

HIGH PLAINS EDUCATIONAL COOPERATIVE #611

EMPLOYEE DENTAL PLAN

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SCHEDULE OF BENEFITS

DEDUCTIBLE

Individual: \$25.00
Family: \$75.00

The Deductible does not apply to Class I Dental Expenses.

Calendar Year Maximum: \$1,500.00

Temporomandibular Joint Treatment
(and related diagnoses) \$1,000.00

Copayment Percentages:

Class I – Preventive Services	100%
Class II – Basic Services	85%
Class III – Major Services	50%
Class IV – Orthodontia	Not Covered

DEFINITIONS

“Calendar Year” means the period beginning on January 1st of any year and ending on December 31st of that year.

“Copayment” means that portion of eligible expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It, also, is the basis used to determine any out-of-pocket expenses in excess of the annual deductible which is to be paid by the Participant.

Covered Entity means (1) health plans; (2) health care clearinghouses; and (3) health care providers that conduct certain types of transactions in electronic form in relation to HIPAA's administrative simplification rules.

“Dental Hygienist” means an individual who is duly licensed to practice hygiene and acting under the supervision of a dentist within the scope of that license in treating the dental condition.

“Dentally Necessary and Dental Necessity” means a service or treatment which is appropriate and consistent with the diagnosis and which is in accordance with accepted dental standards. The service or treatment must be essential for the necessary care of the teeth and supporting tissues.

“Dental Treatment Plan” means the dentist's report of recommended treatment which contains:

- an itemization of the charges and dental procedures required for the dentally necessary care;
- any supporting preoperative x-rays; and
- any other appropriate diagnostic materials required by the Plan.

“Dentist” means an individual who is duly licensed to practice dentistry and acting within the scope of that license in treating the dental condition.

“Denturist” means an individual who is duly licensed to make dentures and acting within the scope of that license in treating the dental condition.

“Dependent” means the employee's dependent as described below:

- the employee's legally married spouse; and
- the employee's naturally born child, legally adopted child (including a child for whom adoption proceedings have been started and who has no other dental coverage available) or stepchild who is less than 26 years of age.
- the employee's children who are incapable of self-sustaining employment due to mental retardation or physical handicap if said incapacity began prior to the limiting age specified in the second bulleted item above.

Any person who is covered as an employee shall not be considered a dependent, and no person shall be considered as a dependent of more than one employee.

Electronic Protected Health Information (PHI) has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means Protected Health Information (PHI) that is transmitted or maintained in any electronic media.

“Employee” means any certified personnel working at least one-half of the full-time equivalent or school board employee working for High Plains Educational Cooperative #611 (HPEC) on a full-time basis of at least 30 hours per week, or office staff working an average of thirty (30) or more hours per week.

HPEC’s personnel who are seasonal, temporary, part-time (less than 30 hours per week, except for part-time certified personnel), consultants, paraprofessionals, or directors are not considered to be Employees under the Plan.

“Experimental” shall mean: as to other treatment, services or supplies, those that are not approved or generally accepted by the medical/dental profession within the United States as essential to the treatment of the symptoms or diagnosed condition in question.

Indications of experimental treatment may include, but are not limited to:

1. A minimal number of treated patients whose cases have been reported.
2. A randomized clinical study trial that indicates a benefit over conventional therapy has not been established.
3. A threshold for rate of cure or improvement in the quality of life has not been established.
4. Response to therapy is usually of short duration.
5. There is significant risk involved as compared to standard therapy.

The Plan Administrator in its sole discretion shall determine if a drug, medicine, treatment, procedure, service, device or supply is experimental. The Plan Administrator may employ the services of such medical/dental peer review service organizations as the Medical Review Institute or UMAC and utilize data obtained from such national assessment organizations as HCFA, the Office of Health Technology Assessment and Institutes of the Department of Health and Human Services and the American Dental Association (ADA) to aid in its determination.

Health Information means any information, whether oral or recorded in any form or medium, that:

1. is created or received by a health care provider, Health Plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Health Plan means any individual or group plan that provides or pays the cost of medical care (as defined in Section 2791(a)(2) of the PHS Act, 42 U.S.C. § 300gg-91(a)(2)).

“Immediate Family Member” means a person who is related to you in any of the following ways:

- parent,
- spouse,
- child,
- brother, or
- sister.

“Incurred” means the service date relative to expenses covered under this Plan (i.e., the date when the service was actually provided or the date on which the purchase was made), and NOT when the service or purchase is formally billed, charged, or paid.

Individually Identifiable Health Information means a subset of Health Information, including demographic information collected from an individual, and:

1. is created or received by a health care provider, Health Plan, employer, or health care clearinghouse; and
2. relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - a. that identifies the individual; or
 - b. with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

“Injury” means accidental bodily damage occurring unexpectedly and unintentionally while you or any dependents are covered under the Plan.

“Medically Necessary” shall mean that the services or supplies needed to identify or treat the patient’s illness are:

- a. consistent with the symptoms or diagnosis and treatment of the person’s condition;
- b. appropriate by standards of accepted medical practice;
- c. not solely for the convenience of the patient or medical provider; and
- d. not experimental.

“Medicare” means a portion of Title XVIII of the United States Social Security Act of 1965, as amended.

“Metals”

- **“Nonprecious”** means a material which has a combined content of less than 10% gold, platinum and/or palladium.
- **“Precious”** means material which has a combined content of more than 70% gold, platinum and/or palladium.

- **“Semiprecious”** means material which has a combined content of 10 to 70% of gold, platinum and/or palladium.

“Periodontal Prophylaxis” means scaling and polishing of the teeth when the following conditions are, or have been present in the mouth:

1. a moderate or severe amount of redness, swelling and bleeding of the gum tissue;
2. periodontal pockets greater than 4 millimeters deep;
3. bone loss; and
4. a moderate or heavy amount of deposit.

“Person” means you and your covered dependent.

“Plan” means without qualification the Plan Document and the benefits within that document.

“Plan Administrator” means High Plains Educational Cooperative #611 is responsible for the day-to-day functions and arrangement of this Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services.

“Pre-Estimate Review” means the review of a dentist’s statement, including diagnostic x-rays, describing the planned treatment and expected charges.

Protected Health Information (PHI) – means Individually Identifiable Health Information:

1. Except as provided in paragraph (2) of this definition, that is:
 - a. transmitted by electronic media;
 - b. maintained in any media described in the definition of electronic media at 42 CFR § 162.103; or
 - c. transmitted or maintained in any other form or medium.
2. Protected Health Information excludes Individually Identifiable Health Information in:
 - a. education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g;
 - b. records described at 20 U.S.C. § 1232g(a)(4)(B)(iv); and
 - c. employment records held by a Covered Entity in its role as Employer.

“Sickness” means disease or illness of you or your covered dependent while covered under the Plan.

Security Incidents has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Summary Health Information means information that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

“Total Disability or Totally Disabled” means:

1. For you - you are unable to perform each and every duty of your occupation at your customary place of work and are under the regular care of a physician.
2. For your dependent - he or she is unable to engage in his or her normal and customary duties and activities and is under the regular care of a physician.

Transaction means the transmission of information between two parties to carry out financial or administrative activities related to health care.

“Usual, Customary and Reasonable (UCR Charge)” means only that part of a charge which is usual, customary and reasonable is covered. A covered dental expense will include only the lesser of the usual, customary and reasonable charge for a service or supply and is determined as follows:

1. **“Usual Charge”** means the fee regularly charged for a service or supply to the majority of a dentist's patients and accepted as payment in full by and individual dentist office. If more than one fee is charged, the fee determined to be the usual fee will not be greater than the lowest fee which is regularly charged or offered to patients.
2. **“Customary Charge”** means the fee for a given service or supply which, as determined by the Plan does not exceed the amount ordinarily charged by the majority of dentists in the locality. Locality is either a county or such geographically significant area as is necessary to establish a representative base of charges for the type of service for which the charge is made.
3. **“Reasonable”** means if the usual and customary charge for a service or supply cannot be determined because of the unusual nature of the service or supply, the Plan Administrator will determine to what extent the charge is reasonable, taking into account:
 - a. the complexity involved;
 - b. the degree of professional skill required; and
 - c. other pertinent factors.

“You, Your” means an employee covered under the Plan.

DENTAL EXPENSES BENEFITS

The Plan will pay benefits for covered dental expenses identified in the Plan document when incurred by you or your dependent, while covered under the Plan. The Plan will pay the co-payment percentage shown in the Schedule of Benefits after you or your covered dependent has satisfied any deductible requirements for the calendar year.

Covered dental expenses will only include services provided to you or your covered dependent for which, as outlined in the Covered Dental Expenses section, the date started and the date completed is while the individual is covered under the Plan. No payment will be made for a program of dental treatment already in progress on the effective date of your or your dependent's coverage.

Deductible

The deductible is the amount shown in the Schedule of Benefits and will be applied to each class of dental services as indicated in your Schedule of Benefits. The deductible is the amount of covered dental expenses that you and your covered dependents must incur in a calendar year before the Plan will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to the Claims Administrator, the deductible will be satisfied. The Plan will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a calendar year, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that calendar year.

The deductible will apply to you and each covered dependent separately each calendar year except as stated in the Maximum Family Deductible section.

Maximum Family Deductible

The family deductible is shown in your Schedule of Benefits. It indicates the number of persons who must satisfy his or her deductible in order to satisfy the family deductible. Once that number of persons have each satisfied a deductible for a calendar year, the Plan will consider each person's deductible to be satisfied for that calendar year.

Maximum Calendar Year Benefit

The maximum benefit payable to you and your covered dependent during a calendar year is shown in the Schedule of Benefits. This maximum will apply even if coverage is interrupted or if you or your covered dependent has been covered both as an employee and a dependent.

The maximum benefit payable to you or your covered dependent during a calendar year for a fixed bridge is the amount of the maximum calendar year benefit remaining on the date the fixed bridge is actually cemented in the mouth.

Maximum Benefit for Temporomandibular Joint (TMJ)

The maximum benefit payable to you or your covered dependent for treatment of Temporomandibular Joint Dysfunction (including, Myofascial Pain Syndrome, or treatment of muscular, neural, or skeletal disorder, dysfunction or disease or temporomandibular joint including treatment of the muscles of mastication to relieve pain and/or muscle spasm) is shown in the Schedule of Benefits. Any benefits applied to this maximum will also be applied to the Maximum Calendar Year Benefit.

COVERED DENTAL EXPENSES

Covered dental expenses include only the lesser of the usual or customary expenses incurred by you or your covered dependent. The services or treatment must be:

1. performed by or under the direction of a dentist, or performed by a dental hygienist or denturist;
2. dentally necessary; and
3. started and completed while you or your dependent are covered under the Plan, except as provided in the Extension of Benefits provisions.

The Plan considers a dental service to be started as follows:

- For a full or partial denture, the date the first impression is taken
- For a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared.
- For root canal therapy, the date a canal is first explored.
- For periodontal surgery, the date the surgery is actually performed.
- For all other services, the date a service is actually performed.

The Plan considers a dental service to be completed as follows:

- For a full or partial denture, the date a final completed appliance is inserted in the mouth.
- For a fixed bridge, crown, inlay or onlay, the date an appliance is cemented in place.
- For root canal therapy, the date a canal is permanently filled.

Expenses submitted to the Claims Administrator should identify the services performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by narrative description. The Plan reserves the right to request x-rays, narratives and other diagnostic information, as seen fit to determine benefits.

The Plan will only pay for dental expenses which, in our opinion, have a reasonably favorable prognosis.

The Plan considers a temporary service to be an integral part of the final service. The sum of the fees for temporary and permanent services will be used to determine whether the charges are usual, customary, and reasonable.

The following is a complete list of covered dental expenses. The Plan will not pay benefits for expenses incurred for any service not listed in the Plan booklet unless the Plan Administrator agrees to accept such service as a covered dental expense. If payment of a service that is not listed is approved, it will be covered on the same basis as a service which is included in the list.

CLASS I: PREVENTIVE DENTAL SERVICES

Procedure	Limitation
Oral Examination	Limited to two times in any 12-month period.
Emergency Oral Examination	As Dentally Necessary.
Complete Mouth Survey or Panoramic X-ray	Limited to one time in any 36-month period. Includes bitewings and 10 to 14 periapical X-rays.
Individual Periapical X-rays	As Dentally Necessary.
Occlusal X-rays	Limited to two films in any 12 month period.
Extraoral X-rays	Limited to two films in any 12 month period.
Bitewing X-rays	Limited to one time in any 12 month period.
Other X-rays (except TMJ X-rays)	As Dentally Necessary.
Dental Prophylaxis	Limited to two times in any 12 month period.
Fluoride Treatment	Limited to children under age 24 and two times in any 12 month period.
Palliative (temporary) Treatment	Paid as a separate benefit only if no other services (except X-rays) is rendered during the visit.
Sealants	Limited to one time per tooth every 48 months. Allowed only for permanent molar teeth on children to age 24.
Space Maintainers	Limited to children to age 25 and all adjustments made within six months of installation.
Bacteriological Studies	As Dentally Necessary.
Histopathological Examination	As Dentally Necessary.
Consultation or Office Visit	No benefit payable if any other covered dental service performed on the same day.

CLASS II: BASIC DENTAL SERVICES NON-RESTORATIVE

Procedure	Limitation
Stainless Steel Crowns	Covered only when tooth cannot be restored by a filling and then only one time in a consecutive 36-month period.
Scaling and Root Planing, Gingivectomy, Gingival Curettage, Osseous Grafts, Mucogingival or Osseous Surgery, Pedicle Grafts, Tissue Grafts, Vestibuloplasty	These services and surgical procedures are limited to one time per quadrant of the mouth in any 36 consecutive month period. Charges will be combined for each of these procedures performed in the same quadrant within the same 36-month period.
Periodontal Appliance	Limited to one application in any 12-month period.
Root Canal Therapy	Includes all pre-operative and post-operative X-rays and follow-up care. Limited to one time on same tooth in any 24 consecutive months.
Periodontal Prophylaxis	Limited to two dental prophylaxis or two periodontal prophylaxis in any 12-month period.
Intravenous Sedation	Paid as a separate benefit only if required for complex oral procedures (as determined by the Plan Administrator) which are covered under the Plan.
Re-Cement Inlays	As Dentally Necessary.
Re-Cement Crowns	As Dentally Necessary.
Pulpotomy	As Dentally Necessary.
Hemisection	As Dentally Necessary.
Provisional Splinting	No payment will be made for crowns or inlays for the purpose of periodontal splinting.
Tissue Conditioning	Limited to repairs or adjustment performed more than 12 months after initial insertion.
Re-Cement Bridges	Limited to repairs or adjustment performed more than 12 months after initial insertion.
Simple Extraction	As Dentally Necessary.
Surgical Extractions (including extraction of impacted teeth)	As Dentally Necessary.
Root Recovery	As Dentally Necessary.
Biopsy	As Dentally Necessary.
Excision of Pericoronal Tissues	As Dentally Necessary.
Incision and Drainage	As Dentally Necessary.
Therapeutic Drug Injections	As Dentally Necessary.

CLASS II: BASIC DENTAL SERVICES - RESTORATIVE

Procedure

Limitation

Amalgam Restorations

Multiple restorations on one surface will be paid as a single filling. Includes polishing.

Pin Retention Restorations

Covered only in conjunction with an amalgam or composite restoration; pins limited to one time per tooth.

Silicate Restorations

As Dentally Necessary.

Plastic Restorations

As Dentally Necessary.

Composite Restorations

Mesial-lingual, distal-lingual, mesial-buccal, and restorations on anterior teeth will be considered single surface restorations. (Acid etch is not covered as a separate procedure.)

CLASS III: MAJOR DENTAL SERVICES

All benefits for the services listed below include an allowance for all temporary restorations and appliances, and one year follow-up care.

Procedure

Limitation

Gold (precious metal inlays and onlays)

Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than five years has elapsed since last placement.

Porcelain Restoration on Anterior Teeth

As Dentally Necessary.

Nonprecious Metal Crowns

Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than 60 months have elapsed since last placement.

Post and Core

Covered only for endodontically treated teeth requiring crowns.

Crown and Build-Up

Includes pins and/or prefabricated posts.

Full Dentures

There are no additional benefits for over dentures, customized dentures, duplication of dentures or assorted procedures.

Partial Dentures

There are no additional benefits for precision or semi-precision attachments. A partial denture includes two clasps and rests.

Repairs to Full of Partial Dentures, Bridges
Crowns and Inlays

Limited repairs or adjustments performed more than 12 months after initial insertion.

Each Additional Clasp and Restoration

As Dentally Necessary

Denture Adjustments

Only covered one time in any 12-month period, and only if performed more than 12 months after the insertion of the denture.

Procedure

Relining or Rebased Dentures

Fixed Bridges

Maryland Bridge

Tooth Re-Plantation

Tooth Transplantation

Alveoplasty

Stomatoplasty

Removal of Exostosis

Frenectomy (Frenulectomy)

Excision of Hyperplastic Tissue

Orthognathic Surgery

Treatment of TMJ

Limitation

Limited to relining or rebasing done more than 12 months after the initial insertion, and not more than one time in any 36 month period.

The maximum benefit payable for a single fixed bridge will be applied to one calendar year maximum and cannot be applied to multiple calendar years maximums.

As Dentally Necessary.

As Dentally Necessary.

As Dentally Necessary.

As Dentally Necessary.

As Dentally Necessary.

As Dentally Necessary.

As Dentally Necessary.

As Dentally Necessary.

As Dentally Necessary.

The benefit does not include any allowance for: appliances for tooth movement or guidance; electronic diagnostic modalities; occlusal analysis; or muscle testing. This benefit includes coverage for TMJ X-rays and occlusal adjustments. The maximum Benefit for Temporomandibular Joint (TMJ) Treatment and the Maximum Calendar Year Benefit are show in your Schedule of Benefits.

PRE-ESTIMATE

If the charge for any dental treatment is expected to exceed \$300, a dental treatment plan should be submitted to the Claims Administrator for review before treatment begins. An estimate of the benefits payable will be sent to you and the dentist.

In estimating the amount of benefits payable, the plan will consider whether or not an alternate procedure may accomplish a professionally satisfactory result. If you and/or your covered dependent and the dentist agree to a more expensive method than that pre-estimated by the Claims Administrator, the Plan will not pay the excess amount.

The pre-estimate is not an agreement for payment of the dental expenses. The procedure lets you and or your covered dependent know in advance approximately what portion of the expenses will be considered.

ALTERNATE PROCEDURE

If an alternate procedure, service, or course of treatment can be performed to correct a dental condition, the maximum covered dental expense that will be considered for payment will be the most economical procedure which will, as determined by the Plan, produce a professionally satisfactory result.

SPECIAL LIMITATIONS

Late Entrant Limitation

If you did not elect coverage within 31 days after you or your dependent first became eligible, you and/or your dependents are late entrants. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

1. Until the late entrant has been covered under the Plan for 12 months consecutively , benefits will include coverage for only Class I and Class II restorative services; and
2. Until the late entrant has been covered under the Plan for 24 months consecutively, benefits for the second 12 months will then include coverage for Class I and Class II restorative and nonrestorative services.

Missing Teeth Limitation

The Plan will not pay benefits for replacement of teeth missing on or before you or your covered dependent's effective date of coverage for the initial placement of a full denture, partial denture or fixed bridge. However, the Plan will consider expenses as follows:

1. The initial placement of full or partial dentures will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while covered under this Plan.
2. The initial placement of a fixed bridge will be considered a covered dental expense if the placement includes the initial replacement of a functioning natural tooth extracted while covered under this Plan. Replacement will include only teeth extracted while covered under this Plan and will not extend to other teeth previously missing prior to the effective date of Dental coverage.

Dental or Bridge Replacement/Addition

The Plan will not pay benefits for the replacement of a full denture, partial denture, fixed for teeth added to a partial denture except as follows:

1. If you or your covered dependent has been covered for less than 24 months, the replacement of a full denture, or partial denture , fixed bridge or teeth added to a partial will be considered a covered dental expense only if:
 - a. necessary because a functioning tooth is extracted while covered under the Plan;
 - b. replacement is within 12 months of the extraction.

GENERAL EXCLUSIONS

The Plan will not pay benefits for expenses incurred for any of the following:

1. Procedures which are:
 - a. not included in the list of covered dental services;
 - b. not dentally necessary; or
 - c. which do not have uniform professional endorsement.
2. Crowns for teeth that are restorable by other means or the purpose of periodontal splinting.
3. Procedures, appliances or restoration (except full dentures) whose primary purpose is for bite registration, bite analysis, cosmetic purpose or to alter vertical dimension.
4. An implant, related appliance or the surgical removal of implants.
5. Replacement of lost or stolen appliance (including retainers, athletic mouthguards myofunctional appliances, etc.) or prosthesis (including precision or semi-precision attachments or dentures).
6. Educational procedures (e.g. oral hygiene, plaque control or dietary instructions), completion of claim forms, missed dental appointments, or personal supplies or equipment (e.g. Water pik, toothbrush, floss holder).
7. Treatment for a jaw fracture.
8. Orthodontic treatment.
9. Procedures which are covered under any other plan established by High Plains Educational Cooperative #611 which provides group hospital, surgical, dental or medical benefits.
10. Services provided by a dentist, dental hygienist, denturist or physician who is a member of the person's immediate family or ordinarily resides with the person.
11. Hospital or facility charges for room, supplies or emergency room expenses; or routine chest x-rays and medical exams prior to oral surgery.
12. Services for any dental treatment performed outside the United States or Canada except for emergency treatment. Emergency treatment is a dental condition of a

serious nature, developing suddenly and unexpectedly, and demanding immediate treatment.

13. A dental service which results from or in the course of a person's regular occupation for pay or profit. (A corporate officer, partner, or sole proprietor of the participating employer who is not eligible for coverage under Worker's Compensation, Employer's Liability, or similar law, will have 24 hour coverage.)

A dental service for which a person is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law, or similar law; you must promptly claim and notify the Claims Administrator of such benefits.

14. Treatment, service or supply for which these conditions exist:
- a. charges payable or reimbursable by or through a plan or program of any governmental agency, except if the change is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, the Plan will reimburse any state or local medical assistance (Medicaid) agency for covered dental expenses.
 - b. charges are not imposed against the person or for which the person is not liable.
 - c. charges are reimbursable by Medicare Part A & Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under the Plan will be reduced by any amount that would have been reimbursed by Medicare, where permitted by law.

15. Administration of General Anesthesia.

COORDINATION WITH OTHER BENEFIT PLANS

If you or your covered dependent has other dental coverage in addition to coverage under the High Plains Education Cooperative Dental Plan, when benefits are paid they will be coordinated with the benefits from the "other plan." The intent is to provide combined benefits which equal no more than 100% of the total covered dental expenses. Submit all claims to the Claims Administrator and all other providers of dental coverage at the same time so that the proper benefits can be quickly determined and paid.

"Other Plan" means any other plan or insurance which provides dental expenses benefits or services by:

1. group, blanket or franchise insurance;
2. service plan or contract, group or individual practice or other pre-payment plan;
3. any employer or employee self-insurance plan;
4. coverage arranged through any trustee, union, employee benefit or association; or
5. no-fault automobile insurance (but only where permitted by law).

If you or your covered dependent is entitled to benefits provided by another plan but does not claim them, the Plan will consider the benefits to which you or your covered dependent is entitled as benefits provided.

The Claims Administrator has the right to:

1. release or obtain claim information from any other organization or individuals;
2. pay out normal benefit to any organization which has paid benefits that the Plan should have paid; and
3. recover any overpayment made by us from the person to whom the payment was made.

The Plan contains the full details of this provision. The Plan also gives the order of benefit determination if any other plan has a similar provision. You may obtain additional information about this provision from the Plan Administrator.

ELIGIBILITY FOR COVERAGE

The Plan has the right to verify your and your covered dependent's eligibility at any time before or while coverage is in force.

Employee

Any employee is eligible for coverage under this Plan after completion of any required waiting period, unless he or she is a member of a class of employees who are excluded from being eligible.

You will become eligible for coverage on the latest of the following dates:

1. the effective date of the Plan;
2. the date you become eligible as specified by the Plan.
3. the date the Plan is amended to include your classification; or
4. the date you become a member of a classification eligible for coverage under this Plan.

An employee must continue to:

1. meet the definition of employee as defined in the Definitions section;
2. be a member of a class covered under the Plan; and
3. make any required contribution.

If High Plains Educational Cooperative has two or more employees in the same family who are eligible as both an employee and a dependent under this Plan, the following will apply:

1. an employee may not be covered as both an employee and a dependent; and

2. based on the employee's age, the older employee will be covered as the covered employee and the younger employee will be covered as the dependent of the covered dependent.

Dependent

Your dependent is eligible for coverage on the latest of the following dates:

1. the date you become eligible for coverage;
2. the date a person becomes a dependent as defined in the Definitions section;
3. the date the dependent's coverage is effective; or
4. the date the Plan is amended to include your classification as being eligible for dependent coverage.

Coverage for Handicapped Child

If a dependent child is not capable of self-sustaining employment because of mental retardation or physical handicap, his or her coverage will not terminate at the age stated in the definition of Dependent. The coverage will continue as long as the child remains handicapped, unless otherwise terminated as described in the Termination section. If you give us proof within 31 days after the child reaches the limiting age and at any reasonable time after that as the Plan Administrator may require. We will not require proof more than once a year after the two-year period following the date the child reaches limiting age.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within sixty (60) days from the date of the following loss of coverage or gain in eligibility:

1. The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
2. The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the spouse) may be enrolled under this Plan and, the Employee must be enrolled.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. The effective date of coverage will begin the first day following the date of loss of coverage or gain in eligibility.

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and

amended from time to time, to the extent that the State law is applicable to the Employer and its Employees.

For more information regarding your special enrollment rights, contact the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

Employee

Your coverage will take effective on the day you become eligible.

1. If you apply for coverage on or before the date you are eligible for coverage, your coverage will take effect on the date of eligibility.
2. If you apply for coverage within 31 days after you first become eligible, coverage will take effect on the first day of the following month.
3. If you apply for coverage more than 31 days after the date you first become eligible, your coverage will take on the first day of the next month following the approval of your Late Entrant Enrollment Application as called for in the Special Limitations section.

Dependent

Your eligible dependents will not be covered until you are covered under the Plan.

Coverage on an eligible dependent will take effect on the first day of the following month that he or she becomes eligible.

1. If you apply for dependent coverage on or before the date you are eligible for coverage, your coverage will take effect on the date of eligibility.
2. If you apply for dependent coverage within 31 days after you first become eligible, coverage will take effect on the first day of the following month.
3. If you apply for dependent coverage more than 31 days after the date you first become eligible, your coverage will take on the first day of the next month following the approval of your Late Entrant Enrollment Application as called for in the Special Limitations section.

No dependent's coverage will take effect on the date the dependent (other than a newborn child) is hospital confined or disabled so as to be unable to engage in his or her customary duties, activities. Instead it will become effective on the first day after the date the dependent resumes his or her customary duties and activities.

Newborn

Coverage on a newborn dependent child will take effect at birth if:

1. at the time the child is born, you have dependent's coverage under the Plan or any other dependent child; or
2. you apply for dependent coverage on the dependent child and pay any required premium contribution within 31 days after the child's birth.

Adopted Child

Coverage on an adopted child will take effect when the child becomes a dependent as defined in the Definitions section.

Effective Date of Change in Specific Benefits

If a specific benefit is modified, added or terminated, the effective date of such change in benefit, with respect to you or your dependent's coverage, will be the date that benefit is modified, added or terminated.

TERMINATION**Termination of Specific Benefits**

Your coverage or your dependent's coverage with respect to a specific benefit will terminate on the date that benefit terminates.

Employee

Your coverage will terminate on the earliest of the following:

1. the date you terminate employment (employment is considered to terminate when you stop working for High Plains Educational Cooperative, including layoff or leave of absence);
2. the date you no longer meet the definition of an employee as defined under the Definitions section;
3. the date you cease to be a member of a classification eligible for coverage under the Plan;
4. the day before the date you join, on a full-time basis, the military forces of any country or the service of any governmental agency involving employment outside the United States; or
5. the date the Plan terminates; or
6. otherwise coverage will cease for certified employees on the date established by the negotiated agreement.

Dependent

Coverage on your dependents will terminate the earliest of the following:

1. the date your dependent ceases to be a dependent as defined in the Definitions section.
2. the date you cease to be a member of a classification eligible for dependent's coverage;
3. the date your coverage under the Plan terminates;
4. the day before the date a dependent joins, on a full-time basis, the military forces of any country or the service of any governmental agency involving employment outside the United States; or
5. the date the Plan terminates.

EXTENSION OF BENEFITS

If you or your dependent's coverage under the Plan terminates, any claim for dental services rendered on a specific tooth prior to termination will not be affected as follows:

1. the plan will extend benefits for services for a period not to exceed 30 days after the date of termination;
2. any extension of benefits will be subject to payment of the maximum yearly benefit and other limitations of the Plan. The extension will not apply if High Plains Educational Cooperative terminates the Plan and it is replaced with another type of dental coverage.

HIPAA PRIVACY AND SECURITY INFORMATION

DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI") TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

- i. The following employee(s), or class(es) of employee(s), or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Treasurer and Privacy Officer

- ii. The access to and use of PHI by the individual(s) described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
- iii. In the event any of the individual(s) described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from coverage by the Plan to the Plan Sponsor.

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

PLAN SPONSOR OBLIGATIONS REGARDING SECURITY OF ELECTRONIC PHI

Where Electronic Protected Health Information (PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information (PHI) as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information (PHI) that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information (PHI) agrees to implement reasonable and appropriate security measures to protect such Information; and
4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information (PHI); and
 - b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis annually, or more frequently upon the Plan's request.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (i.e., COBRA continuation coverage) in certain instances where coverage under the plan would otherwise end. The information contained in this section of the plan is intended to inform covered persons and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final regulations published by the Department of the Treasury. This information is intended to reflect the law and does not grant or take away any rights under the law. This information generally explains COBRA continuation coverage, when it may become available, and what is needed to protect the right to receive it. Complete instructions on COBRA and other information will be provided by the Plan Administrator. COBRA election forms will be provided by the COBRA administrator at Employee Benefit Management Services, Inc. to covered employees and their covered dependents who become qualified beneficiaries under COBRA.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of plan coverage that the employer must offer to certain covered employees and their covered dependents (i.e., qualified beneficiaries) at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of certain life events, known as "qualifying events," that result in the loss of coverage under the terms of the employer's plan. The coverage must be identical to the plan coverage that the qualified beneficiary had immediately before the qualifying event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly-situated active employees who have not experienced a qualifying event (i.e., similarly situated non-COBRA beneficiaries).

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, it should be taken into account that a failure to elect COBRA will affect future rights under federal law. First, the right to avoid having pre-existing condition exclusions applied by other group health plans may be lost if there is more than a sixty-three (63)-day gap in health coverage. Electing COBRA may help avoid that gap. Second, the right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions may be lost if COBRA coverage is not chosen for the maximum time available. Finally, the right to special enrollment under HIPAA for another group health plan may be lost if COBRA coverage is not chosen for the maximum time available.

QUALIFIED BENEFICIARY

In general, a qualified beneficiary is:

1. Any individual who, on the day before the qualifying event, is covered under the plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of a covered employee. If, however, an individual is denied or not offered coverage under the plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual

will be considered to have had the plan coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.

2. Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the plan coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
3. A covered employee who retired on or before the date of substantial elimination of plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the employer, and/or the spouse, surviving spouse or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse or dependent child was a beneficiary under the plan.

An individual is **not** a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

Each qualified beneficiary, including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, shall be offered the opportunity to make an independent election to receive COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their eligible spouses, and parents may elect COBRA continuation coverage on behalf of their eligible dependent child(ren). Each qualified beneficiary who elects COBRA will have the same rights under the plan as other participants or beneficiaries covered by the plan(s) elected by the qualified beneficiary including open enrollment and special enrollment rights. Under the plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

A child of the covered Employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the employer during the covered employee's period of employment with the employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

QUALIFYING EVENT

A qualifying event is any of the following if the Plan provides that the covered employees and their covered dependents would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage:

1. The death of a covered employee.
2. The voluntary or involuntary termination (other than by reason of the employee's gross misconduct) of the covered employee's employment.
3. The reduction of hours of a covered employee's employment.

4. The divorce or legal separation of a covered employee from his/her spouse.
5. A covered employee's entitlement to the Medicare program (under Part A, Part B, or both).
6. A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (e.g., attainment of the maximum age for dependency under the plan).
7. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an employer from whose employment a covered employee retired at any time.

If the qualifying event causes the covered employee, or the spouse or a dependent child of the covered employee to cease to be covered under the plan under the same terms and conditions as in effect immediately before the qualifying event (or in the case of the bankruptcy of the employer, any substantial elimination of coverage under the plan occurring within twelve [12] months before or after the date the bankruptcy proceeding commences), the person(s) losing such coverage become qualified beneficiary(ies) under COBRA if all other conditions of the COBRA law are also met.

The taking of leave under the Family and Medical Leave Act (FMLA) of 1993 does not constitute a qualifying event. A qualifying event occurs, however, if a covered employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a qualifying event occurs, it occurs on the earlier of: a) the last day of FMLA leave if the covered employee is not returning to employment; or b) the date the covered employee gives notice to the employer that he/she will not be returning to employment. The applicable maximum coverage period is measured from this date (i.e., unless coverage is lost at a later date and the plan provides for the extension of the required periods, in which case the maximum coverage period is measured from the date when the coverage is lost). Note that the covered employee and eligible family members will be entitled to COBRA continuation coverage even if they fail to pay the employee portion of premiums for coverage under the plan during the FMLA leave as long as they were covered on the day before the first day of the leave or become covered during the FMLA leave.

NOTIFICATION OF QUALIFYING EVENT

When the qualifying event is the end of employment, reduction of hours of employment of the employee, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare Benefits under Part A, Part B, or both, the plan will send election notices regarding the rights of COBRA continuation coverage to qualified beneficiaries, as applicable. Notification to the plan of these five (5) events is not typically required by the employee, spouse of the employee, or other dependent of the employee.

For the other qualifying events, the plan will send election notices regarding the rights of COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified by the employee, spouse of the employee or other dependent of the employee that a qualifying event has occurred.

Employee/Qualified Beneficiary Notice Requirements

Each covered employee or qualified beneficiary is responsible for notifying the Plan Administrator in writing of the occurrence of a qualifying event that is:

1. a dependent child's ceasing to be a dependent child under the generally applicable requirements of the Plan;
2. the divorce or legal separation of the covered employee;
3. a second qualifying event;
4. a qualified beneficiary who is entitled to receive continuation with a maximum duration of eighteen (18) months, and he/she is determined, at any time during the first sixty (60) days of COBRA, by the Social Security Administration to be disabled; and
5. a qualified beneficiary ceasing to be disabled.

The written notice to the Plan Administrator of any of the above qualifying events by the employee or qualified beneficiary is required. Such notification shall be acceptable if either: 1) a form provided by the plan is completed and returned to the Plan Administrator; or 2) the following information is provided in writing (e.g., letter format) to the Plan Administrator:

1. the name of the plan;
2. the name and address of the employee or former employee who is or was covered under the plan;
3. the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event, as applicable;
4. the qualifying event, the second qualifying event, disability determination and/or statement of cessation of disability;
5. the date that the qualifying event occurred, the second qualifying event occurred, the date of the disability determination and/or the date of cessation of disability; and
6. the signature, name and contact information of the individual sending the notice.

For divorce and legal separation notices, please include a copy of the decree of divorce or legal separation.

The time period the qualified beneficiary has to furnish a notice to the Plan Administrator of a qualifying event that is a dependent child ceasing to be a dependent, a divorce or legal separation or the occurrence of a second qualifying event is within sixty (60) days after the latest of: 1) the date of the qualifying event; 2) the date on which the qualified beneficiary loses (or would lose) coverage due to the qualifying event; or 3) the date on which the qualified beneficiary is informed, through the Plan Document/SPD or the general notice, of his/her obligation to provide notice including the applicable procedures he/she must follow to provide such notice.

The time period the qualified beneficiary has to furnish a notice of a disability determination to the Plan Administrator is within sixty (60) days after the latest of: 1) the date of the Social Security Administration disability determination; 2) the date on which the qualifying event occurs; 3) the date on which the qualified beneficiary loses (or would lose) coverage due to the qualifying event; or 4) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice including the

applicable procedures he/she must follow to provide such notice. However, such notice must be given to the Plan Administrator before the end of the first eighteen (18) months of COBRA continuation coverage.

The time period the qualified beneficiary has to furnish a notice to the Plan Administrator that a qualified beneficiary is no longer disabled is within thirty (30) days after the later of: 1) the date of the final determination by the Social Security Administration that the individual is no longer disabled; or 2) the date on which the individual is informed of the obligation to provide such notice including the applicable procedures he/she must follow to provide such notice.

All notices of qualifying events to the Plan Administrator must be in writing and mailed or hand delivered to:

**Treasurer and Privacy Officer
High Plains Educational Cooperative #611
621 E. Oklahoma
Ulysses, KS 67880**

Oral notice, including notice by telephone, is **not** acceptable. Electronic notices (including email or facsimile) are not acceptable. If mailed, the notice must be postmarked no later than the deadline described above. If hand-delivered, the notice must be received by the individual at the address specified above no later than the deadline described above.

COBRA ELECTION PERIOD

An election period is the time period within which the qualified beneficiary can elect COBRA continuation coverage under the employer's plan. A plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period.

Once the plan has been adequately notified of a qualifying event, a COBRA election notice shall be sent within fourteen (14) days for a qualifying event that is divorce, legal separation or a dependent child's ceasing to be a dependent child under the generally applicable requirements of the plan, and within forty-four (44) days for a qualifying event that is termination of employment, reduction of hours of employment, the employee's death, the employee's becoming entitled to Medicare, or the employer's bankruptcy. The qualified beneficiary shall have sixty (60) days after the date that Plan coverage terminates or, if later, sixty (60) days after the date the election notice is sent to make an election for COBRA continuation coverage.

Failure to make a timely election as stated above may forfeit the qualified beneficiary's opportunity to continue his/her coverage under COBRA.

Under the Trade Act of 2002, certain individuals who become eligible for trade adjustment assistance (TAA) will be allowed a second, sixty (60)-day COBRA election period. An individual, who is either an eligible TAA recipient or an eligible alternative TAA recipient and who did not elect continuation coverage during the initial sixty (60)-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, may elect continuation coverage during a second sixty (60)-day period that begins on the first day of the month in which he/she is determined to be a TAA-eligible

individual provided such election is made not later than six (6) months after the date of the TAA-related loss of coverage. The individual may elect coverage for both himself/herself and his/her eligible family members. Any continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed. However, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has had a sixty-three (63)-day break in coverage under HIPAA. Please notify the Employer promptly after qualifying for TAA or alternate TAA, or the right to elect COBRA during a special second election period may be lost.

NOTICE OF UNAVAILABILITY OF COBRA CONTINUATION COVERAGE

If the plan determines that a covered employee or covered dependent or qualified beneficiary who furnished the plan with a notice of a qualifying event, a notice of a second qualifying event or disability determination is not entitled to COBRA continuation coverage or an extension of the original maximum coverage period, then the Plan will provide the individual(s) with a notice of unavailability of COBRA coverage. In general, such notice is required to be provided when the Plan Administrator denies COBRA continuation coverage because it has determined that no qualifying event has occurred, because the individual did not furnish the notice of qualifying event in a timely manner, or he/she did not provide complete information about the qualifying event.

Delivery of such notice shall be made to the individual by the plan within the same time frames that would apply for providing an election notice had the individual been eligible for COBRA continuation coverage (i.e., within fourteen [14] days for a qualifying event that is divorce, legal separation or a dependent child's ceasing to be a dependent child under the generally applicable requirements of the plan, and within forty-four [44] days for a qualifying event that is termination of employment, reduction of hours of employment, the employee's death, the employee's becoming entitled to Medicare, or the employer's bankruptcy).

One notice may be sent to all qualified beneficiaries residing at the same residence, and separate notices for qualified beneficiaries residing at different residences. Such notice is considered furnished as of the date of mailing or when it is actually received when hand-delivered.

If an employee or qualified beneficiary(ies) believe his/her rights to continuation coverage have been improperly denied, he/she may request a review of the Plan Administrator's decision by contacting the Plan Administrator in writing at the address specified in this Plan document's Summary Plan Description section. Such request for review needs to: 1) be sent within thirty (30) days of receipt of the notice of unavailability of COBRA continuation coverage; and 2) explain why you believe that COBRA continuation coverage must be provided including all information that should be reviewed. Please include your name, current address, and the names of any other individuals' coverage to be reviewed in the appeal. The Plan Administrator will respond to the request for review within fourteen (14) days of its receipt.

ELECTING COBRA COVERAGE

To elect COBRA, the election form that is part of the Plan's COBRA election notice must be completed and submitted to the COBRA administrator at Employee Benefit Management Services, Inc.

Mail or hand-deliver the completed election form to:

**COBRA Administrator
Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575**

The election form must be completed in writing and mailed or hand-delivered to the individual and address specified above. The following are **not** acceptable as COBRA election and will not preserve COBRA rights: oral communications regarding COBRA coverage including in-person or telephone statements about an individual's COBRA coverage; and electronic communications (including email or facsimile)

If mailed, the election form must be postmarked (and if hand-delivered, the election form must be received by the individual at the address specified above) no later than sixty (60) days after the date that Plan coverage terminates or, if later, sixty (60) days after the date the COBRA election notice was sent. **If the election form is not completed and submitted by this due date, the right to elect COBRA will be lost.**

WAIVER OF COBRA CONTINUATION COVERAGE

If, during the sixty (60)-day election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is revoked during the election period, coverage will **not** be provided retroactively (i.e., coverage will not be provided for the period of time from the date of loss of coverage until the date the waiver was revoked). Coverage will only be provided beginning on the date the waiver is revoked. Waivers and revocations of waivers are considered made on the date they are sent to the employer or Plan Administrator, as applicable. Waiver of COBRA continuation coverage can only be made by the qualified beneficiary to whom the coverage relates (e.g., a spouse cannot waive coverage for the employee or vice versa).

MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE

The maximum coverage periods are based on the type of the initial qualifying event and the status of the qualified beneficiary, as shown below.

1. In the case of a qualifying event that is a termination of employment or reduction of hours of employment and there is not a disability extension, the maximum coverage period ends eighteen (18) months after the qualifying event or the loss of coverage, whichever is later.
2. In the case of a covered employee's entitlement to the Medicare program before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered employee ends on the later of:
 - a. thirty-six (36) months after the date the covered employee became entitled to the Medicare program; or

- b. eighteen (18) months after the date of the covered employee's termination of employment or reduction of hours of employment, or loss of coverage, whichever is later.
3. In the case of a bankruptcy qualifying event, the maximum coverage period for a qualified beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a qualified beneficiary who is the spouse, surviving spouse or dependent child of the retired covered employee ends on the earlier of the date of the qualified beneficiary's death or the date that is thirty-six (36) months after the death of the retired covered employee.
4. In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the maximum coverage period is the remainder of the maximum coverage period applicable to the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption (e.g., if a child is born during the fifth [5th] month of the Employee's eighteen [18]-month COBRA coverage due to termination of employment, then that child's COBRA coverage would continue for thirteen [13] months only).
5. In the case of any other qualifying event than that described above, the maximum coverage period ends thirty-six (36) months after the qualifying event (i.e., death of the employee, the employee's divorce or legal separation from his/her spouse, or a dependent child's losing eligibility as a dependent child).

DISABILITY EXTENSION OF COBRA COVERAGE

A disability extension of COBRA coverage may be granted if the employee, his/her spouse or dependent child(ren) who are covered under the plan is/are determined by the Social Security Administration to be disabled. If such determination is made, the employee and his/her spouse, and/or child(ren) who are qualified beneficiaries may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage for a total maximum of twenty (29) months if he/she remains disabled during the first eighteen (18) months of COBRA coverage. To qualify for the disability extension, the qualified beneficiary must provide the Plan Administrator with written notice of the disability determination.

Please see the "Notification of Qualifying Event" subsection for information about providing notice of a disability determination to the Plan Administrator.

SECOND QUALIFYING EVENT EXTENSION OF COBRA COVERAGE

If while receiving eighteen (18) months of COBRA continuation coverage a second qualifying event occurs that allows for up to an additional eighteen (18) months of COBRA continuation coverage (i.e., for a maximum of thirty-six [36] months), the spouse and dependent child(ren) may be eligible for the extension of the COBRA coverage if notice of the second qualifying event is properly given to the plan. The spouse and dependent child(ren) must be qualified beneficiaries at the time of both qualifying events. Such second qualifying events that could expand the original coverage period from eighteen (18) months up to thirty-six (36) months are if the former employee: 1) dies, 2) becomes entitled to Medicare benefits (under Part A, Part B or both), 3) gets divorced or legally separated. Additionally, if the dependent child is no longer eligible under the plan

as a dependent child, this could be a second qualifying event. Under no circumstances can the COBRA maximum coverage period be expanded to more than thirty-six (36) months after the date of the determination and before the end of the original eighteen (18)-month maximum coverage. In order for the COBRA continuation coverage to be eligible to be extended, any such second qualifying event would have to cause the spouse or dependent child(ren) to lose coverage under the plan had the first qualifying event not occurred.

Please see the "Notification of Qualifying Event" subsection for information about providing notice of a second qualifying event to the Plan Administrator.

PAYMENT FOR COBRA CONTINUATION COVERAGE

For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled Qualified Beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not paid to the Plan with respect to that Qualified Beneficiary.

This Plan shall be in compliance with the American Recovery and Reinvestment Act of 2009 (ARRA), in effect as of the first period of COBRA Continuation Coverage starting on or after February 17, 2009, and as amended from time to time. ARRA may reduce the COBRA premium in some cases. You may qualify for a premium reduction. This premium reduction may only continue for a limited time and you may be subject to certain eligibility restrictions and obligations. You should consult the COBRA Administrator if you have questions or if you believe you are eligible for a premium reduction.

The Trade Act of 2002, as amended, created a new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). Under the applicable tax provisions, TAA-eligible individuals can either take a tax credit or get advance payment of premiums paid for qualified health coverage including continuation coverage. If you elect a tax credit under the Trade Act, you will not be eligible for other Federal COBRA premium subsidies which may be available. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 866-628-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/.

TIMELY PAYMENT FOR PAYMENT OF COBRA CONTINUATION COVERAGE

A plan cannot require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. However, if the qualified beneficiary fails to make the initial premium payment within the forty-five (45)-day period, then the Plan Administrator may terminate COBRA coverage retroactive to the beginning of the maximum coverage period.

After the first payment for COBRA continuation coverage is made, subsequent payments shall be made on a monthly basis. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying

event. "Timely Payment" means payment that is made to the plan by the date that is thirty (30) days after the first day of that period. Payment that is made to the plan by a later date is also considered Timely Payment if either under the terms of the plan, covered employees or qualified beneficiaries are allowed: 1) until that later date to pay for their coverage for the period, or 2) under the terms of an arrangement between the employer and the entity that provides plan benefits on the employer's behalf, the employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

If an insignificant underpayment is submitted, notification will be provided to the qualified beneficiary that he/she has a thirty (30)-day grace period to submit the difference. Failure to remit payments within the grace period will cause coverage to be cancelled. This coverage CANNOT be reinstated.

EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

A plan that terminates COBRA continuation coverage of a qualified beneficiary prior to the end of the maximum coverage period shall provide a written notice of termination of COBRA coverage to the affected qualified beneficiary(ies). Such notice shall contain an explanation of why coverage was terminated early, the date of termination, and a statement that the qualified beneficiary may have rights under the plan and/or applicable law to elect other coverage or individual coverage (i.e., conversion rights).

Delivery of such notice will be in written form and sent as soon as possible. One notice may be sent to all qualified beneficiaries residing at the same residence, and separate notices for qualified beneficiaries residing at different residences. Such notice is considered furnished as of the date of mailing or when it is actually received when hand-delivered.

If an employee or qualified beneficiary(ies) believes his/her rights to continuation coverage have been improperly terminated, he/she may request a review of the Plan Administrator's decision by contacting the Plan Administrator in writing at the address specified in this Plan Document's Summary Plan Description section. Such request for review needs to: 1) be sent within thirty (30) days of receipt of the notice of termination of COBRA continuation coverage; and 2) explain why you believe that COBRA continuation coverage was improperly terminated including all information that should be reviewed. Please include your name, current address, and the names of any other individuals' coverage to be reviewed in the appeal. The Plan Administrator will respond to the request for review within fourteen (14) days of its receipt.

TERMINATION OF COBRA CONTINUATION COVERAGE

During the election period, a qualified beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning the date of the qualifying event or the date coverage is lost, whichever is later, and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the plan with respect to the qualified beneficiary.

3. The date upon which the employer ceases to provide any group health plan (including successor plans) to any employee.
4. The date, after the date of the election, that the qualified beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary.
5. The date, after the date of the election, that the qualified beneficiary is entitled to the Medicare program (either Part A or Part B, whichever occurs earlier).
6. In the case of a qualified beneficiary entitled to a disability extension, the later of:
 - a. (i) twenty-nine (29) months after the date of the qualifying event or the date coverage is lost, whichever is later, or (ii) the first (1st) day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - b. the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

The plan can terminate for cause the coverage of a qualified beneficiary on the same basis that the plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is **not** a qualified beneficiary and who is receiving coverage under the plan solely because of the individual's relationship to a qualified beneficiary (e.g., a spouse who is newly-acquired during the qualified beneficiary's COBRA coverage period and is added to the qualified beneficiary's coverage due to the special enrollment event of marriage), if the plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, the plan is not obligated to make coverage available to the individual(s) who is/are not a qualified beneficiary.

ADDRESS CHANGES

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your and/or your family members' addresses. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

GENERAL PROVISIONS

How to File a Claim

As you and/or your family member(s) accumulate expenses, you should file a claim for review and appropriate reimbursement.

When possible, please try to bundle claims together and submit them at one time. This helps control claims Administration fees that the Plan must pay. Specific data regarding all claims is necessary for prompt payment. This information includes employee or dependent's name, dental diagnosis and itemized bills from providers of services.

Please submit all data and itemized bills, with your name, address and High Plains Educational Cooperative clearly identified, directly to:

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

Employee Benefit Management Services, Inc. will promptly review all information, make proper payments and, if necessary, request from you or any medical providers other information that is needed. Call Employee Benefit Management Services, Inc. directly with any questions that you might have.

Timely Filing of Claims

Except in the absence of legal capacity, in no event will an expense be considered if the claims is filed more than one year after the date the expense was incurred.

Claims Appeal Procedure

If your claim has been denied, or if you have not heard anything within 90 days after you have sent it in, you can appeal the denial in writing and have your claim reviewed. You have 60 days to appeal from the time you are notified of the denial or 60 days from the end of the processing period if you have heard nothing by that time.

Besides having the right to appeal, you or your authorized representative can examine any Plan documents related to your claim. You can also submit, in writing, reasons why you think the claim should not be denied.

Those reviewing your appeal have to act within 60 days of receiving it. However, in special cases, they may be allowed 120 days. The final decision will be sent to you in writing, together with an explanation of how the decision was made.

Facility of Payment

If any benefits due under the Plan are payable to the participant at his death, the claims administrator may issue direct payment to any one or more of the surviving relatives of the participant (spouse, mother, father, child, or children, brothers or sisters; or the executors or administrators of the participant's estate.

Any payment for the participant in accordance with the previous plan shall be considered a complete payment.

Coordination of Benefits

When both husband and wife are working, quite often members of a family are covered under more than one health care plan. In this case, benefits are usually coordinated between plans so that up to 100% of the allowable expenses during a calendar year are paid.

An allowable expense is defined as any necessary, usual, reasonable and customary item of expense covered either in full or in part under both of the group plans being coordinated.

Other plans include group plans sponsored by either an employer or an organization or any federal, state, or local program providing medical or dental benefits or services on an insured or uninsured basis.

Which plan pays first depends upon which of the plans is the Primary Plan and which is the Secondary Plan. The Primary Plan, naturally, pays first.

To obtain all of the benefits available, you and your family members should file claims under each plan. The two Plans will decide which is primary, however, in general, the Plan covering you as an employee is primary and children are primary under the parent whose birthday occurs first in the calendar year.

When husband and wife are both covered under the High Plains Educational Cooperative Plan as employees, the Plan will not be subject to Coordination of Benefits. Claims will be paid as if the individual was only covered once.

Any benefits you may receive from personal, individual insurance policies will not be affected by this Coordination of Benefits provision. Such benefits will be in addition to your benefits from the High Plains Educational Cooperative group coverage.

Third Party Liability Exclusion

No benefits will be paid under this Plan on behalf of an individual who has medical charges, or loss of earnings if the individual has received payment from a third party, or its insurer, for past or future medical or loss of earnings expenses as the result of the negligence or intentional act of a third party.

If the individual makes claim for benefits under this Plan prior to receiving payment from a third party, or its insurer, the individual (or legal representative of a minor or incompetent) must agree in writing to repay the Plan from any amount of money received by the individual from the third party, or its insurer. The repayment will be to the extent of the benefits paid by the Plan.

The repayment agreement will be binding upon the individual (or legal representative of a minor or incompetent) whether or not:

1. the payment received from the third party, or its insurer, is the result of:
 - a. a legal judgment; or
 - b. an arbitration award; or
 - c. a compromise settlement; or
 - d. any other arrangement; or
2. the third party, or its insurer, has admitted liability; or
3. the medical or dental charges or loss of earnings are itemized in the third party payment.

Assignment of Benefits

All benefits payable by the Plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment.

Recovery of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual (including yourself), medical provider, insurance company or other

organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent incomplete or misleading information provided by you, or a medical provider, the plan will exercise their right to withhold payment on future benefits until the overpayment is recovered.

Right To Receive and Release Necessary Information

The plan may, without the consent of or notice to any person, release to or obtain from any organization or person information needed to implement plan provisions. When you request benefits, you must furnish all the information required to implement this plan provision. The release and handling of any protected health information (PHI) and/or transactions will be administered in compliance with the plan's HIPAA Privacy Information provisions.

Subrogation Rights

In the event of any payments for benefits provided to you or your eligible dependent under the Plan, High Plains Educational Cooperative, to the extent of claims paid, will be subrogated to all rights of recovery you or your eligible dependent has against any person or organization; and you or your dependent will execute and deliver instruments and papers as may be required and do whatever else is necessary to secure those rights to us and will do nothing after loss to prejudice our rights. If we are precluded from exercising our Subrogation Rights, we may exercise our Right to Reimbursement.

Right to Reimbursement

If you or your dependent:

1. seeks legal recourse (whether by suit, settlement, judgment or otherwise) against any person or organization; and
2. recovers payment, in whole or in part, from any such person or organization for the benefits previously paid under the Plan, then you or your dependent must reimburse us for all payments made under the Plan for which you have received reimbursement.

Any payments made prior to determination of work-related injury will be reimbursed upon determination of such payment.

However, the reimbursement will not exceed:

1. the amount of the benefit payment made under the policy for which payment is recovered from any person or organization; or
2. the amount recovered from any such person or organization as payment for the same covered dental expenses.

You or your dependents are not obligated by this provision to seek legal action against any person or organization for which benefits have been paid under this Plan.

Workers' Compensation

Coverage under the Plan does not replace or affect any requirements for coverage by Workers' Compensation Insurance. If state law allows, we may participate in a Workers' Compensation dispute arising from a claim for which benefits were paid.

High Plains Educational Cooperative #611 reserves the right to amend or terminate all Plans at its sole discretion and to make administrative decisions necessary to operate

the Plan. This description is the Plan Document and Summary Plan Description for the Dental benefits.

Authority to Interpret Plan

The Plan Administrator or, where responsibility has been delegated to others, its delegates shall have complete authority to determine the standard of proof required in any case and to apply and interpret the Plan Document. The decisions of the Plan Administrator or its delegates shall be final and binding.

All questions or controversies, of whatsoever character arising in any manner or between any parties or persons in connection with this Plan or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of the Plan Document, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Plan Administrator or, where responsibility has been delegated to others, to such delegates for decision. The decision of the Plan Administrator or its delegates shall be binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court having jurisdiction over such matters.

SUMMARY PLAN DESCRIPTION

General Information

1. Names of the Plan and Plan Number:

High Plains Educational Cooperative #611, Dental Benefit Plan - #368

The Plan is for the benefit of employees of High Plains Educational Cooperative. The Employer I.D. number is 48-0856876.

2. Name and Address of Employer whose Employees Are Covered by the Plans:

High Plain Educational Cooperative #611
621 East Oklahoma
Ulysses, KS 67880

3. Plan Year:

The Plan Year begins on October 1st and ends on the last day of September each year.

4. Plan Administrator:

High Plain Educational Cooperative #611
621 East Oklahoma
Ulysses, KS 67880

5. Agent for Service of Legal Process:

Plan Administrator

6. Claims Administrator

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

7. Funding:

The Dental Plan is self-funded by employee and employer contributions and is managed by the Plan Administrator.

ADOPTION

Sponsor: High Plains Educational Cooperative #611

Plan Document: Dental

Summary Plan Description: Dental

Effective Date: February 1, 1997

Revised and Restated: July 1, 2001

October 1, 2010

Adopted:

High Plains Educational Cooperative #611:

Mike Lewis

Name

Mike Lewis

Signature

Director

Title

10/29/2010

Date