent who is (i) related to the employee by blood or marriage, or if not related to the employee, resides with the employee as a member of his/her household; and (ii) dependent upon the employee for more than half of his/her support as defined by the Internal Revenue Code of the United States, and as to whom the employee is entitled to claim exemption for a dependent;

And who has been enrolled as a dependent and has maintained membership under the plan.

The date of eligibility for dependents of employees who enroll during the initial enrollment period is the latest to occur of the following:

1. The effective date of any part providing dependent benefits.
2. The date of eligibility of the employee.
3. The date the employee acquires his/her first dependent after the employee's date of eligibility.

The date of eligibility for dependents of employees who declined enrollment during the initial enrollment period or dependents that do not request enrollment within 31 days of eligibility as provided above, shall be determined as follows:

1. A dependent who is a late enrollee and who has declined enrollment during the initial enrollment period, or dependents who do not request enrollment within 31 days of eligibility as provided above, shall be eligible for coverage the earlier of, 12 months from the date of the late enrollee's request for enrollment, or at the employer's next open enrollment period.
2. A dependent will not be considered a late enrollee if he/she or the employee loses coverage under a previous Employer dental plan and shall be eligible for coverage on the date of loss of coverage, provided enrollment is requested within 31 days after termination of that other employer dental plan coverage. Written evidence of the loss of coverage is required.
3. An employee may add newly acquired dependents and himself/herself:
  - a. To continue coverage of a newborn or child placed for adoption;
  - b. To add a spouse after marriage;
  - c. To add himself/herself and spouse following birth of a newborn or placement of a child for adoption;
  - d. To add himself/herself and spouse after marriage;
  - e. To add himself/herself and his/her newborn or child placed for adoption, following birth or placement for adoption.
4. If a husband and wife are both eligible to be employees, their children may be eligible and may be enrolled as Dependents of both parents.

### **Effective Date of the Dependent Benefits for an Employee**

Dependent benefits for an employee shall become effective only after the employee has made written application. Benefits are effective as follows:

The dependent benefits of any employee who enrolls during the initial enrollment period shall become

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effective on the date the employee becomes eligible.

1. The dependent benefits of any employee who is a late enrollee or a dependent who is a late enrollee shall become effective the earlier of, 12 months from the date the late enrollee requests enrollment or at the employer's next open enrollment period.
2. The benefits of a dependent who is not a late enrollee shall become effective on the date of loss of coverage under another employer dental plan provided enrollment is requested within 31 days of the loss of that other dental coverage. The employee must furnish written evidence of the loss of coverage.
3. An employee requesting reinstatement of his/her benefits after he/she has been discontinued due to voluntary cancellation while he/she remained eligible, with respect to his/her dependents, the dependent's benefits shall be effective the earlier of, 12 months from the date the employee requested reinstatement or at the employer's next open enrollment period.
4. Dependent benefits for a spouse or Dependent child for who a court has ordered the employee to provide coverage under the employee's benefit plan shall become effective within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in subdivision (j) of Section 14124.93 of the Welfare and Institutions code or Medic-Cal program.
5. Dependent benefits for a newborn child are effective on the child's date of birth. Coverage will cease on the 32<sup>nd</sup> day at 12:01 a.m. Pacific Time following the Dependent's effective date of coverage except that coverage shall not cease if a written application for the addition of the Dependent is submitted to and received by the College prior to the 31<sup>st</sup> day following the effective date of coverage.
6. Dependent benefits for a child placed for adoption are effective the date the employee or spouse has the right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form, or a relinquishment form. Coverage will cease on the 32<sup>nd</sup> day at 12:01 a.m. Pacific Time following the Dependent's effective date of coverage except that coverage shall not case if a written application for the addition of the dependent is submitted to and received by the College prior to the 31<sup>st</sup> day following the effective date of coverage.
7. Dependent benefits for a new spouse are effective on the date of marriage.

### **Termination of the Dependent Benefits of an Employee**

The Dependents benefits of an Employee shall cease on the first to occur of the following dates:

1. The date this contract is canceled.
2. The end of the last period for which the employee has made his/her contribution for dependent benefits, if he/she has notified the College that his/her payroll deduction order is to be canceled, or otherwise failed to make his/her contribution when due.
3. The date of the termination of the Employee's coverage.

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4. The last day of the month in which the dependent ceases to qualify as a “Dependent” as defined, including a spouse following the entry of a final decree of divorce, annulment or dissolution of marriage from the employee, except that if coverage for a dependent child would be terminated solely because of age and at the time of attainment of such age the child is both:
  - a. Incapable of self-sustaining employment by reason of mental retardation or physical handicap and
  - b. Chiefly dependent upon the employee for support and maintenance, then coverage for the dependent will be continued only in accordance with (a) and (b) below:
  - c. The employee must submit to the COS Office of Human Resources a Doctor of Medicine’s written certification of Mental retardation or physical handicap within 31 days of the request for this information by the College, and
  - d. Recertification from a Doctor of Medicine must then be submitted to the College 6 months after the dependent would have been terminated, and then annually thereafter. In no event will coverage be continued beyond the date that the dependent child becomes ineligible for coverage for any reason other than his/her attained age.

The term “Mentally Retarded” includes only those persons, not psychotic, who are so mentally retarded from infancy or before reaching maturity that they are incapable of managing themselves and their affairs independently, with ordinary prudence, or of being taught to do so, and who require supervision, control and care for their own welfare or for the welfare or for the welfare of others or for the welfare of the community.

The term “Physical Handicap” means, for the purposes of this PART, a physical or mental impairment that results in anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

With respect to a dependent child whose effective date of coverage was because of birth or placement of adoption, coverage will cease on the 32<sup>nd</sup> day at 12:01 a.m. Pacific Time following that dependent’s effective date of coverage, except that coverage shall not cease if a written application for the addition of the dependent is filed with the College prior to the 31<sup>st</sup> day following his/her effective date of coverage.

### **Continuation of Coverage (COBRA)**

(Applicable only to Persons when the Person’s Employer (Contractholder) is subject to Title X of the Consolidated Omnibus Budget Reconciliation Act [COBRA] as amended).

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, a Person will be entitled to elect to continue group coverage under this plan if he/she would otherwise lose coverage because of a Qualifying Event that occurs while the contract holder is subject to the continuation of group coverage provisions of COBRA. The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Person if the Qualifying Event had not occurred (including any changes in such coverage).

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### **Qualifying Event**

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences:

1. With respect to the Subscriber:
  - a) the termination of employment (other than by reason of gross misconduct); or
  - b) the reduction of hours of employment to less than the number of hours required for eligibility.
2. With respect to the Dependent spouse and Dependent children (children born to or placed for adoption with the Subscriber during a COBRA continuation period may be immediately added as Dependents, provided the Contract holder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):
  - a) the death of the Subscriber; or
  - b) the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
  - c) the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
  - d) the divorce or legal separation of the Subscriber from the Dependent spouse; or
  - e) the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
  - f) a Dependent child's loss of Dependent status under this plan.
3. With respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.
4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA.

### **Notifying the Contract Holder of a Qualifying Event**

The Person is responsible for notifying the Employer of divorce, legal separation or a child's loss of Dependent status under this plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this plan because of a Qualifying Event.

The Employer is responsible for notifying its COBRA administrator (or Plan administrator if the employer does not have a COBRA administrator) of the Subscriber's death, termination or reduction of hours of employment, the Subscriber's Medicare entitlement, or the Employer's filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will inform the Person within 14 days of his/her right to continue group coverage under

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this plan. The Person must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of his/her right to continue group coverage and (2) the date coverage terminates due to the Qualifying Event. **If the Person does not notify the COBRA administrator within 60 days, his/her coverage will terminate on the date he/she would have lost coverage because of the Qualifying Event.**

### **Duration and Extension of Continuation of Group Coverage**

The Person will be entitled to continue group coverage under this plan up to a maximum of 36 months, except when the Subscriber has lost his/her coverage because of termination or reduction of work hours required for eligibility. For these Subscribers, group coverage may only be continued for a maximum of 18 months. This 18-month period may be extended to 36 months if a second Qualifying Event such as death, divorce, legal separation or Medicare entitlement occurs during the first 18-month period.

The Person's 18 month period may also be extended to 29 months if the Person was disabled on or before the date of termination or reduction in hours of employment, or is determined to be disabled under the Social Security Act within the first 60 days of the initial Qualifying Event and before the end of the 18 month period (non-disabled eligible family members are also entitled to this 29-month extension). The Employer must be notified of the Social Security Act determination within 60 days of the determination and before the end of the

18-month period. The Person is responsible for notifying the Employer within 30 days of any final determination that he/she is no longer disabled.

In no event will continuation of group coverage be extended for more that 3 years from the date the Qualifying Event has occurred which entitled the Person to continue group coverage under this plan.

### **Payment of Dues**

Dues for the Person continuing coverage shall be 102% of the applicable group dues rate, except for the Subscriber who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall be 150% of the applicable group dues rate. If the Person is contributing to the cost of coverage, the Employer shall be responsible for collecting and submitting all dues contributions to Blue Shield of California in the manner and for the period established under this plan.

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### **Effective Date of the Continuation of Coverage**

The continuation of coverage will begin on the date the Person's coverage under this plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as dues are timely paid.

### **Termination of Continuation of Group Coverage**

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this group health services contract;
2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the Employer as applicable;
3. the Person becomes covered under another group health plan that does not include a Pre-existing Condition exclusion or limitation provision that applies to the Person;
4. the Person becomes entitled to Medicare;
5. the continuation of coverage was extended to 29 months and there has been a final determination that the Person is no longer disabled.

Continuation of group coverage in accordance with COBRA will not be terminated except as described in this provision.

### **Additional Continuation of Benefits beyond Termination under COBRA**

Certain former employees and dependent spouses (including a spouse who is divorced from the employee and/or a spouse who was married to the employee or former employee at the time of that employee's death) may be eligible to continue group coverage beyond termination under COBRA. The College will offer the extended coverage to former employees that are subject to the existing COBRA, and to the former employees' dependent spouses, including divorced or widowed spouses as defined above. This additional continuation is subject to the following conditions:

1. The former employee worked for the College for the prior 5 years and was 60 years of age or older on the date his/her employment ended.
2. The former employee was eligible for and elected COBRA for himself/herself and his/her Dependent spouse (a former spouse, i.e., a divorced or widowed spouse as defined above, is also eligible for continuation of group coverage after COBRA. The former spouse must elect such coverage by notifying the plan in writing within 30 calendar days prior to the date that the employee's initial COBRA benefits are scheduled to end).
3. If elected, benefits under the additional continuation of coverage will begin after the COBRA coverage ends and will be the same as if continuation under COBRA had remained in force.

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4. The rate for continuation shall be 213 percent of the applicable current group dues rate or 102 percent of the applicable age adjusted group dues rate.
5. **NOTIFICATION REQUIREMENTS.** The College must notify the employee or dependent spouse (including a former spouse as defined above) regarding availability of continuation of coverage at least 990 calendar days before the end of COBRA coverage. The former Employee (and/or former spouse) must elect to continue coverage by notifying the plan in writing within 30 calendar days before the end of COBRA coverage.
6. **TERMINATION.** Continuation of coverage beyond COBRA will end automatically on the earliest of the following dates:
  - a. The date the former employee, spouse, or former spouse reaches age 65.
  - b. The date the College ceases to maintain any group dental plan.
  - c. The date the former employee, spouse, or former spouse transfers to another dental plan not maintained by the College, whether or not the benefits of the other plan are less valuable than those of the plan maintained by the College.
  - d. The date the former employee, spouse, or former spouse becomes entitled to Medicare.

For a spouse or former spouse, five years from the date the spouse's COBRA coverage would end.

### **Coordination of Benefits**

If a Covered Person is covered under more than one group plan, including this Plan and any other group medical benefits provided through or by the Employer, and one or more other plans, as defined below, the benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, will equal 100% of the Allowable Expenses, also defined below:

#### **Definitions**

**Allowable Expenses:** Any Medically Necessary, Reasonable and Customary item of expense incurred by a Covered Person which is covered at least in part under this Plan.

**Claim Determination Period:** A Calendar or Plan Year or that portion of a Calendar of Plan Year during which the Covered Person for whom claim is made has been covered under this Plan.

**Plan:** Any plan under which medical or dental benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;
2. Preferred Provider Organization (PPO);
3. Wholly or partially self-insured or self-funded group plans;
4. Group coverage under labor-management trustee plans, union welfare plans, and Employer organization plans or employee benefit organization plans;

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5. Coverage including Medicare, under governmental programs or coverage required or provided by any statute, or provided or required by statute, including no-fault auto insurance. (Refer to the Effect of Medicare provision for treatment of this coverage under this Plan).

“Plan” does not include an individual or family indemnity type policy, an excess insurance policy, a policy limited to specified Illnesses or accidents, a Medicare supplement policy or accident coverage of preschool, grammar school, high school or college students on either a twenty-four (24) hour basis or “to and from” school.

### Order of Benefit Determination

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expenses. No plan pays more than it would without the Coordination of Benefits Provision.

When this plan is secondary in the order of payments and the Foundation is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this plan will pay the benefits that would be due as if it were the primary plan, provided that the covered person:

1. Assigns to the Foundation the right to receive benefits from the other plan to the extent of the difference between the benefits which the Foundation actually pays and the amount that the Foundation would have been obligated to pay as the secondary plan,
2. Agrees to cooperate fully with the Foundation in obtaining payment of benefits from the other plan, and
3. Allows the Foundation to obtain confirmation from the other plan that the benefits, which are claimed, have not previously been paid.

A plan without a Coordination of Benefits provision is always the primary plan. If all plans have such a provision:

1. The Plan covering the person directly, rather than as an employee’s dependent, is primary and the others are secondary.
2. Dependent children of parents not separated or divorced:
  - a. The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second;
  - b. If both parents have the same birthday, the plan which covers the parent the longer period of time, pays first.

However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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3. Dependent children of separated or divorced parents: When parents are separated or divorced, neither the male/female nor the birthday rules apply. Instead:
  - a. The plan of the parent which custody pays first;
  - b. The plan of the spouse of the parent with custody (the step-parent) pays next; and
  - c. The plan of the parent without custody pays last.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefit of that parent's plan has the actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided during the Plan Year before that entity has actual knowledge, this "court decree" rule is not applicable to those benefits

4. Active/Inactive Employee: The plan covering a person as an employee who is neither laid off nor retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid off or retired employee (or as that person's dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

### **Recovery**

If the amount of the payment made by this Plan is more than it should have paid, the Contract Administrator has the right to recover the excess from one or more of the following:

1. The person this Plan has paid or for which it has paid;
2. Insurance companies;

### **Procedure for Filing a Claim**

Your College of the Sequoias dental and vision plans are administered locally by the Foundation for Medical Care of Tulare and Kings Counties. All payments for covered services and supplies are made through the Foundation.

You do not have an identification card for the vision plan. The Foundation will accept direct billing from your eye care provider, or you may pay the provider and submit a copy of your receipt and the vision examination results to the Foundation for reimbursement.

To use your dental plan, simply present your dental identification card when you first visit your dentist. The card enables the dentist to bill the Foundation for covered services. Payments for benefits of the plan are made to the dentist. If a provider does not bill the Foundation, you should submit your

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completely itemized bill to the Foundation at the address listed in this booklet. No special claim forms are necessary. You will be reimbursed for covered services in the manner described in this booklet.

Your itemized bills must be properly identified showing the following information:

1. Patient's name, date of birth, and relationship to subscriber.
2. Group and subscriber numbers (from your Foundation identification card)
3. Subscriber address
4. Provider (hospital, physician, etc.) name and address
5. Date and type of service
6. Diagnosis
7. Itemization and charge for each service

To facilitate reimbursement for covered services, be sure to write your group and subscriber numbers on all bills. All claims for reimbursements must be submitted to the Foundation within six months after the month of service.

### **Termination of the Plan**

The Employer shall have the right, at any time, to terminate this Plan. The employer makes no promise to continue these benefits in the future and the right to future benefits will never vest. Upon termination, the rights of the Covered Persons to benefits are limited to claims incurred and due up to the date of termination.

### **Amendment of the Plan**

The Employer shall have the right, at any time, to amend this Plan. Any such amendment shall become effective on the date specified in the written document. The Employer will inform all Covered Persons of any amendment modifying the substantive terms of this Plan as soon as possible, but in no event later than two hundred and ten (210) days after the close of the Plan Year in which the amendment was adopted.

### **Claims Review**

The Foundation reserves the right to review all claims to determine whether any exclusion of limitations applies. The Foundation may use the services of physician consultants, peer review committees of professional societies, and other consultants to evaluate claims.