

**PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION**

for the

**CITY OF MCKINNEY
DENTAL BENEFIT PLAN**

This booklet describes the Plan Benefits
in effect as of January 1, 2016

The Plan has been established for the benefit of
eligible Employees and their Dependents of:

CITY OF MCKINNEY

Claims Processed By:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.

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INTRODUCTION

Effective January 1, 2016 City of McKinney, hereinafter referred to as "City", establishes the benefits, rights and privileges which will pertain to participating Employees, referred to as "Participants," and the eligible Dependents of such Participants, as defined, and which benefits are provided through a fund established by the City and referred to as the "Plan." This booklet describes the Plan in effect as of January 1, 2016.

Coverage provided under this Plan for Employees and their Dependents will be in accordance with the Eligibility, Effective Date, Qualified Medical Child Support Order, Termination, Family and Medical Leave Act and other applicable provisions as stated in this Plan.

City of McKinney (the Plan Sponsor) has retained the services of an independent Plan Supervisor, experienced in claims processing, to handle health claims. The Plan Supervisor for the Plan is:

Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

We recommend that you read this booklet carefully before incurring any dental expenses. If you have specific questions regarding coverage or benefits, you are urged to refer to the Plan Document/Summary Plan Description which is available for your review in the Personnel Office or at the office of the Plan Supervisor. If you wish, you may call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions you may have concerning the Plan.

This Plan is not intended to, and cannot be used as workers compensation coverage for any employee or any covered dependent of an employee. Therefore, this plan generally excludes claims related to any activity engaged in for wage or profit including, but not limited to, farming, ranching, part-time and seasonal activities. See Plan Exclusions for specific information.

The information contained in this Plan Document/Summary Plan Description is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO's. It is not intended to be and should not be relied upon as complete legal information about those subjects. Covered Persons and Employers should consult their own legal counsel regarding these matters.

**SCHEDULE OF DENTAL BENEFITS
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS**

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND LIMITATIONS OF THE PLAN AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

Services of a contracted Dentist are reimbursed based on the contracted fee agreed upon by the provider and the Plan Sponsor. Services of a non-contracted Dentist are based on the Usual, Customary and Reasonable charge.

THE BENEFIT PERIOD IS A CALENDAR YEAR

DEDUCTIBLE

Annual Deductible Per Covered Person per Benefit Period	\$50
Annual Deductible Per Family per Benefit Period	\$150

DENTAL EXPENSES

Type A (Preventive Care) Dental Expenses	
Deductible	Waived
Benefit Percentage	100%
Type B (Basic Care) Dental Expenses	
Deductible	Applies
Benefit Percentage	80%
Type C (Major Restorative) Dental Expenses	
Deductible	Applies
Benefit Percentage	50%

ORTHODONTIC TREATMENT BENEFIT

Lifetime Deductible	\$50
Benefit Percentage	50%

BENEFIT MAXIMUMS

Maximum Benefit Per Benefit Period Per Covered Person	\$1,500
(Type A, B and C Expenses)	
Maximum Lifetime Maximum per Covered Person	\$1,500
(Orthodontic Treatment)	

DENTAL BENEFITS

ELIGIBLE EXPENSES

Services, treatments or supplies are an eligible Dental Expense if they meet all of the following requirements:

1. They are administered, provided by or ordered by a Dentist, Denturist, Dental Hygienist or other Licensed Health Care Provider covered by the Plan; and
2. They are Dentally Necessary for the diagnosis and treatment of a dental condition or dental disease unless otherwise specifically included as an Eligible Expense; and
3. Charges therefore do not exceed the Usual, Customary and Reasonable limits of the Plan. If two or more procedures are separately suitable for the correction of a specific condition, the Eligible Expense will be based upon the least expensive procedure; and
4. They are not excluded under any provision or section of this Plan.

DEDUCTIBLE AND BENEFIT PERCENTAGE

The Deductible applies to Eligible Expenses incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period. Also, if members of a Family have satisfied individual Deductible amounts that collectively equal the Deductible per Family, as stated in the Schedule of Dental Benefits, during the same Benefit Period, no further Deductible will apply to any member of that Family during that Benefit Period. **An individual Covered Person cannot receive credit toward the Family Deductible for more than the Individual Annual Deductible as stated in the Schedule of Dental Benefits.**

Eligible Expenses Incurred by a Covered Person will be paid by the Plan according to the applicable Benefit Percentage stated in the Schedule of Dental Benefits. The Plan will pay the percentage of the Eligible Expense indicated as the Benefit Percentage.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles will be applied to Eligible Expenses in the chronological order in which they are adjudicated by the Plan. Eligible Expenses will be paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and Eligible Expenses are paid by the Plan will be conclusive and binding on all Covered Persons and their assignees.

MAXIMUM BENEFIT PAYABLE

The Maximum Benefit per Benefit Period as specified in the Schedule of Dental Benefits is the maximum amount that may be paid by the Plan for Eligible Expenses Incurred by each individual Covered Person in each Benefit Period as indicated in the Schedule of Dental Benefits. The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Dental Benefits, for any reason.

EXPENSES INCURRED

For a dental appliance, or modification of a dental appliance, an expense is considered Incurred at the time the impression is made. For a crown, bridge or gold restoration an expense is considered Incurred at the time the tooth or teeth are prepared. For root canal therapy an expense is considered Incurred at the time the pulp chamber is opened. All other expenses are considered Incurred at the time a service is rendered or a supply furnished.

PREDETERMINATION OF BENEFITS

Charges that are expected to exceed five hundred dollars (\$500.00) may be predetermined by having the Dentist complete the Predetermination of Benefits portion of the claim form and listing the procedures he/she is recommending, including an estimate of charges for the procedures and submit the claim form to the Plan Supervisor for Predetermination of Benefits payable.

Upon the Plan's receipt of the Predetermination of Benefits request, the Plan Supervisor will determine the eligibility of the Covered Person and determine the coverage available under the Plan for the recommended dental procedures. After determining the benefits payable under the Plan, the Plan Supervisor will return the claim form to the Dentist. A copy of the predetermination of benefits will also be mailed to the covered Employee, informing the Employee of the amount of benefits estimated to be covered by the Plan for the recommended dental procedures.

A PREDETERMINATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME SERVICES ARE PERFORMED OR CHARGES ARE INCURRED.

DENTAL EXPENSES*TYPE A (PREVENTIVE CARE) EXPENSES*

The following general dental expenses will be considered "Type A" for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Oral Examination (including prophylaxis--scaling and cleaning of teeth), but not more than twice in any Benefit Period.
2. Topical application of sodium fluoride or stannous fluoride for Dependent children under age nineteen (19). Benefits for topical application of sodium fluoride or stannous fluoride will be provided only once every Benefit Period.
3. Dental x-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental x-rays, but not more than one full mouth x-ray or series in any three (3) Benefit Periods and not more than two (2) sets of supplementary bitewing x-rays in any Benefit Period.
4. Sealants for Dependents under age nineteen (19) but not more than one treatment per permanent tooth every three (3) Benefit Periods.
5. Space maintainers, fixed unilateral, limited to non-orthodontic treatment.

TYPE B (BASIC CARE) EXPENSES

The following general dental expenses will be considered "Type B" for reimbursement purposes as stated in the Schedule of Dental Benefits:

1. Emergency palliative care to relieve dental pain.
2. Extractions, except for orthodontic extractions.
3. Oral surgery.
4. Fillings.
5. Nitrous Oxide when administered in connection with covered dental services.

6. General anesthesia or conscious intravenous "IV" sedation when Dentally Necessary and administered in connection with oral surgery or other Covered Dental Benefits.
7. Treatment, including periodontal surgery of diseased periodontal structures for periodontal and other diseases affecting such structures.
8. Endodontic treatment, including root canal therapy.
9. Injection of antibiotic drugs.
10. Repair or recementing of crowns, inlays, bridgework or dentures; or relining of dentures.
11. Prophylaxis for periodontal treatment.
12. Gold fillings.

TYPE C (MAJOR RESTORATIVE) EXPENSES

The following general dental expenses will be considered "Type C" for reimbursement purposes:

1. Inlays, onlays or crowns (including precision attachments for dentures).
2. Initial installation of fixed bridgework (including crowns and inlays to form abutments) to replace one or more natural teeth extracted.
3. Replacement of an existing partial denture or fixed bridgework by a new fixed bridgework, or the addition of teeth to an existing fixed bridgework. However, this item will apply only to replacements and additions that meet the "Prosthesis Replacement Rule" below.
4. Initial installation of partial or full removable dentures (including adjustments for the six (6) month period following installation) to replace one or more natural teeth extracted.
5. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture, or the addition of teeth to an existing partial denture. However, this item applies only to replacements and additions that meet the "Prosthesis Replacement Rule" below.
6. Surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.
7. Treatment of bruxism, including appliances such as night guards.

ORTHODONTIC TREATMENT BENEFIT

The following expenses will be considered "Orthodontic" for reimbursement purposes and will be payable as stated in the Schedule of Dental Benefits and subject to any separate Deductible or Maximum Lifetime Benefit applicable to Orthodontic Treatment:

1. Treatment for a diagnosed malocclusion.
2. Cephalometric X-ray once in any two (2) Benefit Periods.
3. One set of study models per Covered Person.

4. Initial placement of braces or appliances, ongoing treatment adjustment, removal and follow-up related to said initial placement.
5. Orthodontic extractions.

If Orthodontic Treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

PROSTHESIS REPLACEMENT RULE

Replacement of or additions to existing dentures or bridgework as described under Type B and Type C Expenses will be covered only if evidence satisfactory to the Plan Supervisor is furnished that one of the following applies:

1. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.
2. The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement.
3. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

DENTAL BENEFIT LIMITATIONS

Charges for the replacement of existing dentures or removable or fixed bridgework will be considered an eligible expense only if the existing appliance is not serviceable and cannot be repaired.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following general exclusions and limitations apply to all Expenses Incurred under this Plan:

1. Charges for any services or supplies to the extent that benefits are otherwise provided under this Plan, or under any other plan of group benefits that the Participant's Employer contributes to or sponsors.
2. Charges for treatment which is not rendered by or in the presence of a Dentist or other Licensed Health Care Provider covered by the Plan except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if the treatment is rendered under the supervision or the direction of the Dentist.
3. Charges for dentures, crowns, inlays, onlays, bridgework or other appliances which are not dentally necessary and performed solely or primarily for Cosmetic or personal reasons, personal comfort, convenience, or beautification items, including charges for personalization or characterization of dentures. **This exclusion will not apply when such treatment is rendered to correct a congenital anomaly.**
4. Charges for facility, Ambulatory Surgery Center and Hospital charges.
5. Charges for local anesthesia administered in conjunction with covered dental services or procedures, when billed separately (unbundled) from the charge for the Covered Service or procedure.
6. Charges for the replacement of a lost, missing, or stolen appliance device or for an additional (spare) appliance.
7. Charges for any condition, Illness, Injury or complication thereof arising out of or in the course of employment unless the Covered Person receives wages as a contract Employee or is operating as a sole proprietor where there is no other coverage available. In those cases the Plan reserves the right to pursue subrogation rights against another third party if such coverage exists (i.e. motor vehicle coverage, home-owners insurance, or other liability coverage).
8. Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
9. Charges for oral hygiene and dietary instructions.
10. Charges for root canal therapy for which the pulp chamber was opened before the individual became a Covered Person.
11. Charges for temporary dentures.
12. Charges incurred for services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions. This includes charges for dentures, crowns, inlays, onlays, bridgework or other appliances or services which were not ordered while the individual was a Covered Person. The date a prosthetic dental appliance is placed in the mouth is considered the date of service.
13. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature including, but not limited to, correction of the position of the jaws in relation to each other (orthognathic surgery), realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery, or retrognathia. This includes expenses incurred for any appliance or prosthetic device used to replace tooth structure lost as a result of abrasion or attrition.

14. Charges for any services, supplies or appliances which are not specifically listed as a benefit of this Plan.
15. Charges which are caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression, or caused during service in the armed forces of any country.
16. Broken or missed appointments.
17. Charges for infection control (OSHA) fees or claim filing.
18. Travel Expenses Incurred by any person for any reason.
19. Charges for non-dental services such as training, education, instructions or educational materials, even if they are performed or provided by a dental service provider.
20. Hypnosis, prescribed drugs, premedications or any euphoric drugs, with the exception of nitrous oxide.
21. Biopsies or oral pathology, except as specifically provided for under Covered Dental Services.
22. To the extent that the Covered Person could have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of dental emergencies or for coverage provided by Medicaid.
23. Charges for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Dentally Necessary for the diagnosis and/or treatment of an active Dental condition or dental disease, or which are Experimental or Investigational, except as specifically stated as a Covered Benefit of this Plan.
24. Expenses Incurred by persons other than the person receiving treatment.
25. Charges in connection with services and supplies which are in excess of the Eligible Expense.
26. Charges for services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.
27. Charges for extracoronal and other periodontal splinting, except treatment for bruxism.
28. Charges for professional services on an Outpatient basis in connection with disorders of any type or cause, that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.
29. Charges for services, treatment or supplies not considered legal in the United States.
30. Charges for preparation of reports or itemized bills in connection with Eligible Expenses, unless specifically requested and approved by the Plan.

31. Charges for the following treatments, services or supplies:
 - A. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.
 - B. Charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.
32. Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.

COORDINATION OF BENEFITS

The Coordination of Benefits provision prevents the payment of benefits which exceed the Allowable Expense. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan(s). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan(s), will not exceed 100% of the Allowable Expense. Only the amount paid by this Plan will be charged against the Plan maximums.

In the event of a motor vehicle or premises accident; or an act of violence with the intent to disrupt electronic, communications, or any other business system, this Plan will be secondary to any auto "no fault" and traditional auto "fault" type contracts, homeowners, commercial general liability insurance and any other medical benefits coverage.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision.

DEFINITIONS

"Allowable Expense" as used herein means:

1. If the claim as applied to the primary plan is subject to a contracted or negotiated rate, Allowable Expense will be equal to that contracted or negotiated amount.
2. If the claim as applied to the primary plan is not subject to a contracted or negotiated rate, but the claim as applied to the secondary plan is subject to a contracted or negotiated rate, the Allowable Expense will be equal to that contracted or negotiated amount of the secondary plan.
3. If the claim as applied to the primary plan and the secondary plan is not subject to a contracted or negotiated rate, then the Allowable Expense will be equal to the secondary plan's chosen limits for non-contracted providers.

"Plan" as used herein means any plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis including, but not limited to:
 - A. Hospital indemnity benefits; and
 - B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims; or
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision; or
4. A licensed Health Maintenance Organization (H.M.O.); or
5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or

6. Any coverage under a Governmental program, and any coverage required or provided by any statute; or
7. Automobile insurance; or
8. Individual automobile insurance coverage on an automobile leased or owned by the Company or any responsible third-party tortfeasor; or
9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage; or
10. Homeowner or premise liability insurance, individual or commercial.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent**

The plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. **Child Covered Under More Than One Plan**

A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

- 1) The parents are married;
- 2) The parents are not separated (whether or not they have ever been married), or
- 3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

B. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

C. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph will not apply with respect to any claim determination period, Benefit Period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.

D. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

- 1) The plan of the custodial parent.
- 2) The plan of the spouse of the custodial parent.
- 3) The plan of the non-custodial parent.
- 4) The plan of the spouse of the non-custodial parent.

3. Active or Inactive Employee

The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

4. Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

- A. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.
- B. The start of a new plan does not include:
 - 1) A change in the amount or scope of a plan's benefits;
 - 2) A change in the entity that pays, provides, or administers the plan's benefits; or
 - 3) A change from one type of plan to another (such as from a single employer plan to that of a multiple-employer plan).
- C. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

5. No Rules Apply

If none of these preceding rules determines the primary plan, the Allowable Expense will be determined equally between the plans.

COORDINATION WITH MEDICAID

If a Covered Person is also entitled to and covered by Medicaid, this Plan will always be primary and Medicaid will always be secondary coverage.

COORDINATION WITH TRICARE/CHAMPVA

If a Covered Person is also entitled to and covered under TRICARE/CHAMPVA, this Plan will always be primary and TRICARE/CHAMPVA will always be secondary coverage. TRICARE coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

If the Covered Person is eligible for Medicare and entitled to veterans benefits through the Department of Veterans Affairs (VA), this Plan will always be primary and the VA will always be secondary for non-service connected medical claims. For these claims, this Plan will make payment to the VA as though this Plan was making payment secondary to Medicare.

PROCEDURES FOR CLAIMING BENEFITS

Claims must be submitted to the Plan within twelve (12) months after the date services or treatment are received or completed. Non-electronic claims may be submitted on any approved claim, available from the provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

- Date of service;
- Name of the Participant;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- Diagnosis [code] of the condition being treated;
- Treatment or service [code] performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the dental necessity of the treatment or service being provided and sufficient to enable the Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Plan.

When completed, the claim must be sent to the Plan Supervisor, Allegiance Benefit Plan Management, Inc., at P.O. Box 3018, Missoula, Montana 59806-3018, (855) 999-1054 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

In no event will any claim be considered for payment of benefits if it is initially submitted to the Plan more than twelve (12) months from the date that such claim was incurred.

Upon termination of the Plan, final claims must be received within three (3) months of termination or such lesser time as is established by the Plan Administrator.

CLAIMS WILL NOT BE DEEMED TO BE SUBMITTED UNTIL RECEIVED BY THE PLAN SUPERVISOR.

The Plan will have the right, in its sole discretion and at its own expense, to require a claimant to undergo a dental examination, when and as often as may be reasonable, and to require the claimant to submit, or cause to be submitted, any and all dental and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized dental knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. For purposes of this section, "Covered Person" will include the claimant and the claimant's Authorized Representative; however, "Covered Person" does not include a health care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

"Authorized Representative" means a representative authorized by the claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization.

In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim. Upon written notice to the Covered Person of the circumstances requiring an extension and the date by which the Plan expects to render a decision, this time period may be extended fifteen (15) days for reasons beyond the Plan's control. If the extension is necessary due to a failure of the claimant to submit information necessary to decide the claim, the extension notice will specifically describe the information needed, and the claimant will be afforded forty-five (45) days from receipt of the notice within which to provide the specified information. Once sufficient information is received to decide the claim, the Plan will provide timely notice of the determination after receiving sufficient information.

APPEALING AN UN-REIMBURSED CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan Supervisor at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action under Section 502(a) of ERISA. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

A Covered Person has no more than one hundred eighty (180) days after an Adverse Benefit Determination to appeal the denial. When appealing an Adverse Benefit Determination, the Covered Person should include any additional information supporting the claim or the information required by the Plan which was not initially provided and forward it to the Plan Supervisor within the permitted time period. Failure to appeal the Adverse Benefit Determination within the permitted time period will render the determination final; appeals received after the permitted time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

If a claimant requests review of an Adverse Benefit Determination, this Plan provides two (2) levels of benefit determination review.

FIRST LEVEL OF BENEFIT DETERMINATION REVIEW

The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within sixty (60) days following the date the Plan Supervisor receives the request for reconsideration.

If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same, the Covered Person has the right to a second level of review as stated below. To obtain a second level of review, the Covered Person must request the second review in writing and send it to the Plan Supervisor not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review.

SECOND LEVEL OF BENEFIT DETERMINATION REVIEW

The Plan Administrator will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Plan Administrator who is neither the original decisionmaker nor the decisionmaker's subordinate. The Plan Administrator cannot give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized dental judgment. Where the appeal involves issues of dental necessity or experimental treatment, the Plan Administrator will consult with a health care professional with appropriate training who was neither the dental professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, within a reasonable time, but no later than sixty (60) days from the date the appeal is received by the Plan. Such notice will contain the same information as notices for the initial determination.

All claim payments are based upon the terms and provisions contained in the Plan Document which is on file with the Plan Administrator and the Plan Supervisor. The Covered Person may also request, free of charge, more detailed information, names of any dental professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

ELIGIBILITY PROVISIONS

If both spouses are employed by the City, and both are eligible for Dependent Coverage, either spouse, but not both, may elect Dependent Coverage for their eligible Dependents. No one can be covered under this Plan as both an Employee and a Dependent. No one can be covered under this Plan as a Dependent by more than one Participant.

EMPLOYEE ELIGIBILITY

An Employee becomes eligible under this Plan for each classification of employees as follows:

1. Class I - Is classified as a regular full-time Employee and is employed by the City on a continuing and regular basis for at least thirty (30) hours per week; or
2. Class II - Is employed by the City as a Variable Hour Employee which includes Employees working less than thirty (30) hours and completes a Measurement Period of twelve (12) consecutive months, during which the Variable Hour Employee averages thirty (30) hours per week of actual work and/or paid leave, FMLA leave or jury duty whether paid or not ,for twelve (12) consecutive months.

“Measurement Period” is the period of time adopted by the Plan for Variable Hour Employees during which such Employees’ work hours and applicable leave are measured to determine whether such Employees are eligible for coverage.

An Employee is not eligible while on active military duty if that duty exceeds a period of thirty-one (31) consecutive days.

WAITING PERIOD

With respect to a person covered by a previous plan or previous group health insurance of the Employer on the effective date of this Plan, the effective date of coverage under this Plan will be the effective date of the Plan.

With respect to an eligible Employee not covered under the Plan, coverage under the Plan will not start until the Employee completes the applicable Waiting Period. The Waiting Period commences with the date the Employee meets the eligibility requirements stated above (Enrollment Date) and ends the last day of the month following twenty-eight (28) days from the Enrollment Date.

For a Class I Employee only, an ineligible Employee who has an employment status change which makes him/her eligible for coverage will be given credit for days of employment with the City as an ineligible Employee which credit will be applied toward the Waiting Period.

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant has been assigned by the Employer, and who is either:

1. The Participant's legal spouse, according to the marriage laws of the state where the marriage was first solemnized or established.

An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant's Dependent child who meets all of the following "Required Eligibility Conditions":
 - A. Is a natural child; step-child; legally adopted child; a child who has been Placed For Adoption with the Participant and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and
 - B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time.

An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child.

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

Each Employee will become eligible for Dependent Coverage on the latest of:

1. The date the Employee becomes eligible for Participant coverage; or
2. The date on which the Employee first acquires a Dependent.

DECLINING COVERAGE

If an eligible person declines coverage under this Plan, he/she will state his/her reason(s) for declining, in writing. Failure to provide those reasons in writing may result in the Plan refusing enrollment at a later date.

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan will commence at 12:01 A.M. in the time zone in which the Covered Person permanently resides, on the date such coverage becomes effective.

PARTICIPANT COVERAGE

Participant coverage under the Plan will become effective on the first day immediately after the Employee satisfies the applicable eligibility requirements and Waiting Period. If these requirements are met, the Employee must be offered coverage or an opportunity to waive coverage even if the offer is after the date coverage should become effective, regardless of the time that has elapsed, provided that the reason coverage was not offered before the end of the Waiting Period was as a result of an administrative error on the part of the Employer, Plan Administrator or Plan Supervisor.

An eligible Employee who declines Participant coverage under the Plan during the Initial Enrollment Period will be able to become covered later in only two situations, Open Enrollment and Special Enrollment.

A Variable Hour Employee will remain covered for a period of time not to exceed twelve (12) months from the effective date of coverage (the Coverage Period) regardless of the number of hours worked and applicable leave, as long as the individual remains employed by the City. At the end of the Coverage Period, if the individual remains employed as a Variable Hour Employee and averages at least thirty (30) hours per week during the Coverage Period, the individual will remain covered for a period of time not to exceed an additional twelve (12) months.

“Coverage Period” is the maximum period of time Variable Hour Employees can be covered under the Plan as active Employees after completion of a Measurement Period as defined in the “Eligibility Provisions under the “Employee Eligibility” subsection.

DEPENDENT COVERAGE

Each Participant who requests Dependent Coverage on the Plan’s enrollment form will become covered for Dependent Coverage as follows:

1. On the Participant’s effective date of coverage, if application for Dependent Coverage is made on the same enrollment form used by the Participant to enroll for coverage. This subsection applies only to Dependents who are eligible on the Participant’s effective date of coverage.
2. In the event a Dependent is acquired after the Participant’s effective date of coverage as a result of a legal guardianship or in the event that a Participant is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage will begin on the first day of the month following the Plan’s receipt of an enrollment form and copy of said court order, if applicable.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will generally be during the months of October or November of each year, as determined and communicated by the Plan Administrator, during which an Employee and the Employee’s eligible Dependents, who are not covered under this Plan, may request Participant or Dependent coverage. Coverage must be requested on the Plan’s enrollment form.

Coverage requested during any Open Enrollment Period will begin on January 1st following the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

In addition to other enrollment times allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below.

“Special Enrollment Period” means a period of time allowed under this Plan, other than the eligible person’s Initial Enrollment Period or an Open Enrollment Period, during which an eligible person can request coverage under this Plan as a result of certain events that create special enrollment rights.

For birth, adoption or Placement for Adoption, coverage will become effective on the date of the event if the Employee makes a special enrollment request within thirty (30) days.

For marriage or loss of coverage, coverage will become effective on the first day of the month following the enrollment request, if the request is made within thirty (30) days.

1. An eligible Employee who is not enrolled and eligible Dependents, including step children, who are acquired under the following specific events may enroll and become covered:
 - A. Marriage to the Employee;
 - B. Birth of the Employee’s child; or
 - C. Adoption of a child by the Employee, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

2. A Participant may enroll eligible Dependents, including step children, who are acquired under the following specific events:
 - A. Marriage to the Participant;
 - B. Birth of the Participant’s child; or
 - C. Adoption of a child by the Participant, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

3. The spouse of a Participant (Covered Employee), may enroll and will become covered on the date of the following specific events:
 - A. Marriage to the Participant;
 - B. Birth of the Participant’s child; or
 - C. Adoption of a child by the Participant, provided the child is under the age of 19; or
 - D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

4. The following individuals may enroll and become covered when coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated (Loss of Coverage), subject to the following:

- A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
- B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

Further, Loss of Coverage means only one of the following:

- A. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or
- B. Group or insurance health coverage that has been terminated as a result of termination of employer contributions* towards that other coverage; or
- C. Group or insurance health coverage (includes other coverage that is Medicare) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:
 - 1) Legal separation or divorce of the eligible Employee;
 - 2) Cessation of Dependent status;
 - 3) Death of the eligible Employee;
 - 4) Termination of employment of the eligible Dependent;
 - 5) Reduction in the number of hours of employment of the eligible Dependent;
 - 6) Termination of the eligible Dependent's employer's plan; or
 - 7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
 - 8) Any loss of eligibility for individual or group coverage because the eligible Employee or Dependent no longer resides, lives or works in the service area of the HMO or other such plan.

*Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A loss of eligibility for coverage does not occur if coverage was terminated due to a failure of the Employee or Dependent to pay premiums on a timely basis or coverage was terminated for cause.

5. Individuals may enroll and become covered when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility, subject to the following:

- A. A request for enrollment must be made either verbally or in writing within sixty (60) days after this special enrollment event, and written application for such coverage must be made within ninety (90) days after such event.
- B. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
- C. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

6. Individuals who are eligible for coverage under this Plan may enroll and become covered on the date they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (CHIP or Medicaid). A request for enrollment, either verbal or in writing, must be made within sixty (60) days after this special enrollment event, and written application for such coverage must be made in writing within ninety (90) days after such event.

For any Special Enrollment event, the Participant may also elect to change coverage options to any coverage option offered by the Plan. The Coverage Option for the Dependent must be the same as the Participant.

CHANGE IN STATUS

If a Covered Dependent under this Plan becomes an eligible Employee of the City, he/she may continue his/her coverage as a Dependent or elect to be covered as a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the City, but is eligible to be covered as a Dependent under another Employee/Participant, he/she may elect to continue his/her coverage as a Dependent of such Employee/Participant.

Application for coverage due to a Change in Status must be made on the Plan's enrollment form, within thirty (30) days immediately following the date the Employee becomes or ceases to be an eligible Employee. A Change in Status will not be deemed to be a break or termination of coverage and will not operate to reduce or increase any coverage or accumulations toward satisfaction of the deductible and Out-of-Pocket Maximum to which the Covered Person was entitled prior to the Change in Status.

RETIREE CONTINUATION COVERAGE

A Retiree from the City of McKinney under the Texas Municipal Retirement System (TMRS) may elect to continue dental coverage for himself/herself and any Dependent(s) who are covered under the plan as of the date of retirement. Retiree Continuation Coverage is not available for anyone who is eligible for Medicare or who has already been terminated from the plan.

To elect Retiree Continuation Coverage, the Retiree must notify the City of McKinney Human Resources Department no later than the date of retirement. The Retiree may elect to drop coverage for one or more persons, while continuing it for others. However, once coverage is dropped for an individual, coverage cannot be reinstated. No new Dependents may be added to Retiree Continuation Coverage.

If the Retiree or his/her Dependent is eligible for Medicare as of the date of retirement, the Retiree may elect to purchase a Medicare supplement offered by the City or you coverage may continue according to your rights under the federal continuation coverage law (COBRA). If the Retiree elect federal continuation coverage (COBRA), coverage under this Plan will terminate and cannot be elected at a later time. If Retiree Continuation Coverage ends for the Retiree or a Dependent due to eligibility for Medicare, the Retiree may elect to purchase a Medicare supplement offered by the City.

Retirees or their Dependents must make monthly payments to continue coverage. Payments are due at the first of each month for that month's coverage. If the Retiree fails to make a required payment on time, coverage may be terminated.

Eligibility and Continuation Provision for a Certified Public Safety Officer (Defined in Section 1204 of Title I of the Omnibus Crime Control and Safe Streets Act of 1968) as provided under Omnibus Appropriations Act, 1997 of section 615 of P.L. 104-208.

A certified public safety officer (law enforcement officer or fire fighter) who retires or is separated from service due to Injury suffered as a direct and proximate result of a personal Injury sustained in the line of duty while responding to an emergency situation as such terms are defined by State law will be able to retain coverage under the Employee Healthcare Plan at his/her own expense. The Plan Administrator will review such cases to determine eligibility under this category of benefit.

ELIGIBILITY OF SURVIVING SPOUSE/CHILDREN OF CERTIFIED PUBLIC SAFETY OFFICER OR RETIREE CONTINUATION COVERAGE

The Dependent spouse and/or Dependent child (ren) of a City of McKinney, Texas certified public safety officer (law enforcement officer or firefighter) who is killed in the line of duty may continue their dental coverage under the Plan provided coverage was in place at the time of the event, or if not currently covered under the Plan, may so elect to join the Plan at the time of the event. Such continuation will be offered on a contributory basis. The contribution will be the total current cost to cover a similarly situated active Employee or Dependent. The surviving spouse and/or surviving child(ren) shall notify the City, in writing, within ninety (90) days of notification of the date of the Employee's death of the continuation election. Coverage, as amended periodically, will remain in force until the earliest of the following dates:

1. The date the spouse remarries;
2. The date the child (ren) no longer meet(s) the Dependent eligibility requirements;
3. The date which is the end of the period for which a contribution was made if the required contribution is not made within thirty (30) days of the due date; or
4. The date the City terminates this Plan.

The spouse and/or child(ren) of a deceased Retiree may continue coverage under this Plan on a contributory basis. Such continuation shall end on the earliest of the following dates:

1. In the case of a surviving spouse, when coverage becomes available under another group health plan through employment or remarriage;
2. In the case of a Dependent child, the date the child no longer meets this Dependent eligibility requirements or the date coverage becomes available under another group health plan through a parent, guardian or employment;
3. The date which represents the end of the period for which a contribution was made if the required contribution is not made within thirty (30) days of the due date;
4. The date the spouse or Dependent becomes ineligible due to other limitations of this Plan or as the matter of law; or
5. The date the City terminates this Plan. In the event a surviving spouse or surviving child is or becomes ineligible for these continuation provisions, the continuation provisions of this Plan will apply as of the date of ineligibility.

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the date you meet the following criteria:

1. Change of Status. Change in status is defined as:
 - A. Change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
 - B. Change in number of Dependents due to birth, adoption, Placement for Adoption, or death of a Dependent;
 - C. Change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
 - D. Changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
 - E. Change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
 - F. Changes which cause a Dependent to become eligible or ineligible for coverage.
2. Court Order. A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.
3. Medicare or Medicaid Eligibility/Entitlement. The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.
4. Change in Cost of Coverage. If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

5. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

PURPOSE

Pursuant to Section 609(a) of ERISA, the Plan Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Employer adopts ERISA standards to comply with child support enforcement obligation of Part D of Title IV of the Social Security Act of 1975 as amended.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.
2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:
 - A. Provides for child support for a child of a Participant under this Plan; or
 - B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and
 - C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.
3. "Plan" means this self-funded Employee Health Benefit Plan, including all supplements and amendments in effect.
4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

To be qualified, a Medical Child Support Order must clearly:

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and
2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

In the case of any Medical Child Support Order received by this Plan:

1. The Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether Medical Child Support Orders are qualified orders; and
2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

NATIONAL MEDICAL SUPPORT NOTICE

If the Plan Administrator of a group health plan which is maintained by the Employer of a non-custodial parent of a child, or to which such an employer contributes, receives an appropriately completed National Medical Support Notice as described in Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the criteria shown above for a qualified order, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such child.

FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act (FMLA) requires Employers who are subject to FMLA to allow their “eligible” Employees to take unpaid, job-protected leave. The Employer may also require or allow the Employee to substitute appropriate paid leave including, but not limited to, vacation and sick leave, if the Employee has earned or accrued it. The maximum leave required by FMLA is twelve (12) workweeks in any twelve (12) month period for certain family and medical reasons and a maximum combined total of twenty-six (26) workweeks during any twelve (12) month period for certain family and medical reasons and for a serious Injury or Illness of a member of the Armed Forces to allow the Employee, who is the spouse, son, daughter, parent, or next of kin to the member of the Armed Forces, to care for that member of the Armed Forces. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the Employee may work a part-time schedule.

DEFINITIONS

For these Family and Medical Leave Act of 1993 provisions only, the following definitions apply:

1. “Member of the Armed Forces” includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation or therapy.
2. “Next of Kin” means the nearest blood relative to the service member.
3. “Parent” means Employee’s biological parent or someone who has acted as Employee’s parent in place of Employee’s biological parent when Employee was a son or daughter.
4. “Serious health condition” means an Illness, Injury impairment, or physical or mental condition that involves:
 - A. Inpatient care in a hospital, hospice, or residential medical facility; or
 - B. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).
5. “Serious Injury or Illness” means an Injury or Illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform his or her military duties.
6. “Son or daughter” means Employee’s biological child, adopted child, stepchild, legal foster child, a child placed in Employee’s legal custody, or a child for which Employee is acting as the parent in place of the child’s natural blood related parent. The child must be:
 - A. Under the age of eighteen (18); or
 - B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.
7. “Spouse” means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including “common law” marriage and same-sex marriage.

EMPLOYERS SUBJECT TO FMLA

In general, FMLA applies to any employer engaged in interstate commerce or in any industry or activity affecting interstate commerce who employs 50 or more Employees for each working day during each of 20 or more calendar work weeks in the current or preceding Calendar Year. FMLA also applies to those persons described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States government, state governments and political subdivisions thereof.

ELIGIBLE EMPLOYEES

Generally, an Employee is eligible for FMLA leave only if the Employee satisfies all of the following requirements as of the date on which any requested FMLA leave is to commence: (1) has been employed by the Employer for a total of at least twelve months (whether consecutive or not); (2) the Employee has worked (as defined under the Fair Labor Standards Act) at least 1,250 hours during the twelve-(12) month period immediately preceding the date the requested leave is to commence; (3) the Employee is employed in any state of the United States, the District of Columbia or any Territories or possession of the United States; and (4) at the time the leave is requested, the Employee is employed at a work site where 50 or more Employees are employed by the Employer within 75 surface miles of the work site.

REASONS FOR TAKING LEAVE

FMLA leave must be granted (1) to care for the Employee's newborn child; (2) to care for a child placed with the Employee for adoption or foster care; (3) to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; (4) because the Employee's own serious health condition prevents the Employee from performing his or her job; or (5) because of a qualifying exigency, as determined by the Secretary of Labor, arising out of the fact that a spouse, son, daughter or parent of the Employee is on active duty or has been called to active duty in the Armed Forces in support of a contingency operation (e.g., a war or national emergency declared by the President or Congress).

ADVANCE NOTICE AND MEDICAL CERTIFICATION

Ordinarily, an Employee must provide thirty (30) days advance notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one to two working days. An employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

PROTECTION OF JOB BENEFITS

For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same conditions as coverage would have been provided if the Employee had been in Active Service during FMLA leave period. Taking FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave, unless the loss would have occurred even if the Employee had been in Active Service.

UNLAWFUL ACTS BY EMPLOYERS

Employers cannot interfere with, restrain or deny the exercise of any right provided under the FMLA or to manipulate circumstances to avoid responsibilities under the FMLA. Employers may not discharge, or discriminate against any person who opposes any practice made unlawful by the FMLA or who may be involved in a proceeding under or relating to the FMLA.

ENFORCEMENT

The U.S. Department of Labor is authorized to investigate and resolve complaints of FMLA violations. An eligible Employee may also bring a civil action against an employer for FMLA violations. The FMLA does not supersede any federal or state law prohibiting discrimination, and does not supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. For additional information, contact the nearest office of Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Participant's employment terminates; or
2. On the last day of the month in which the Participant ceases to be eligible for coverage; or
3. The date the Participant fails to make any required contribution for coverage; or
4. The date the Plan is terminated; or
5. The date the City terminates the Participant's coverage; or
6. The date the Participant dies; or
7. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Participant; or
8. For Variable Hour Employees on the last day of the Coverage Period, unless at the expiration of the Coverage Period, the Participant is otherwise eligible as the result of a subsequent Measurement Period or as a result of being reclassified as a Full Time Employee.

TEMPORARY LAYOFF OR LEAVE OF ABSENCE

A Participant whose Active Service ceases due to temporary layoff or leave of absence may remain covered as an Employee in Active Service until such coverage is canceled by the City.

If, after depletion of sick leave and vacation time, Active Service ceases due to an approved non-medical temporary Leave of Absence, lay-off, an approved Medical and Disability Leave, an approved leave of absence subject to the Family and Medical Leave Act (FMLA) or approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave), the Plan Administrator may, while the Plan is in force, continue the Employee's coverage (Employee and Dependent) during the period after cessation of Active Service due to:

1. Approved non-medical temporary Leave of Absence, or lay-off, as specified in the City of McKinney Employee Handbook, provided any required Employee contributions are made; or
2. Approved Medical and Disability Leave of Absence, as specified in the City of McKinney Employee Handbook, provided any required Employee contributions are made; or
3. Approved Family and Medical Leave (FMLA), but not to exceed a period of twelve (12) weeks (or twenty-six (26) weeks in the case of a family service member medical leave) provided any required Employee contributions are made; or
4. Approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave) for up to the minimum amount of time required by such State law provided any required Employee contributions are made.

The approved non-medical Leave of Absence and approved Medical and Disability Leave are concurrent with, and not in addition to, the twelve (12) week (or twenty-six (26) weeks in the case of a family service member medical leave) approved Family and Medical Leave (FMLA) or the minimum amount of time required by an approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave).

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary lay off, the amount of his or her coverage will be the same as the Plan benefits in force for an active Employee, subject to the Plan's right to amend coverage and benefits.

RETIREE TERMINATION

For anyone covered under the Retiree Continuation Coverage, coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. The date he/she becomes eligible for Medicare;
2. The date on which he/she attains age sixty-five (65) or otherwise ceases to be eligible for coverage;
3. The last day for which any required contribution for coverage; or
4. The date the Plan is terminated; or
5. The date the City terminates the Retiree's coverage; or
6. The date the Retiree dies.

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of reduction in hours and who again becomes eligible for coverage under the Plan within one (1) year immediately following the date of such termination of coverage will become eligible for reinstatement of coverage on the date of renewed eligibility.

An Employee whose coverage terminates by reason of termination of employment and who again becomes eligible for coverage under the Plan within a ninety (90) day period immediately following the date of such termination of employment will become eligible for reinstatement of coverage on the date of renewed eligibility.

Coverage will be reinstated for the Employee and eligible Dependents on the first of the month following the date of renewed eligibility, if covered on the date of termination, provided that application for such coverage is made on the Plan's enrollment form within thirty (30) days after the date of renewed eligibility. Reinstatement of Coverage is subject to the following:

1. Credit will be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.
2. All prior accumulations toward annual or lifetime benefit limits will apply.

If renewed eligibility occurs under any circumstances other than as stated in this sub-section, enrollment for coverage for the Employee and his/her Dependents will be treated as if initially hired for purposes of eligibility and coverage under this Plan.

The Reinstatement of Coverage provision is not applicable to a Variable Hour Employee except for any period of time that the Variable Employee is actually enrolled and covered during the Coverage Period.

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of Dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination.

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan; or
2. On the last day of the month in which the Participant's coverage terminates under the Plan; or
3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage; or
4. The date the Participant fails to make any required contribution for Dependent Coverage; or
5. The date the Plan is terminated; or
6. The date the City terminates the Dependent's coverage; or
7. On the last day of the month in which the Participant dies; or
8. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Dependent whose coverage is to be terminated.

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more Employees.

The Plan Administrator is City of McKinney; 222 North Tennessee St; McKinney, Texas 75069; (972) 547-7560. COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222.

COBRA Continuation Coverage is available to any Qualified Beneficiary whose coverage would otherwise terminate due to any Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day following the date of the Qualifying Event.

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:
 - A. The termination (other than by reason of gross misconduct) of the Participant's employment.
 - B. The reduction in hours of the Participant's employment.
2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:
 - A. Death of the Participant or Retiree.
 - B. Termination of the Participant's employment.
 - C. Reduction in hours of the Participant's employment.
 - D. The divorce or legal separation of the Participant or Retiree from his or her spouse.
 - E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Employer of the following Qualifying Events within sixty (60) days after the date the event occurs. The Employer must notify the Plan Administrator of any of the following:

1. Death of the Participant or Retiree.
2. The divorce or legal separation of the Participant or Retiree from his or her spouse.
3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

The Employer must notify the COBRA Administrator of the following Qualifying Events within thirty (30) days after the date of the event occurs:

1. Termination (other than by reason of gross misconduct) of the Participant's employment.
2. Reduction in hours of the Participant's employment.

ELECTION OF COVERAGE

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of continuation coverage. Monthly premium for continuation of coverage must be paid in advance to the Plan Administrator. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).
2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.
3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:
 - A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.
 - B. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Employer of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Employer.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806.

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

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and Dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent children if the former employee dies or becomes divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. **In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The dependents of a former employee are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the former employee's enrollment in Part A, Part B or Part D of Medicare, whichever occurs earlier.

When the former employee enrolls in Medicare before the Qualifying Event of termination, or reduction in hours, of employment occurs, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends on the later of:

1. Eighteen (18) months after the Qualifying Event of termination of employment or reduction in hours of employment; or
2. Thirty-six (36) months after the former employee's enrollment in Medicare.

When the former employee enrolls in Medicare after the Qualifying Event of termination, or reduction in hours, of employment, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends eighteen (18) months after the Qualifying Event, unless a second Qualifying Event, as described above occurs within that eighteen (18) month period.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage and any coverage under the Plan that has been elected with respect to any Qualified Beneficiary will cease on the earliest of the following:

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance.
2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A, Part B or Part D).
3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Plan Administrator.
4. On the date the Employer ceases to provide any group health plan coverage to any Employee.
5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.

6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:
 - A. Eighteen (18) months for a former employee who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment;
 - B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;
 - C. For the Dependent who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment of the former employee if that former employee enrolled in Medicare before termination, or reduction in hours, of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.
 - D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.
 - E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.
 - F. Thirty-six (36) months for all other Qualified Beneficiaries.
7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to Allegiance COBRA Services, Inc. or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

In order to protect the Employee's family's rights, the Employee should keep the Plan Administrator informed of any changes in the addresses of family members. The Employee should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

COVERAGE FOR A MILITARY RESERVIST

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. If a Participant is absent from employment with Employer by reason of service in the uniformed services, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:
 - A. The twenty-four (24) month period beginning on the date on which the Participant's absence begins; or
 - B. The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment, as required by USERRA.
2. A Participant who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.
3. In the case of a Participant whose coverage under the Plan is terminated by reason of service in the uniformed services, a Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if a Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is reemployed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. **This provision will not apply to the coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.**

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAW WHICH PERMITS CRIMINAL PENALTIES FOR FRAUDULENT ACTS COMMITTED AGAINST THE PLAN. STATE LAW MAY ALSO APPLY.

Anyone who knowingly defrauds or tries to defraud the Plan, or obtains Plan funds through false statements or fraudulent schemes, may be subject to criminal prosecution and penalties. The following may be considered fraudulent:

1. Falsifying eligibility criteria for a Dependent to get or continue coverage for that Dependent when not otherwise eligible for coverage;
2. Falsifying or withholding medical history or information required to calculate benefits;
3. Falsifying or altering documents to get coverage or benefits;
4. Permitting a person not otherwise eligible for coverage to use a Plan ID card to get Plan benefits; or
5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person;

The Plan Administrator, in its sole discretion, may take additional action against the Participant or Covered Person including, but not limited to, terminating the Participant or Covered Person's coverage under the Plan.

MISSTATEMENT OF AGE

If the Covered Person's age was misstated on an enrollment form or claim, the Covered Person's eligibility or amount of benefits, or both, will be adjusted to reflect the Covered Person's true age. If the Covered Person was not eligible for coverage under the Plan or for the amount of benefits received, the Plan has a right to recover any benefits paid by the Plan. A misstatement of age will not continue coverage that was otherwise properly terminated or terminate coverage that is otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Participant misrepresents a Dependent's marital status, age, full-time student status, dependent child relationship or other eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent will terminate as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not otherwise eligible as a Covered Person to use an ID card, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the Covered Person's coverage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan but for whom benefits were paid based upon fraud as defined in this section must be reimbursed to the Plan by the Participant. Failure to reimburse the Plan upon request may result in an interruption or a loss of benefits by the Participant and Dependents.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefitted from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits, or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf.

Payment of benefits by the Plan for Participants' spouses, ex-spouses, or children, who are not eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate, false information provided by, or information omitted by, the Employee will be reimbursed to the Plan by the Employee. The Employee's failure to reimburse the Plan after demand is made, may result in an interruption in or loss of benefits to the Employee, and could be reported to the appropriate governmental authorities for investigation of criminal fraud.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine.

The provisions of this section apply to any Physician or Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Physician or Licensed Health Care Provider fails to refund a payment of benefits, the Plan may refuse to recognize future assignments of benefits to that provider.

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was responsible or liable for payment of those medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid.

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the Plan, the Covered Person agrees to hold the money received in trust for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from any third party who is liable to the Covered Person for a loss or benefits paid by the Plan. The Plan may proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover benefits paid under the Plan.

The Covered Person agrees to subrogate to the Plan any and all claims, causes of action or rights that he or she has or that may arise against any entity who has or may have caused, contributed to or aggravated the accident, Injury, condition or Illness for which the Plan has paid benefits, and to subrogate any claims, causes of action or rights the Covered Person may have against any other coverage including, but not limited to, liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Covered Person decides not to pursue a claim against any third party or insurer, the Covered Person will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. Under the terms of this Plan, the Plan Supervisor is not required to pay any claim where there is evidence of liability of a third party unless the Covered Person signs the Plan's Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Plan Supervisor not to withhold payment of benefits while the liability of a party other than the Covered Person is being legally determined. If a repayment agreement is requested to be signed, the Plan's right of recovery through Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.
2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment.
3. The Covered Person will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the Plan from any liable third party. This cooperation includes, but is not limited to, make full and complete disclosure in a timely manner of all material facts regarding the accident, Injury, condition or Illness to the Plan Administrator; report all efforts by any person to recover any such monies; provide the Plan Administrator with any and all requested documents, reports and other information in a timely manner, regarding any demand, litigation or settlement involving the recovery of benefits paid by the Plan; and notify the Plan Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.
4. Covered Persons will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers including, but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.
5. The Covered Person will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.
6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order, except as limited by state law.

PLAN ADMINISTRATION

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of Eligible Expenses for dental services. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees and their covered Dependents.

EFFECTIVE DATE

The effective date of the Plan is January 1, 2016.

PLAN YEAR

The Plan Year will commence January 1st and end on December 31st of year.

PLAN SPONSOR

The Plan Sponsor is City of McKinney.

PLAN SUPERVISOR

The Supervisor of the Plan is Allegiance Benefit Plan Management, Inc.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is City of McKinney, a political subdivision of the State of Texas who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits under this Plan.

PLAN INTERPRETATION

The Named Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith will be final and binding.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

The Company will periodically evaluate the costs of the Plan and determine the amount to be contributed by the Company, if any, and the amount to be contributed, if any, by each Participant.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Plan Document contains all the terms of the Plan and may be amended at any time by the Plan Administrator. Any changes will be binding on each Participant and on any other Covered Persons referred to in this Plan Document. The authority to amend the Plan is delegated by the Plan Administrator to the City Manager or his or her designee, whichever is applicable, of the City. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the City Manager or his or her designee, whichever is applicable, of the City. Written notification of any amendments, modifications, revocations or terminations will be given to Plan Participants at least sixty (60) days prior to the effective date, except for amendments effective on the first day of a new Plan Year, for which thirty (30) days advance notice is required.

NOTICE OF REDUCTION OF BENEFITS

All changes or amendments to this Plan that directly or indirectly reduce any benefit or coverage under the Plan, including any increase in contribution for coverage required from a Participant, will be reported to all eligible Participants and Dependents within sixty (60) days of the date such change or amendment is adopted.

TERMINATION OF PLAN

The Company reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the Company will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

SUMMARY PLAN DESCRIPTIONS

Each Participant covered under this Plan will be issued a Summary Plan Description (SPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits, the limitations and exclusions of the Plan and summarizing the provisions of the Plan.

GENERAL PROVISIONS

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during pendency of the claim hereunder. The Plan will also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan. No payments will be made to any provider of services unless the Covered Person is liable for such expenses.

If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate. The Plan, in its sole option, may require that an estate, guardianship or conservatorship be established by a court of competent jurisdiction prior to the payment of any benefit. Any payment made under this subsection will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Plan will not be required to oversee the application of the money so paid.

LEGAL PROCEEDINGS

No action at law or equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

VERBAL STATEMENTS

Verbal statements or representations of the Plan Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF DENTAL SERVICE PROVIDER

The Covered Person will have free choice of any licensed Dental Service Provider and the patient-provider relationship will be maintained.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law will be amended to conform; all other parts of the Plan will remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Plan Document constitutes the primary authority for plan administration. The establishment, administration and maintenance of this Plan will not be deemed to constitute a contract of employment, give any Participant of the Company the right to be retained in the service of the Company, or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If the defined term is not used in this document, the term does not apply to this Plan.

Masculine pronouns used in this Plan Document will include either the masculine or feminine gender unless the context indicates otherwise.

Any words used herein in the singular or plural will include the alternative as applicable.

ACTIVE SERVICE

“Active Service” means that an Employee is in service with the Company on a day which is one of the Company's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the Company on a regular basis, either at one of the Company's business establishments or at some location to which the Company's business requires him/her to travel.

ADVERSE BENEFIT DETERMINATION

“Adverse Benefit Determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Dentally Necessary or appropriate.

AMBULATORY SURGICAL CENTER

“Ambulatory Surgical Center” (also called same-day surgery center or outpatient surgery center) means a licensed establishment with an organized staff of physicians and permanent facilities, either freestanding or as a part of a hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for surgical facilities in the state in which the facility is located. “Ambulatory Surgical Center” does not include an office or clinic maintained by a dentist or physician for the practice of dentistry or medicine, a hospital emergency room or trauma center.

BENEFIT PERCENTAGE

“Benefit Percentage” means that portion of Eligible Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

“Benefit Period” refers to a time period of one year, which is either a Calendar Year or Plan Year, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or
2. The day the Maximum Lifetime Benefit applicable to the Covered Person becomes paid; or
3. The date the Plan terminates.

CALENDAR YEAR

“Calendar Year” means a period of time commencing on January 1 and ending on December 31 of the same year.

CITY

“City” means City of McKinney or any affiliated agencies or boards that have adopted this Plan for its Employees.

CLOSE RELATIVE

“Close Relative” means the spouse, parent, brother, sister, child, or in-laws of the Covered Person.

COBRA

“COBRA” means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

“COBRA Continuation Coverage” means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of “COBRA”.

COSMETIC

“Cosmetic” means services or treatment ordered or performed solely to change a Covered Person's appearance rather than for the restoration of bodily function.

COVERED PERSON

“Covered Person” means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

DEDUCTIBLE

“Deductible” means a specified dollar amount of Eligible Expenses that must be incurred before the Plan will pay any amount for any Eligible Expense during each Benefit Period.

DENTAL HYGIENIST

“Dental Hygienist” means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

DENTALLY NECESSARY

“Dentally Necessary” means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose a Dental condition or dental disease; and
2. Are ordered by a Dentist or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the dental condition or dental disease; and

3. Are not primarily for the convenience of the Covered Person, Dentist or other Licensed Health Care Provider; and
4. Are the standard or level of services most appropriate for good dental practice that can be safely provided to the Covered Person; and
5. Are not of an Experimental/Investigational or solely educational nature; and
6. Are not provided primarily for dental, medical or other research; and
7. Do not involve excessive, unnecessary or repeated tests; and
8. Are commonly and customarily recognized by the dental profession as appropriate in the treatment or diagnosis of the diagnosed condition; and
9. Are approved procedures or guidelines by the Food and Drug Administration, Healthcare Financing Administration (HCFA), the American Dental Association, pursuant to that entity's program oversight authority based upon the dental treatment circumstances.

DENTIST

"Dentist" means a person holding one of the following degrees—Doctor of Dental Science, Doctor of Medical Dentistry, Master of Dental Surgery or Doctor of Medicine (oral surgeon)-- who is legally licensed as such to practice dentistry in the jurisdiction where services are rendered, and the services rendered are within the scope of his or her license.

A "Dentist" will not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

DENTURIST

A dental technician, duly licensed, specializing in the making and fitting of dentures.

DEPENDENT

"Dependent" means a person who is eligible for coverage under the Dependent Eligibility subsection of this Plan.

DEPENDENT COVERAGE

"Dependent Coverage" means eligibility for coverage under the terms of the Plan for benefits payable as a consequence of Eligible Incurred Expenses for a dental condition or dental disease of a Dependent.

ELIGIBLE EXPENSES

"Eligible Expenses" means the maximum amount of any charge for a covered service, treatment or supplies listed as Covered Services and that are not specifically excluded by the Plan and which meet all the requirements outlined in the Covered Expenses provision may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible. Eligible Expenses are equal to the actual billed charge or UCR, whichever is less.

EMPLOYEE

“Employee” means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer’s W-2 payroll.

Employee does not include any employee leased from another employer including, but not limited to, those individuals defined in Internal Revenue Code Section 414(n), or an individual classified by the Employer as a contract worker or independent contractor if such persons are not on the Employer’s W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as “Kelly,” “Manpower,” etc.

EMPLOYER

“Employer” means the City or any affiliated agencies or boards that have adopted this Plan for its Employees.

ENROLLMENT DATE

“Enrollment Date” means the date a person becomes eligible for coverage under this Plan or the eligible person’s effective date of coverage under this Plan, whichever occurs first.

ERISA

The term “ERISA” refers to the Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL/INVESTIGATIONAL

“Experimental/Investigational” means:

1. Any drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The services, supplies, treatments or procedures are not recognized in the dental community as an accepted standard of dental care or not dentally necessary for the diagnosis and/or treatment of an active dental condition or dental disease; or
3. Any drug, device, dental treatment or procedure for which the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
4. Based upon Reliable Evidence, any drug, device, treatment or procedure that is the subject of on-going Phase I or Phase II clinical trials, is the research, Experimental, study or investigational arm of on-going Phase III clinical trials, or is otherwise under ongoing study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally dentally accepted means of treatment or diagnosis; or
5. Based upon Reliable Evidence, any drug, device, treatment or procedure that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally accepted means of treatment or diagnosis; or
6. Any drug, device, treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, Health Care Financing Administration, American Dental Association, American Medical Association).

“Reliable Evidence” means only reports and articles published in authoritative medical and scientific literature; the written protocol or protocols used by a treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the informed consent document used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

FAMILY

“Family” means a Participant and his or her eligible Dependents as defined herein.

FMLA

“FMLA” means Family and Medical Leave Act.

HOSPITAL

“Hospital” means an institution which meets all of the following conditions:

1. It is engaged primarily in providing dental care and treatment to ill and injured persons on an Inpatient basis at the patient's expense; and
2. It is licensed as a Hospital under authority of the laws of the jurisdiction in which the facility is physically located; and
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and dental and surgical treatment of an Illness or an Injury; and
4. It provides treatment for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses (R.N.'s); and
5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and
6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

ILLNESS

“Illness” means a bodily disorder, Pregnancy, disease, physical sickness, mental illness, or functional nervous disorder of a Covered Person.

INCURRED EXPENSES OR EXPENSES INCURRED

“Incurred Expenses” or “Expenses Incurred” means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the treatment, service or supply is actually provided.

INITIAL ENROLLMENT PERIOD

“Initial Enrollment Period” means the time allowed by this Plan for enrollment when a person first becomes eligible for coverage.

INJURY

“Injury” means physical damage to the Covered Person's natural teeth or gums sustained as a result of an external force or forces and which is not caused by disease or bodily infirmity.

LICENSED HEALTH CARE PROVIDER

“Licensed Health Care Provider” means any provider of health care services who is licensed or certified by any applicable regulatory authority to the extent that services are within the scope of its license or certification and are not specifically excluded by this Plan.

MAXIMUM LIFETIME BENEFIT

“Maximum Lifetime Benefit” means the maximum benefit payable while a person is covered under this Plan. It will not be construed as providing lifetime coverage, or benefits for a person’s Dental condition or dental disease after coverage terminates under this Plan.

MEDICAID

“Medicaid” means that program of dental care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICARE

“Medicare” means the programs established under the “Health Insurance for the Aged Act,” Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those age 65 or older, those with end-stage renal disease, or with disabilities.

NAMED FIDUCIARY

“Named Fiduciary” means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

ORTHODONTIC TREATMENT

“Orthodontic Treatment” means an appliance or the surgical or functional/myofunctional treatment of dental irregularities which either result from abnormal growth and development of the teeth, gums or jaws, or from Injury which requires the positioning of the teeth to establish normal occlusion.

ORTHODONTIST

“Orthodontist” means a Dentist with special training who uses braces or corrective appliances to straighten teeth, correct jaw position and improve facial balance.

PARTICIPANT

“Participant” means an Employee of the Company who is eligible and enrolled for coverage under this Plan.

PLACEMENT OR PLACED FOR ADOPTION

“Placement” or “Placed for Adoption” means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child’s adoption. The child’s placement for adoption with such person ends upon the termination of such legal obligation.

PLAN

“Plan” means the Dental Benefit Plan for Employees of the Company, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

“Plan Administrator” means the Company and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of any applicable state legislation of a similar nature, the Company will be deemed to be the Plan Administrator of the Plan unless by action of the Board of Directors, the Company designates an individual or committee to act as Plan Administrator of the Plan.

PLAN SUPERVISOR

“Plan Supervisor” means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Plan Supervisor is Allegiance Benefit Plan Management, Inc. The Plan Supervisor provides ministerial duties only, exercises no discretion over plan assets and will not be considered a fiduciary as defined by ERISA (Employee Retirement Income Security Act) or any other State or Federal law or regulation.

PROSTHETIC APPLIANCE

“Prosthetic Appliance” means a device or appliance that is designed to replace all or part of a missing tooth or teeth.

QUALIFIED BENEFICIARY

“Qualified Beneficiary” means an Employee, former Employee or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA or Section 609(a) of ERISA in relation to QMCSO's.

“Qualified Beneficiary” will also include a child born to, adopted by or placed for adoption with an Employee or former Employee at any time during COBRA Continuation Coverage.

QMCSO

“QMCSO” means Qualified Medical Child Support Order as defined by Section 609(a) of ERISA, as amended.

RETIREE

“Retiree” means an Employee who retires from the City of McKinney under the Texas Municipal Retirement System (TMRS).

USERRA

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act, as amended.

USUAL, CUSTOMARY AND REASONABLE FEE (UCR)

“Usual, Customary and Reasonable (UCR)” means the maximum amount considered for payment by this Plan for any covered treatment, service, or supply, subject however, to all Plan annual and lifetime maximum benefit limitations. The following will apply in the order below to determine the Usual, Customary and Reasonable amount:

1. A contracted amount as established by a preferred provider or other discounting contract; or
2. An amount established through a nationally recognized, published Usual, Customary and Reasonable (UCR) data base utilized by the Plan Supervisor and adopted by the Plan Administrator using the 90th percentile of said database; or
3. The billed charge if less than 2 above.

**CITY OF MCKINNEY
MEDICAL BENEFIT PLAN
PLAN SUMMARY**

The following information, together with the information contained in this booklet, form the Summary Plan Description.

1. PLAN

The name of the Plan is CITY OF MCKINNEY MEDICAL BENEFIT PLAN, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

This Plan provides benefits for Eligible Expenses Incurred by eligible participants for:

Dental Expenses

3. PLAN EFFECTIVE DATE

This Plan was established effective January 1, 2015, restated January 1, 2016.

4. PLAN SPONSOR

Name: City of McKinney
Phone (972) 547-7560
Address: 222 North Tennessee St
McKinney, Texas 75069

5. PLAN ADMINISTRATOR

The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

Name: City of McKinney
Phone (972) 547-7560
Address: 222 North Tennessee St
McKinney, Texas 75069

8. PLAN TERMINATION

The right is reserved by the Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

9. IDENTIFICATION NUMBER

Group Number: 2001065
Employer Identification Number: 75-6000599

10. PLAN SUPERVISOR

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 3018
Missoula, MT 59806

11. ELIGIBILITY

Employees and dependents of employees of the Plan Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

12. PLAN FUNDING

The Plan is funded by contributions from the Employer and Employees.

13. AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator is the agent for service of legal process.
