FIRST AMENDMENT TO THE
SPARTA AREA SCHOOLS
VISION BENEFITS PLAN
FOR TEACHERS
AS AMENDED AND RESTATED
EFFECTIVE JANUARY 1, 2012

WHEREAS, Sparta Area Schools has adopted the Sparta Area Schools Vision Benefits Plan for Teachers Effective January 1, 2012 (The Plan); and

WHEREAS, Sparta Area Schools has reserved the right to amend the Plan at anytime; and

WHEREAS, Sparta Area Schools wishes to amend the Plan at this time to ensure a certain level of benefits for Plan participants.

NOW, THEREFORE, BE IT RESOLVED, that the Plan is hereby amended as follows:

EFFECTIVE SEPTEMBER 1, 2013

Wherever the plan states that the Claim Administrator of the Plan is ASR Health Benefits (ASR), along with their address and telephone number are deleted and replaced with:

NGS CoreSource
PO Box 2310
Mt. Clemens, MI 48046
(800) 521-1555

****

Vision claims can be sent to:

NGS CoreSource
PO Box 2310
Mt. Clemens, MI 48046
(800) 521-1555

****

IN WITNESS WHEREOF, Sparta Area Schools has adopted this First Amendment to the Plan, this 16 day of September, 2013.

SPARTA AREA SCHOOLS

BY: _____

TITLE: _____

SUMMARY OF PLAN CHANGE TO
SPARTA AREA SCHOOLS
VISION BENEFITS PLAN
FOR TEACHERS
AS AMENDED AND RESTATED
EFFECTIVE JANUARY 1, 2012

EFFECTIVE SEPTEMBER 1, 2013

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Mt. Clemens, MI 48046
(800) 521-1555

THIS IS AN AMENDED AND RESTATED

VISION BENEFITS PLAN FOR

SPARTA AREA SCHOOLS

Effective Date of Amended and Restated Plan:

January 1, 2012

Group Number: G-421

SPECIAL NOTE ON CLAIM FILING

ALL BILLS MUST BE SUBMITTED TO THE PLAN WITHIN 12 MONTHS FROM THE DATE THE CHARGES WERE INCURRED IN ORDER TO BE CONSIDERED FOR PAYMENT (EXCEPT AS REQUIRED BY LAW, e.g., MEDICAID).

This requirement regarding the time period for filing claims shall supersede any other provision in the Plan document regarding the specific time period allowed for submitting bills or filing claims.

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INTRODUCTION

SPARTA AREA SCHOOLS has established the Vision Benefits Plan as a self-funded employer group benefits plan in order to provide certain benefits for certain Employees and their eligible Dependents. Sparta Area Schools executes this amended and restated document, including any future addenda, to re-establish this Plan for the exclusive benefit of the participating Employees and their Dependents. This document is also considered to be the Summary Plan Description and is intended to explain the Plan. Please read this document carefully and acquaint your Family with its provisions.

This Plan is not an arrangement whereby each enrollee is covered by insurance. Instead, the School District funds claims. However, if for some reason the claims that are eligible for payment under the Plan are not paid, the individuals covered by the Plan could ultimately be responsible for those expenses.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is **SPARTA AREA SCHOOLS**. The Plan Administrator shall have the authority and discretion 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.

CLAIM ADMINISTRATOR

The Claim Administrator of the Plan is **ASR HEALTH BENEFITS (ASR)**. The Claim Administrator shall only have the responsibilities delegated to it in writing in an Administration Agreement or other written agreement. The Claim Administrator is not a fiduciary.

The Claim Administrator processes claims and does not insure that any claims of Covered Persons will be paid.

SCHOOL DISTRICT'S OBLIGATIONS

The School District shall pay all benefits and expenses of the Plan from its general assets. The School District does not establish a separate fund for the payment of Plan benefits.

OTHER BASIC INFORMATION ABOUT THE PLAN

1.	*Plan Name:*	Vision Benefits Plan for Sparta Area Schools
2.	*Type of Plan:*	Welfare Benefit Plan providing vision benefits
3.	*Group Number:*	G-421

4.	*Plan Sponsor/Plan Administrator:*	Sparta Area Schools 465 S. Union Street Sparta, Michigan 49345 (616) 887-8253
5.	*Employer Identification No.:*	38-6002095
6.	*Claim Administrator:*	ASR Health Benefits P.O. Box 6392 Grand Rapids, Michigan 49516-6392 (616) 957-1751 or (800) 968-2449
7.	*Type of Administration:*	The Claim Administrator administers claims for benefits pursuant to a contract with the Plan Sponsor/Plan Administrator.
8.	*Agent for Service of Legal Process:*	Superintendent Sparta Area Schools 465 S. Union Street Sparta, Michigan 49345 Service of process may be made upon the Plan Administrator.
9.	*Effective Date of Amended and Restated Plan:*	January 1, 2012. The Plan has been in effect since September 1, 1991 and has been periodically amended and restated, most recently as of January 1, 2003.
10.	*Plan Year:*	September 1 through August 31

***PLEASE NOTE*: THIS PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION DESCRIBES THE CIRCUMSTANCES WHEN THE PLAN PAYS FOR VISION CARE. THERE MAY BE CIRCUMSTANCES WHEN YOU AND YOUR PHYSICIAN DETERMINE THAT VISION CARE THAT IS NOT COVERED BY THIS PLAN IS APPROPRIATE. REMEMBER THAT ALL DECISIONS REGARDING YOUR VISION CARE ARE UP TO YOU AND YOUR PHYSICIAN.**

HOW TO FILE A VISION CLAIM

If the bill is not being submitted directly by the provider, please submit itemized copies of any bills that have been incurred to the Claim Administrator, ASR Health Benefits (ASR), at the following address:

P.O. Box 6392
Grand Rapids, Michigan 49516-6392
(616) 957-1751, or (800) 968-2449

CLAIMS HANDLING

Complete and proper claims for benefits made by Covered Persons will be promptly processed but in the event there are delays in processing claims, Covered Persons shall have no greater rights to interest or other remedies against the Claim Administrator than as otherwise afforded by law.

All information will be reviewed promptly. The Plan Administrator or ASR may request missing or additional data if needed. The Plan Administrator or ASR reserves the right to require an original claim form or billing statement.

In order for any bill to be considered, the bill must be complete. Make sure that the bill shows the patient's full name, the date that services were rendered or purchases made, the type of care or supply received, and the cost per item.

Generally, the provider of service will be automatically reimbursed unless proof of prior payment is submitted when the claim is filed. Once a claim is processed, ASR will, acting on behalf of the Plan Administrator, send the School District or the Participant a check for the amount due and/or an "Explanation of Benefits" that is issued to others on behalf of the Covered Person. The Plan Administrator reserves the right to pay the approved portion directly to the Participant. Be sure to check for amounts that the Covered Person may be responsible for paying.

Try to keep copies of all bills and to submit expense claims to ASR as soon as each bill is received, even if the Deductible, if any, has not yet been met. Please read this booklet before a claim occurs because certain expenses are not covered under the Plan. If you have any questions, be sure to ask the School District or ASR.

BENEFITS

Benefits are described and are subject to the terms and conditions set forth in the pages that follow.

SCHEDULE OF VISION BENEFITS

BENEFITS	LIMITS
▪ Vision Examinations	$10 co-payment per exam, then Plan pays 100%*
▪ Eyeglass Frames and Lenses	$25 co-payment per set, then Plan pays 100%*
Maximum benefit paid per Covered Person per Plan Year for eyeglass frames	$65
▪ Contact Lenses (All kinds, including hard, soft, gas permeable, and disposable)	Plan pays 100%*
Maximum benefit paid per Covered Person per Plan Year for cosmetic contact lenses (includes examination charges)	$90**

**Charges for optically required contact lenses will not be subject to the above maximum benefit. For this purpose, "optically required" means a Covered Person's vision is not correctable to 20/70 in the better eye with spectacle lenses, but can be corrected to at least 20/70 by the use of contact lenses.

NOTE: The Plan will allow charges for one vision examination and **either** one set of eyeglass frames and lenses **or** contact lenses (one pair of conventional contact lenses or a one-year supply of extended wear/disposable contact lenses) per Covered Person every Plan Year.

*Subject to any limitations stated above, the Plan will pay at the benefit percentage stated above if the Participant's employment status is full-time. If the Participant's employment status is less than full-time, the benefit percentage may be prorated according to the number of hours at work.

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS

Notwithstanding the Payment Priorities rules set forth in the General Provisions section, the following special coordination rule applies regarding automobile insurance. If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides benefits, this Plan shall be the primary plan and the automobile insurance shall be the secondary plan for purposes of paying benefits.

GENERAL BENEFIT PROVISIONS

In order for the Plan to pay any benefits, all of the following requirements must be met:

A. An expense must be incurred by a Covered Person while this Plan is effective and the Covered Person participates in the Plan. Unless otherwise provided in the Plan, a Covered Expense, loss, charge, or claim is incurred on the date that services or materials are provided.

B. The Covered Person must follow the claim procedures of this Plan.

C. The benefit must be one of the benefits described in this Plan, including all causation limitations, Deductibles (if any), maximum limits and caps, benefit percentages, and any other payment limitations within the benefit.

D. The expense incurred by a Covered Person must be a Covered Expense payable under a benefit described in the Plan or a charge expressly covered by a benefit in the Plan.

E. The expense will be paid or reimbursed only to the extent that it is submitted with appropriate procedural and diagnostic codes for the service(s) rendered.

F. The expense must not be excluded or in excess of a limitation as provided in the General Plan Exclusions and Limitations section.

G. The expense must not be payable or reimbursable by another plan whose coverage is primary to the coverage of this Plan, as provided in the Coordination of Benefits section.

If a change in the coverage of a Covered Person that increases or decreases any maximum benefit applicable to the Covered Person becomes effective in accordance with the terms of the Plan, that increase or decrease shall apply immediately.

VISION BENEFITS

If a Covered Person incurs covered vision expenses, the Plan will pay benefits at the percentages stated in the Schedule of Benefits, subject to the maximums stated in the Schedule of Benefits. The following charges incurred by Covered Persons are considered Covered Expenses under this Plan:

A. Vision examinations by a Physician, limited to one examination in any Plan Year, including glaucoma testing.

B. Frames for prescription eyeglass lenses.

C. Eyeglass or Contact Lenses.

Only one pair of frames and eyeglass lenses, OR contact lenses up to the maximum amount allowed, will be covered by the Plan in any Plan Year.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all benefits provided by this Plan. No benefits shall be payable by the Plan for the following items:

A. *Charges Above Usual and Customary*

Charges that meet either of the following criteria:

1. Are in excess of Usual and Customary charges.

2. Are not in compliance with generally accepted billing practices for unbundling or multiple procedures.

B. *Completion of Claim Forms*

Charges incurred for completion of insurance or benefit payment claim forms.

C. *Correctional Institutions*

Charges resulting from, or in connection with, a Covered Person while the Covered Person is confined in a penal or correctional institution.

D. *Corrective Vision Surgery*

Charges incurred for or related to radial keratotomy, radial keratectomy, Lasik, or similar procedures.

E. *Cosmetic Procedures*

Charges incurred in connection with the care, treatment, or surgery performed for a Cosmetic Procedure. This exclusion shall not apply to procedures necessary to lessen or correct a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease for a Covered Person.

F. *Effective Date of Coverage*

Charges incurred before a Covered Person's effective date of coverage under the Plan, or after coverage and any extensions of participation are terminated.

G. *Extra Costs*

Charges associated with the extra cost of the following:

1. Progressive lenses.
2. Blended lenses.
3. Oversized lenses.
4. Tinted or coated lenses (other than pink #1 or #2).

H. *Fees and Taxes*

Charges for sales tax, processing fees, fees for the attainment of patient records, and the like.

I. *Illegal Acts*

Charges incurred for an illness or injury resulting from or occurring during the commission of a violation of law by the Covered Person, including, but not limited to, the engaging in an illegal occupation or act, the commission of an assault or battery, or the operation of a Motor Vehicle while the Covered Person is under the influence of alcohol or illegal drugs, but excluding minor, non-criminal traffic violations and similar civil infractions.

J. *Legal Obligation to Pay Charges*

Charges incurred 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.

K. *Lost, Stolen, or Broken*

Charges for the replacement of lost, stolen, or broken items, including eyeglasses and contact lenses, if benefits applicable to the replacement were previously provided during the Plan Year.

L. *Missed Appointments*

Charges for failure to keep an appointment.

M. *Non-Accepted Treatment and Procedures*

Charges for services or supplies that meet any of the following criteria:

1. Constitute personal comfort or beautification items.

2. Are for education or training purposes.

3. Are not recognized by the vision community as generally accepted care.

4. Are specifically listed by those communities as having no recognized value.

N. *Orthoptics, Vision Therapy, or Vision Aids*

Charges for Orthoptics, Vision Therapy, or sub-normal vision aids.

O. *Over-the-Counter Products*

Charges for all over-the-counter products, even though prescribed by a Physician.

P. *Provider Related to Covered Person*

Charges for services rendered by a Physician to a Covered Person if the Physician is the Covered Person, a Close Relative of the Covered Person, or resides in the same household as the Covered Person.

Q. *Services Provided by the U.S. Government*

Unless required by federal law, charges for services, treatments, or supplies furnished by the United States Government or any of its agencies.

R. *War or Armed Forces Service*

Charges caused as a result of war or any act of war, whether declared or undeclared, if incurred during service (including part-time service and national guard service) in the armed forces of any country.

S. *Work-Related*

Charges for the treatment of an injury or illness that arose out of or in the course of any employment or occupation for wage or profit for which the Covered Person is eligible for benefits or claims or has claimed to be eligible for benefits under any worker's compensation or occupational disease law, or any similar law, whether or not he or she has applied for these benefits.

NOTE: **These exclusions will not apply to the extent they would violate the Americans With Disabilities Act or any other applicable law. Further, these exclusions will not apply to the extent a court or other judicial body requires the Plan to provide coverage.**

ELIGIBILITY AND PARTICIPATION

SCHEDULE FOR ELIGIBILITY AND PARTICIPATION

PARTICIPANT ELIGIBILITY REQUIREMENTS

In order to be eligible to participate in this Plan, an individual must be currently employed by the School District as a teacher and must be recorded as eligible for coverage by the School District.

PARTICIPANT EFFECTIVE DATE

Participation in the Plan will start for new applicants on the first day on which they meet the Participant Eligibility Requirements stated above and meet the requirements described in the Participant Enrollment section below.

SCHOOL DISTRICT-PROVIDED EXTENSIONS OF PARTICIPATION

NOTE: A School District-provided extension of participation (including a Family and Medical Leave Act of 1993 [FMLA] extension of participation) will be in addition to the length of a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, extension of participation.

Medical Leave Extension of Participation ..... *In accordance with the FMLA*

Other Approved Leave of Absence Extension of Participation ..... *Until expiration of contract*

Layoff Extension of Participation ..... *As determined on a prorated basis, according to the number of days worked divided by the number of days that could have been worked in a 12-month period*

Extension of Dependent Participation Following Participant's Death.....*Through the end of the month in which the death occurred*

Additional information regarding Extensions of Participation is provided on page 18.

REINSTATEMENT.....*Unavailable*

RETIREE COVERAGE.....*Unavailable*

INITIAL REQUIREMENTS

PARTICIPANT ELIGIBILITY

A person is eligible for Participant Coverage under the Plan if the person meets all of the Participant eligibility requirements listed on the Schedule for Eligibility and Participation.

PARTICIPANT ENROLLMENT

Participant Coverage begins on the first date on which the person meets both of the following requirements:

A. The person is eligible for Participant Coverage.

B. The person has made written application for Participant Coverage on a form acceptable to the Plan Administrator.

If application for Participant Coverage is made after the first date on which coverage could begin, coverage will begin on the date on which the application is made unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

A. The applicant declined coverage when initially eligible because the applicant had coverage under another group plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:

1. The other coverage was COBRA, and it has been exhausted.

2. The applicant became ineligible (i.e., as a result of a Change in Status).

3. Employer contributions for the coverage have been terminated.

4. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).

5. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).

6. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative coverage).

7. A plan's lifetime limit on all benefits was applied.

Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

B. The applicant has acquired a new Dependent by marriage, birth, adoption, or placement for adoption. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, and any child who became a Dependent on account of the marriage, birth, adoption, or placement for adoption.

C. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

An applicant with special enrollment rights must make application for Participant Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage or marriage, birth, adoption, or placement for adoption (whichever is applicable). However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Participant Coverage shall be effective as of the date of the loss of other coverage, the marriage, birth, adoption or placement for adoption, the loss of Medicaid or CHIP eligibility, or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy.

For an applicant with special enrollment rights who fails to make application for Participant Coverage during the Special Enrollment Period, coverage will begin on the date on which the application is made.

All Participant Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

DEPENDENT ELIGIBILITY

A person is eligible for Dependent Coverage under the Plan when both of the following requirements are met:

A. The person is a Dependent.

B. The Participant on whom the person is dependent is eligible for Participant Coverage.

DEPENDENT ENROLLMENT

Dependent Coverage begins when all of the following requirements are met:

A. The person is eligible for Dependent Coverage.

B. The Participant on whom the person is dependent is a Covered Person.

C. The Participant makes a written application for Dependent Coverage on a form acceptable to the Plan Administrator on or before the first date that coverage could begin. This requirement does not apply to newly acquired Dependents by marriage, birth, court order or decree (e.g., adoption or during the placement of the Dependent for adoption), or restoration of Full-Time Student status. For these Dependents, see the next paragraph below.

Notwithstanding the immediately preceding paragraph, the following special rules apply to newly acquired Dependents by marriage, birth, court order or decree (e.g., adoption or during the placement of the Dependent for adoption), or restoration of Full-Time Student status:

1. A Participant's spouse may be enrolled as a Dependent as of the date of marriage if written application for Dependent Coverage for the spouse is made within 30 days of the date of marriage.

2. A Participant's newborn will be covered from the moment of birth if written application for Dependent Coverage for the child is made within 30 days of the child's date of birth.

3. If a Dependent is acquired other than at the time of the Dependent's birth on account of marriage, or a court order or decree, that Dependent may be enrolled as a Dependent as of the date of the marriage, court order or decree, if written application for Dependent Coverage for the new Dependent is made within 30 days of the court order, decree, or marriage. Dependent Coverage for a child to be placed with a Participant through adoption is effective as of the date the child is placed for adoption, if written application for Dependent Coverage for the child is made within 30 days of the child's placement. A child is considered placed for

adoption if the Participant has a legal obligation for total or partial support of the child in anticipation of the child's adoption.

4. If a Dependent is acquired other than at the time of the Dependent's birth owing to restoration of Full-Time Student status, that Dependent may be enrolled as a Dependent as of the date he or she begins regularly attending classes as a Full-Time Student, if written application for Dependent Coverage for the new Dependent is made within 30 days of that date.

If application for Dependent Coverage is not made within 30 days after the date coverage could have begun, coverage will begin on the first day of the following Plan Year unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

1. The applicant declined coverage when initially eligible because the applicant had coverage under another group plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:

   a. The other coverage was COBRA, and it has been exhausted.

   b. The applicant became ineligible (i.e., as a result of a Change in Status).

   c. Employer contributions for the coverage have been terminated.

   d. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).

   e. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).

   f. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative coverage).

   g. A plan's lifetime limit on all benefits was applied.

   Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

   An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

2. The applicant has acquired a new Dependent by marriage, birth, adoption, or placement for adoption. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, and any child who became a Dependent on account of the marriage, birth, adoption, or placement for adoption.

3. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

An applicant with special enrollment rights must make application for Dependent Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage or marriage, birth, adoption, or placement for adoption (whichever is applicable). However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Dependent Coverage shall be effective as of the date of the loss of other coverage, the marriage, birth, adoption or placement for adoption, the loss of Medicaid or CHIP eligibility, or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy.

For an applicant with special enrollment rights who fails to make application for Dependent Coverage during the Special Enrollment Period, coverage will begin on the first day of the following Plan Year.

Except for newborn coverage, which shall begin at the moment of birth, Dependent Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

COURT- OR STATE-INITIATED QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If an Employee participating in the Plan is required to provide health care coverage for a child pursuant to a Qualified Medical Child Support Order (QMCSO) initiated by a court or state administrative agency, the following rules apply:

A. The Plan Administrator must receive notice of the order and must determine, in accordance with established procedures, that the order constitutes a QMCSO. If the Plan Administrator determines that the order constitutes a QMCSO, the remaining provisions in this section shall then apply.

B. The child may be enrolled in the Plan without regard to any enrollment season restrictions (e.g., an annual open enrollment period, if available). Further, if the Employee fails to enroll the child, the child may, in accordance with applicable

law, be enrolled by the state administrative agency initiating the QMCSO or by the non-covered parent. Further, the Plan Administrator cannot refuse to enroll the child because the child was born out of wedlock, was not claimed as a dependent on the Employee's federal income tax return, or does not reside with the Employee.

C. The Employee must pay any required contributions for the child's coverage on the same basis as if the Employee elected Dependent Coverage for the child under the Plan. If the Employee fails to elect or is not eligible to elect the necessary compensation reduction contributions for the child's coverage on a before-tax basis under any Section 125 plan maintained by the School District, the School District may withhold the required contributions from the Employee's paychecks on an after-tax basis to the extent permitted by applicable law.

D. If the Employee is not the custodial parent, the Plan Administrator shall provide whatever information is needed to the custodial parent for the child to obtain benefits.

E. If the Employee is not the custodial parent, the Plan Administrator shall permit the custodial parent to submit claims on behalf of the child without the approval of the Employee.

F. If the Employee is not the custodial parent, the Plan Administrator may make benefit payments to the custodial parent or the state administrative agency initiating the QMCSO, in addition to any other parties to which payment may be made as provided by the Plan.

G. The child's coverage under the Plan may not be terminated, except in the following circumstances:

1. Required contributions for coverage have not been paid in a timely manner.

2. There is written evidence that the QMCSO is no longer in effect.

3. There is written evidence that the child is or will be enrolled in comparable coverage that takes effect not later than the effective date of termination of coverage.

4. The School District has eliminated Dependent Coverage for all participating Employees.

H. The Plan Administrator shall maintain procedures governing the determination as to whether an order constitutes a QMCSO. Covered Persons can obtain, without charge, a copy of the procedures from the Plan Administrator.

SWITCHING COVERAGE STATUS

If a Dependent is eligible to be enrolled as a Participant, enrollment may be effective on the date of the enrollment. If a Participant is eligible to be enrolled as a Dependent, enrollment may be effective on the date of the enrollment. Any switches in coverage status do not interrupt participation in the Plan and do not change a Covered Person's effective date of coverage.

PARTICIPANT CONTRIBUTION

The School District may require a contribution from Participants in order to maintain Employee participation and/or the participation of any Dependents in the Plan. If Participant contributions are required, the School District will notify the Participants of the designated amount. If the School District maintains a Section 125 Plan, the required contributions may be paid on a pre-tax basis under that plan.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation provisions:

A. Through the end of the month in which the Participant's employment terminated.

B. Date on which the Participant goes on a leave of absence, is laid-off, or is, on a regular basis, Actively At Work in employment by the School District for less than the number of hours per week required to be initially eligible for coverage. However, a reduction in hours owing to a family or medical leave as defined by the FMLA shall not cause health coverage to end to the extent required by the FMLA.

C. Date on which the Participant ceases to be in a classification (if any) shown in the Schedule for Eligibility and Participation for Participant Coverage.

D. The last day of the period for which the Participant fails to timely make any required contribution for coverage.

E. Date on which the Plan is terminated; or with respect to any benefit(s) of the Plan, the date of termination of such benefit(s).

F. Date on which the Plan Administrator terminates the Participant's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits. However, coverage cannot be retroactively rescinded absent fraud or intentional misrepresentation.

G. Effective date of the Participant's notice of voluntary withdrawal. However, where required contributions for coverage are paid on a pre-tax basis through the School District's Section 125 plan, a voluntary withdrawal may only occur during the annual open enrollment period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the School District's Section 125 plan.

H. Date of the Participant's death.

Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

REINSTATEMENT

Reinstatement is not available under this Plan, except as required by law. Accordingly, a veteran's right and entitlement to reinstatement on returning from military training or service shall be governed by the Uniformed Services Employment and Reemployment Rights Act (USERRA), and any other applicable laws or regulations. Further, see the Family and Medical Leave Act of 1993 (FMLA) section below regarding the right to reinstatement upon return to work from an FMLA leave. Otherwise, a Participant whose coverage terminates and who resumes employment with the School District in an Employee classification that is eligible for Plan coverage will be considered a new Employee for purposes of determining when coverage begins.

DEPENDENT TERMINATION

Dependent Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation provisions:

A. Date on which the Dependent ceases to be a Dependent.

B. Date of termination of the Participant's coverage under the Plan.

C. The last day of the period for which the Participant fails to make any required contributions for Dependent Coverage in a timely manner.

D. Date on which the Plan Administrator terminates the Dependent's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits. However, coverage cannot be retroactively rescinded absent fraud or intentional misrepresentation.

E. Date on which the Dependent begins Participant Coverage under the Plan.

F. Date on which the Plan or a benefit of the Plan is terminated.

G. Effective date of the notice of voluntary withdrawal made by or on behalf of the Dependent. However, where required contributions for coverage are paid on a pre-tax basis through the School District's Section 125 plan, a voluntary withdrawal may occur only during the annual open enrollment period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the School District's Section 125 plan.

H. Date of the Dependent's death.

The Participant is obligated to immediately report to the Plan Administrator any change that would result in a Dependent's termination of coverage. Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

EXTENSIONS OF PARTICIPATION

A Participant may have participation extended under School District-provided extensions specified in the Schedule For Eligibility And Participation, under the FMLA, or under COBRA. Any School District-provided extension of participation will apply before a COBRA extension of participation and will be in addition to the length of a COBRA extension of participation.

Notwithstanding any of the following provisions concerning extensions of participation, coverage for the Participant or the Participant's Dependent(s) may be immediately reduced or terminated by amendment to the Plan or termination of the Plan. If an event causing the Participant's or the Dependent's coverage to terminate also causes another extension of participation, a new extension period will begin for the Participant or the Participant's Dependent(s) on the date of such event.

Coverage during a School District-provided extension of participation shall be continued on the same basis and at the same contribution level as if the Participant had continued in active employment for the duration of the leave.

SCHOOL DISTRICT-PROVIDED EXTENSIONS OF PARTICIPATION

Medical Leave Extension

Participation for a Participant and any eligible Dependents continues if the Participant has been granted a medical leave by the School District in accordance with the FMLA. This extension of participation begins on the date on which the Participant's approved medical leave begins. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation or the expiration of the approved medical leave, whichever occurs first.

Approved Leave of Absence Extension

Participation for a Participant and any eligible Dependents continues if the Participant is granted an approved leave of absence (other than a medical leave described in the above paragraph) by

the School District under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved leave of absence begins. However, if the Participant's approved leave of absence constitutes an FMLA leave, the extension of participation shall begin on the date on which the FMLA leave expires. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation or the expiration of the approved leave of absence, whichever occurs first.

Layoff Extension

Participation for a Participant and any eligible Dependents continues if the Participant is laid-off by the School District. This extension of participation begins when the Participant is laid-off by the School District and terminates at the end of the time period stated in the Schedule for Eligibility and Participation or the expiration of the layoff, whichever occurs first.

Dependents' Extension if Participant Deceased

Participation for a Participant's Dependents continues if the Participant dies. This extension of participation begins on the date of the Participant's death and terminates at the end of the time period stated in the Schedule for Eligibility and Participation after the Participant's death, or when the spouse remarries, whichever occurs first.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The FMLA provisions of the Plan apply during any Calendar Year when the School District employs 50 or more Employees (including part-time Employees) each working day during 20 or more calendar weeks in the current or preceding Calendar Year. Further, the FMLA provisions apply only to eligible Participants (i.e., Participants who have been employed by the School District for at least 12 months and who have worked at least 1,250 hours in the 12-month period immediately preceding the taking of the FMLA leave). A Participant on leave under the FMLA may continue coverage during the leave on the same basis and at the same Participant contribution as if the Participant had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 weeks per 12-month period (as that 12-month period is defined by the School District). However, if a Participant takes leave under the FMLA to care for a spouse, parent, child, or next of kin injured in the line of active military duty, the maximum period of FMLA leave is 26 weeks per 12-month period. Other provisions regarding an FMLA leave are set forth in the FMLA and the School District's policy regarding the FMLA. If the Participant fails to return from the FMLA leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" as defined in the FMLA or other circumstance considered by the Plan Administrator as beyond the control of the Participant, the School District may recover any School District contribution paid to maintain coverage for the Participant during the leave. If a Participant fails to pay any required contribution for coverage during the FMLA leave within 30 days of the due date for the contribution, coverage shall be suspended upon 15 days advance written notification of the non-payment, subject to the right to reinstatement of coverage upon return to work from FMLA leave with no waiting period or other limitation normally applicable to a new Participant in the Plan.

COBRA EXTENSIONS OF PARTICIPATION

During any Calendar Year following a Calendar Year in which the School District had employed 20 or more Employees (including part-time Employees who are counted as a fraction of a full-time Employee) during at least 50% of the business days in the year, each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this Plan upon the occurrence of a Qualifying Event. Such extended coverage under the Plan is referred to as "Continuation Coverage." This section explains the requirements of COBRA. Individuals with questions regarding COBRA that are not answered in this document should contact the Plan Administrator at the address and telephone number listed in the Other Basic Information About the Plan section.

To protect their rights under COBRA, individuals should inform the Plan Administrator of any changes in the address of family members. Individuals should also keep a copy, for their records, of any notices they send to the Plan Administrator.

A. *Qualifying Event*

Any of the following shall be considered a "Qualifying Event" if the event causes a loss of coverage under the Plan:

1. Death of a Participant.

2. Termination (other than by reason of gross misconduct) of the Participant's employment or reduction of hours of the Participant's employment below any minimum required for participation in the Plan. Notwithstanding the above, a leave under the FMLA shall not constitute a Qualifying Event until the last day of the FMLA leave.

3. Divorce or legal separation of a Participant from the Participant's spouse.

4. A Participant becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act.

5. A Dependent child of a Participant ceasing to be a Dependent under the terms of the Plan (e.g., upon attainment of the age of majority).

B. *Qualified Beneficiary*

A "Qualified Beneficiary" is any person who, on the day before the occurrence of a Qualifying Event, is covered by the Plan as a Participant or a Dependent, unless one of the following exceptions applies:

1. A child born to or placed for adoption with a Participant after the Qualifying Event but before the end of the COBRA continuation period is a Qualified Beneficiary. However, the COBRA continuation period for

such a newborn or newly adopted child shall be measured from the date of the initial Qualifying Event, rather than on the subsequent date of birth or adoption or placement for adoption.

2. The spouse, former spouse, or Dependent children of a Participant are Qualified Beneficiaries upon the divorce or legal separation of the spouse and Participant, even if the Participant previously eliminated their coverage under the Plan in anticipation of the divorce or legal separation.

A child of the Participant who is covered under the Plan pursuant to a QMCSO can be a Qualified Beneficiary. A Participant can be a Qualified Beneficiary only if the Qualifying Event consists of termination of employment (for any reason other than gross misconduct) or reduction of hours of the Participant's employment.

Except as otherwise provided above, an individual is not a Qualified Beneficiary if, as of the day before the Qualifying Event, he or she is covered under the Plan by reason of the election of Continuation Coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event. Furthermore, an individual who fails to elect Continuation Coverage within the election period provided in Subsection I. below shall not be considered a Qualified Beneficiary.

C. *Type of Coverage*

Continuation Coverage means the group vision coverage that is provided to similarly situated non-Qualified Beneficiaries. Generally, this term means the same vision coverage provided to the Qualified Beneficiary immediately before the Qualifying Event. Alternatively, the Qualified Beneficiary may initially elect to purchase one or more of the available vision coverages that are provided by the School District pursuant to any separate group health plans and/or that may be separately elected pursuant to the School District's Section 125 plan (if any). However, each coverage is initially available only if the Qualified Beneficiary was receiving the coverage immediately before the Qualifying Event. Any change in the Plan or in enrollment opportunities affecting similarly situated active Employees, including, without limitation, a change in benefits under the Plan or any change in the Applicable Premium (see Subsection D. below), shall also apply to a Qualified Beneficiary.

D. *Cost of Continuation Coverage*

The School District is not responsible to contribute to the cost of Continuation Coverage. A Qualified Beneficiary who elects to continue coverage under the Plan shall be responsible to arrange for payment of the full cost of that coverage plus any additional amounts permitted by law (Applicable Premium).

A disabled Qualified Beneficiary who elects extended coverage under Subsection E(4) below shall be required to pay 150% of the full cost of coverage for each additional month of coverage after the initial 18-month period. The 150% cost amount shall also apply to the disabled Qualified Beneficiary's family members enrolled in Continuation Coverage, as long as the disabled Qualified Beneficiary is in the COBRA coverage group.

E. *Duration of Continuation Coverage*

1. *General Rule*. For a Qualifying Event caused by a Participant's termination or reduction in hours of employment, Continuation Coverage may extend for 18 months from the date of the Qualifying Event. For all other Qualifying Events, Continuation Coverage may extend for 36 months from the date of the Qualifying Event.

2. *Special Rule Where Coverage is Eliminated in Anticipation of Divorce*. Continuation Coverage may not be available to a Participant's spouse and Dependent children between the date coverage under the Plan is eliminated in anticipation of a divorce or legal separation and the date of the divorce or legal separation.

3. *Multiple Qualifying Events*. If, during an 18-month continuation period (or during the additional 11-month period in the event of disability, as described in Subsection E[4] below), another Qualifying Event that is a divorce, legal separation, the death of the Participant, or a child's loss of Dependent status under the Plan occurs, coverage may be extended for the Participant's Dependents for up to 36 months from the date of the original Qualifying Event. Notice of this second Qualifying Event must be provided to the Plan Administrator within 60 days of the date of the second Qualifying Event. If notice is not provided within this time period, the Qualified Beneficiaries shall be eligible for only 18 months of coverage, rather than 36 months.

4. *Special Rule For Disability*. In the case of a Qualified Beneficiary who is determined to be disabled before the original Qualifying Event or at any time during the first 60 days of Continuation Coverage, the maximum period of coverage for the disabled Qualified Beneficiary and the Qualified Beneficiaries who are his or her Dependents may be extended for an additional 11 months (29 months total from the date of the Qualifying Event).

   For this purpose, a Qualified Beneficiary is disabled only if the Qualified Beneficiary receives a determination of disability under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act.

Notice of the disability determination must be provided to the Plan Administrator before the end of the initial 18-month continuation period and within 60 days of the date of the disability determination or date of the Qualifying Event, if later. If notice is not provided within this time period, the Qualified Beneficiary shall be eligible for only 18 months of coverage, rather than 29 months.

The Qualified Beneficiary or the Qualified Beneficiary's representative must also notify the Plan Administrator within 30 days of any final determination that the Qualified Beneficiary is no longer disabled. The extended continuation coverage for disability shall terminate on the first day of the first month that begins more than 30 days after the date of the final determination that the Qualified Beneficiary is no longer disabled or, if earlier, on the date the Continuation Coverage for the Qualified Beneficiary would otherwise terminate.

5. *Special Rule for Medicare Entitlement.* If a Participant becomes entitled to Medicare during an 18-month continuation period, the maximum period of coverage for Qualified Beneficiaries other than the Participant may be extended to 36 months from the date of the original Qualifying Event if, ignoring the original Qualifying Event, the Participant's entitlement to Medicare would have been a Qualifying Event under the Plan.

   If a Participant becomes entitled to Medicare before experiencing a Qualifying Event that is a reduction in hours or termination of employment, the maximum continuation period for the Qualified Beneficiaries who are the Participant's Dependents shall end on the later of 36 months after the date of the Participant's Medicare entitlement or 18 months (29 months if there is a disability extension) after the date of the reduction in hours or termination of employment.

   Notice of the Participant's entitlement to Medicare must be provided to the Plan Administrator within 60 days of the date the Participant becomes entitled to Medicare or, if later, 60 days after the date of the Qualifying Event. If notice is not provided within this time period, the Qualified Beneficiaries who are the Participant's Dependents shall be eligible for only 18 months of coverage rather than 36 months.

F. *Plan Administrator's and School District's Notice Obligations*

The School District has the obligation to notify the Plan Administrator of certain Qualifying Events. The Plan Administrator has the obligation to provide a Participant, and the Participant's covered spouse (if any) with certain information about Continuation Coverage. This section describes those obligations.

1. *Plan Administrator's Initial Notice.* When an Employee becomes covered under this Plan, the Plan Administrator shall notify the Employee and the

Employee's covered spouse (if any) of their rights under COBRA. The Plan Administrator shall provide this notice no later than the earlier of 90 days from the date on which the Employee and the Employee's covered spouse (if any) first became covered under the Plan, or the date on which the Plan Administrator is required to provide the Participant or the Employee's Dependents with a notice of the right to elect Continuation Coverage (Election Notice).

The Plan Administrator may satisfy this requirement by providing a single notice addressed to both the Participant and the Participant's covered spouse (if any) where the Participant and covered spouse share a residence and the spouse's coverage begins before the date the initial notice is required to be provided to the Participant under this Subsection F(1).

2. *School District's Notice of Qualifying Event*. The School District has 30 days to notify the Plan Administrator of a Qualifying Event resulting from the death of the Participant, entitlement to Medicare, termination of employment, or reduction in hours from the date of its occurrence.

3. *Election Notice from Plan Administrator*. Within 14 days of receiving notice of the occurrence of a Qualifying Event (or a longer period as may be allowed by statute or regulation or as may be required to correct a COBRA failure), the Plan Administrator shall furnish each Qualified Beneficiary with notice of the right to elect Continuation Coverage (Election Notice).

4. *Notice of Unavailability of Continuation Coverage*. The Plan Administrator shall provide a notice of the unavailability of Continuation Coverage where the Plan Administrator determines that Continuation Coverage is not available after receiving notice of a potential Qualifying Event. The Plan Administrator shall also provide a notice of the unavailability of Continuation Coverage where the Plan Administrator determines that an extension of the Continuation Coverage period is not available after receiving notice of a potential second Qualifying Event, the Participant's entitlement to Medicare, or a Social Security disability determination (Extension Event).

   The determination that Continuation Coverage or an extension of Continuation Coverage is not available could be made because the Plan Administrator determines that no Qualifying Event or Extension Event occurred, or because a Qualified Beneficiary's notice of a Qualifying Event or Extension Event was defective. A notice shall be defective if it is not provided within the applicable time limit or if it is not provided in accordance with the requirements of Subsections G. and H.

   The Plan Administrator shall provide the notice of unavailability of Continuation Coverage within 14 days of the date the Plan Administrator

receives the notice of the potential Qualifying Event or Extension Event, or, if later, the deadline for submission of additional information requested by the Plan Administrator to supplement a defective notice. The Plan Administrator shall send the notice of the unavailability of Continuation Coverage to the individual who submitted the notice of the Qualifying Event or Extension Event and to all individuals for whom Continuation Coverage or an extension of the continuation period was potentially available.

In all cases, notice provided to a Participant, spouse of a Participant, or former spouse of a Participant is considered notice to all other Qualified Beneficiaries living with the Participant, spouse, or former spouse.

G. *Qualified Beneficiary's Notice Obligations*

In some situations, the Participant or his or her Dependents have the obligation to provide notice of a Qualifying Event or an Extension Event to the Plan Administrator. This section describes those obligations:

1. *Qualified Beneficiary's Notice of Qualifying Event*. If a Qualifying Event results from divorce, legal separation, or a child losing Dependent status under the terms of the Plan, the Participant, Qualified Beneficiary, or a representative acting on behalf of the Participant or Qualified Beneficiary must notify the Plan Administrator within 60 days of the loss of eligibility caused by the occurrence of the Qualifying Event.

   Notice must be provided in accordance with the procedures set forth in Subsection H. below. If timely notice is not provided in the manner required under Subsection H., Continuation Coverage shall not be available as a result of the divorce, legal separation, or child's loss of Dependent status under the Plan.

2. *Qualified Beneficiary's Notice of Second Qualifying Event*. In order to qualify for an extension of Continuation Coverage as described in Subsection E(3), a Qualified Beneficiary must notify the Plan Administrator of a second Qualifying Event that is a divorce or legal separation, the death of the Participant, or a child's loss of Dependent status under the Plan within 60 days of the date of the second Qualifying Event.

   Notice must be provided in accordance with the procedures set forth in Subsection H. below. If timely notice is not provided in the manner required under Subsection H., Continuation Coverage shall not be extended beyond the initial 18-month period.

3. *Qualified Beneficiary's Notice of Disability Determination*. In order to qualify for the additional 11-month continuation period described in

Subsection E(4), a disabled Qualified Beneficiary must provide the Plan Administrator with notice of the determination of disability before the end of the initial 18-month continuation period and within 60 days after the date of the determination. However, a special rule applies where the determination of disability was made before the date of the initial Qualifying Event. In that event, the disabled Qualified Beneficiary must provide written notice of the determination of disability within 60 days after the date of the initial Qualifying Event.

Notice must be provided in accordance with the procedures set forth in Subsection H. below. If timely notice is not provided in the manner required under Subsection H., Continuation Coverage shall not be extended beyond the initial 18-month period.

4. *Qualified Beneficiary's Notice of Medicare Entitlement*. In order to qualify for the extension of Continuation Coverage described in Subsection E(5), a Qualified Beneficiary must notify the Plan Administrator of the Participant's entitlement to Medicare within 60 days of the later of the date the Participant becomes entitled to Medicare or the date of the initial Qualifying Event.

   Notice must be provided in accordance with the procedures set forth in Subsection H. below. If timely notice is not provided in the manner required under Subsection H., Continuation Coverage shall not be extended beyond the initial 18-month period.

H. Notice Procedures for Qualified Beneficiaries

A Participant, Qualified Beneficiary, or the representative of a Participant or Qualified Beneficiary must provide the notices described in Subsection G. to the Plan Administrator at the address listed in the Other Basic Information About the Plan section. Notice to any other person or entity shall be deemed to be defective.

The Plan Administrator has a form that can be used to provide the required notice. The form can be obtained by contacting the Plan Administrator at the address or telephone number in the Other Basic Information About the Plan section. While use of this form will help ensure that a Participant or Qualified Beneficiary provides all of the required information, the form is not mandatory. The Plan Administrator will also accept written notification that contains all of the following information (as applicable):

1. The name of the Participant.

2. The name of the individual(s) for whom Continuation Coverage or an extension of the continuation period is being requested (i.e., the Qualified Beneficiary[ies]).

3. The date of the Qualifying Event or Extension Event.

4. The current address of the individual(s) for whom Continuation Coverage or an extension of the continuation period is being requested.

5. The nature of the Qualifying Event or Extension Event (e.g., divorce).

Additionally, the following information should accompany the written notification (as applicable):

1. If the notice relates to a divorce, a copy of the judgment of divorce, as signed by the judge.

2. If the notice relates to a legal separation, a copy of the judgment of separate maintenance or other relevant court document establishing the legal separation.

3. If the notice relates to the Participant's entitlement to Medicare, a copy of the document(s) establishing the entitlement.

4. If the notice relates to a determination that a Qualified Beneficiary is entitled to social security disability benefits, a copy of the disability determination.

5. If the notice relates to a determination that a Qualified Beneficiary is no longer entitled to social security disability benefits, a copy of the determination.

Notice of a Qualifying Event must be provided within 60 days after the later of the occurrence of the event or the date coverage is lost owing to the Qualifying Event. Notice of an Extension Event must be provided within the time limit that applies to that event, as described in Subsections E(3), E(4), and E(5). **Failure to provide notice within the applicable time period and in accordance with the procedures described in this Subsection H. may result in forfeiture of the right to Continuation Coverage or an extension of the continuation period.**

If the Plan Administrator receives a written notice of a Qualifying Event or Extension Event that does not contain all of the required information, the Plan Administrator shall request the missing information. If all of the requested information is not provided, in writing, within 30 days of the date the Plan Administrator requests the additional information, the Plan Administrator shall reject the notice. If the notice is rejected, Continuation Coverage or an extension of the continuation period may not be available with respect to that potential Qualifying Event or Extension Event.

After reviewing the information submitted with the notice, the Plan Administrator may also request, in writing, additional information or documentation the Plan

Administrator deems necessary to determine whether a Qualifying Event or Extension Event has occurred. If the additional information or documentation is not provided within 30 days of the date the Plan Administrator requests the information or documentation, the Plan Administrator may determine that Continuation Coverage or an extension of the continuation period is not available.

I. *Time Period for Electing Continuation Coverage*

A Qualified Beneficiary shall have 60 days from the date the Election Notice is mailed or hand-delivered to the Qualified Beneficiary or, if later, from the date of the Qualifying Event or the date coverage terminates (e.g., after a School District-provided extension of participation) to return a signed election form to the Plan Administrator electing Continuation Coverage under the Plan. Failure to mail or otherwise return the signed election form to the Plan Administrator within the 60-day period shall be considered a refusal of the coverage.

Special COBRA election rights may apply if a Participant terminates employment or experiences a reduction in hours and qualifies for a "trade adjustment allowance" or "alternative trade adjustment assistance" under federal trade laws. In this situation, the Participant is entitled to a second opportunity to elect Continuation Coverage for the Participant and certain family members (if they did not already elect Continuation Coverage) but only within a limited period of 60 days (or less) and only during the six months immediately after School District-provided group health plan coverage ends.

J. *Termination of Continuation Coverage*

Notwithstanding any other provision in this Plan, Continuation Coverage shall automatically terminate when any of the following occur:

1. The School District no longer offers vision coverage to any of its Employees.

2. The Applicable Premium for Continuation Coverage is not paid within 30 days of the due date provided by the School District (45 days for initial payment).

3. If after the date of the election of Continuation Coverage, a Qualified Beneficiary becomes entitled to receive benefits under Title XVIII of the Social Security Act (Part A or Part B of Medicare).

4. A Qualified Beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly situated non-Qualified Beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

If a Qualified Beneficiary becomes covered under another group health plan or becomes entitled to Medicare, the Qualified Beneficiary should immediately notify the Plan Administrator. The Plan Administrator shall notify the Qualified Beneficiary if Continuation Coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the Qualified Beneficiary is eligible to elect Continuation Coverage. The Plan Administrator shall provide the notification as soon as practicable following the Plan Administrator's determination that Continuation Coverage shall terminate. Notice of the termination that is provided to a Participant, spouse of a Participant, or former spouse of a Participant is considered notice to all other Qualified Beneficiaries living with the Participant, spouse, or former spouse.

CONTINUATION OF COVERAGE UPON MILITARY LEAVE

If an Employee ceases to be eligible for coverage under the Plan owing to service in the U.S. military, the Plan shall comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA). These requirements include the following:

A. The Employee and any Dependents may elect to continue coverage under the Plan. Such coverage will be available until the earliest of the following:

   1. The expiration of the 24-month period following the Employee's last day of work before beginning service in the U.S. military.

   2. The end of the period allowed by law for the Employee to apply for re-employment following the Employee's service in the U.S. military.

B. USERRA continuation coverage shall run concurrently with an extension of coverage under COBRA.

C. If the Employee gives the School District advance notice of the Employee's service in the U.S. military, the Plan Administrator shall provide the Employee with a notice of the right to continue coverage pursuant to USERRA. If the Employee's service in the U.S. military exceeds 30 days and the Employee fails to return the completed election form to the Plan Administrator within 60 days of the date the election form was provided to the Employee, the Employee and any Dependents shall cease to be eligible to continue coverage pursuant to USERRA as of the Employee's last day of work before beginning service in the U.S. military.

D. If the Employee fails to give the School District advance notice of the Employee's service in the U.S. military, the coverage of the Employee and any Dependents shall be cancelled. However, the coverage of the Employee and any Dependents may be reinstated retroactively to the first day the Employee was absent from work for service in the U.S. military under all of the following circumstances:

1. The Employee is excused from providing advance notice of the Employee's service in the U.S. military as provided under USERRA regulations (e.g., it was impossible or unreasonable for the Employee to provide advance notice, or the advance notice was precluded by military necessity).

2. The Employee elects to reinstate the coverage.

3. The Employee pays all unpaid premiums for the retroactive coverage.

E. The Employee must pay for USERRA continuation coverage. Coverage continued pursuant to USERRA shall be cancelled if the Employee does not timely pay any required premiums for that coverage. The Employee's cost of the coverage is determined as follows:

1. If the period of military service is 30 days or less, the Employee's required contributions for coverage will equal the required contributions for the identical coverage paid by similarly situated active Employees.

2. If the period of military service is more than 30 days, the Employee's required contributions will be 102% of the cost of identical coverage for similarly situated active Employees.

F. The initial premium is due within 45 days after the Employee elects to continue coverage, and subsequent premiums are due on the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the Employee initially elects USERRA continuation coverage. Coverage shall be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of USERRA continuation coverage pursuant to this section with no right to reinstate.

G. Upon re-employment, the coverage of the Employee and any Dependents shall be immediately reinstated under the Plan (i.e., no waiting period shall apply).

GENERAL PROVISIONS

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits that exceed expenses. It applies when the Participant or any Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan(s) pay a reduced benefit. This Plan will

always pay either its benefits in full or a reduced amount that, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If another plan provides benefits in the form of service rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

The Plan Administrator and Claim Administrator may release to, and obtain from, any other insurer, plan, or party any information that it deems necessary for the purposes of this section. A Covered Person shall cooperate in obtaining information and shall furnish all information necessary to implement this provision.

DEFINITIONS

The term "plan," as used in this section to refer to a plan other than this Plan, means any of the following providing benefits or services for vision care or treatment:

A. Group and nongroup insurance and subscriber contracts.

B. Health maintenance organization (HMO) contracts.

C. Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured).

D. Benefits under group or individual automobile contracts.

E. Any federal governmental plan, as permitted by law.

The term "plan" as used in this section does not include any of the following:

A. Hospital indemnity coverage benefits or other fixed indemnity coverage.

B. Accident only coverage.

C. Specified disease or specified accident coverage.

D. Limited benefit health coverage, as defined by state law.

E. School accident-type coverage.

F. Benefits for non-medical components of long-term care policies.

G. Medicare supplement policies.

H. Medicaid policies.

I. Coverage under other federal governmental plans, unless permitted by law.

The term "Allowable Expense" means a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any plan covering the Covered Person. Any expense that is not covered by any plan covering the Covered Person is not an Allowable Expense. Further, the amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with that plan's provisions is not an Allowable Expense.

The term "Primary Plan" means the plan that pays benefits first. The Primary Plan must pay benefits in accordance with its terms without taking into consideration the existence of another plan.

The term "Secondary Plan" means any plan that pays benefits after the Primary Plan. The Secondary Plan may reduce benefits so that the payments from all plans do not exceed 100% of the total Allowable Expense.

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS

Notwithstanding the Payment Priorities rules set forth below, the following special coordination rule applies regarding automobile insurance. If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides benefits, this Plan shall be the Primary Plan and the automobile insurance shall be the Secondary Plan for purposes of paying benefits.

PAYMENT PRIORITIES

Each plan makes its claim payment in the following order:

A. A plan that contains no provision for coordination of benefits, states that its coverage is primary, or does not have the same rules of priority as those listed below shall be the Primary Plan and pay before all other plans, including this Plan, and this Plan shall have only secondary liability.

B. A plan that covers the claimant other than as a dependent (e.g., as an employee or retiree) shall pay before the plan that covers the claimant as a dependent.

C. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:

1. If the dependent child's parents are married or living together, whether or not they have ever been married, the plan of the parent whose birthday falls first (omitting year of birth) in the Calendar Year is the Primary Plan. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan. This process is known as the "birthday rule."

2. If the dependent child's parents are divorced or separated or are not living together, whether or not they have ever been married, payment shall be made as follows:

a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the Primary Plan. This rule applies to plan years commencing after that plan is given notice of the court decree.

b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the birthday rule will determine the order of benefits.

c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the birthday rule will determine the order of benefits.

d. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

i. The plan covering the custodial parent.

ii. The plan covering the spouse of the custodial parent.

iii. The plan covering the non-custodial parent.

iv. The plan covering the spouse of the non-custodial parent.

For this purpose, the custodial parent is the parent awarded custody of the child by court decree. In the absence of a court decree, the parent with whom the child resides more than one-half of the Calendar Year without regard to any temporary visitation shall be considered the custodial parent.

For purposes of this subsection, a parent's "plan" shall include any plan under which the parent has coverage (either as an employee, a dependent spouse, or otherwise).

3. If the dependent child is covered under more than one plan of individuals who are not the parents of the child, the provisions of this subsection shall determine the order of benefits as if those individuals were the parents of the child.

D. The plan that covers the claimant as an active employee or dependent of an active employee shall pay before the plan that covers the claimant as an inactive employee (e.g., an employee who is laid off or retired) or dependent of such an inactive employee. This rule does not apply if the rule under paragraph B. can determine the order of benefits.

E. If a claimant has coverage provided under COBRA or under a right of continuation by state or other federal law ("continuation coverage") and also has coverage under another plan, the plan covering the claimant as an employee or retiree (or as the dependent of an employee or retiree) is the Primary Plan and the continuation coverage is the Secondary Plan. This rule does not apply if the rule under paragraph B. can determine the order of benefits.

F. Covered Persons eligible for Medicaid shall be subject to the following provisions with respect to a state Medicaid program:

1. The Plan will pay benefits with respect to a Covered Person in accordance with any assignment of rights made by or on behalf of the Covered Person under a state plan for health care assistance approved under Title XIX of the Social Security Act (Medicaid).

2. The Plan will not take into account the fact that an individual is eligible for or receives Medicaid assistance when considering eligibility for coverage or when determining or making benefit payments under the Plan.

3. To the extent payment has been made under Medicaid in any case in which the Plan has a legal liability for such payment, then payment under this Plan will be made in accordance with any state law that provides that the state has acquired the rights with respect to a Covered Person for such payment.

G. If the order set out in paragraphs A. through F. above does not apply in a particular case, the plan that has covered the claimant other than as a dependent for the longest period of time shall pay first. To determine the length of time a person has been covered under a plan, two or more successive plans shall be treated as one plan if the claimant was eligible under the successor plan within 24 hours after the prior plan's coverage ended.

These coordination of benefit rules are intended to follow the National Association of Insurance Commissioners (NAIC) group coordination of benefits model regulation. The Plan's coordination of benefit rules shall be interpreted accordingly. To the extent the NAIC model regulation is subsequently amended, the Plan's coordination of benefit rules shall be amended accordingly.

The Plan Administrator has the right to do the following:

A. Obtain from or share information with an insurance company or other organization regarding coordination of benefits, without the claimant's consent.

B. Require that the claimant provide the Plan Administrator with information regarding other plans in which the claimant may participate or be eligible to participate so that this provision may be implemented. A claimant's intentional nondisclosure under this provision shall constitute a misrepresentation in a claim for benefits for purposes of the Termination of Coverage section.

C. Pay the amount due under this Plan to an insurer or other organization if necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

FACILITY OF PAYMENT

Whenever a Covered Person or provider to whom payments are directed becomes mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the School District nor the Trustee, if any, shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, the School District, and Trustee, if any, shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made. Payments may be made in any one or more of the following ways, as determined by the Plan Administrator in its sole discretion:

A. Directly to the Covered Person or provider.

B. To the legal representative of the Covered Person or provider.

C. To a Close Relative or other relative by blood or marriage of the Covered Person or provider.

D. To a person with whom the Covered Person or provider resides.

E. By expending the amount directly for the exclusive benefit of the Covered Person or provider.

PLAN'S RIGHT TO REIMBURSEMENT AND SUBROGATION RIGHT

Plan's Right to Reimbursement

If the Plan pays benefits and another party (other than the Covered Person or the Plan) is or may be liable for the expenses, the Plan has a right of reimbursement that entitles it to recover from the Covered Person or another party 100% of the amount of benefits paid by the Plan to or on behalf of the Covered Person.

The Plan's right to 100% reimbursement applies:

A. Not only to any recovery the Covered Person receives or is entitled to receive from the other party but also to any recovery the Covered Person receives or is entitled to receive from the other party's insurer or a plan under which the other party has coverage.

B. To any recovery from the Covered Person's own insurance policy, including, but not limited to, coverage under any uninsured or underinsured policy provisions.

C. To any recovery, even if the other party is not found to be legally at fault for causing the Covered Person to incur the expenses paid or payable by the Plan.

D. To any recovery, even if the damage recovered or recoverable from the other party, its insurer or plan, or the Covered Person's policy are not for the same charges or types of losses and damages as those for which benefits were paid by the Plan.

E. To any recovery, regardless of whether the recovery fully compensates the Covered Person for his or her injuries and illnesses and regardless whether the Covered Person is made whole by the recovery.

F. To the entire amount of the recovery to the extent of the expenses payable by the Plan. The Plan's right to reimbursement from the recovery is in the first priority and is not offset or reduced in any way by the Covered Person's attorney's fees or costs in obtaining the recovery. The Plan disavows any obligation to pay all or any portion of the Covered Person's attorney's fees or costs in obtaining the recovery. The common fund doctrine and other similar common law doctrines do not reduce or affect the Plan's right to reimbursement.

Plan's Subrogation Right to Initiate Legal Action

If a Covered Person does not bring an action against the other party who caused the need for the benefits paid by the Plan within a reasonable period of time after the claim arises, the Plan shall have the right to bring an action against the other party to enforce and protect its right to reimbursement. In this circumstance, the Plan shall be responsible for its own attorney's fees.

Cooperation of Covered Person

A Covered Person shall do whatever is necessary and shall cooperate fully to secure the rights of the Plan. This includes assigning the Covered Person's rights against any other party to the Plan and executing any other legal documents that may be required by the Plan.

Plan's Right to Withhold Payment

The Plan may withhold payment of benefits when it appears that a party other than the Covered Person or the Plan may be liable for the expenses until such liability is legally determined. Further, as a precondition to paying benefits when it appears that the need for the benefits payable by the Plan was caused by another party, the Plan may withhold the payment of benefits until the Covered Person signs an agreement furnished by the Plan Administrator setting forth the Plan's right to reimbursement and subrogation right.

Preconditions to Participation and the Receipt of Benefits

All of the following rules are preconditions to an individual's participation in the Plan and the receipt of Plan benefits:

A. The Covered Person agrees not to raise any make-whole, common fund, or other apportionment claim or defense to any action or case involving reimbursement or subrogation in connection with the Plan, and acknowledges that the Plan expressly disavows such claims or defenses.

B. The Covered Person agrees not to raise any jurisdictional or procedural issue that would defeat the Plan's claim to reimbursement or subrogation in connection with the Plan.

C. The Covered Person specifically acknowledges the Plan's fiduciary right to bring an equitable reimbursement recovery action should the Covered Person obtain or be entitled to obtain a recovery from another party who is or may be liable for the expenses paid by the Plan and to obtain an equitable lien over any property or recovery to the extent of the expenses payable by the Plan.

D. The Covered Person specifically recognizes that the Plan has the right to intervene in any third party action to enforce its reimbursement rights. The Covered Person consents to such intervention.

E. The Covered Person specifically agrees that the Plan has the right to obtain injunctive relief prohibiting the Covered Person from accepting or receiving any settlement or other recovery related to the expenses paid by the Plan until the Plan's right to reimbursement is fully satisfied. The Covered Person consents to such injunctive relief.

Notice and Settlement of Claim

A Covered Person shall give the Plan Administrator written notice of any claim against another party as soon as the Covered Person becomes aware that he may recover damages from another party. A Covered Person shall be deemed to be aware that he may recover damages from another party upon the earliest of the following events:

A. The date the Covered Person retains an attorney in connection with the claim.

B. The date a written notice of the claim is presented to another party or the other party's insurer or attorney by the Covered Person or by the Covered Person's insurer or attorney.

A Covered Person shall not compromise or settle any claim against another party without the prior written consent of the Plan Administrator. If a Covered Person fails to provide the Plan Administrator with written notice of a claim as required in this section, or if a Covered Person compromises or settles a claim without prior written consent as required in this section, the Plan Administrator shall deem the Covered Person to have committed fraud or misrepresentation in a claim for benefits and accordingly, shall terminate the Covered Person's participation in the Plan.

PROVISIONAL PAYMENT OF DISPUTED CLAIM

In the event of a conflict between the Coordination of Benefits provisions of this Plan and any other plan, the Plan Administrator may take such action as it considers reasonably necessary to avoid hardship caused by a delay in payment of the disputed claim, including payment of such claim with reservation of the Plan's rights of recovery from the other plan in accordance with the reimbursement and subrogation provisions of this Plan.

NOTICE AND PROOF OF CLAIM

Written notice of injury or illness upon which a claim may be based should be given to the Plan Administrator within 30 days of the date on which the first loss occurred for which benefits arising out of such injury or illness may be claimed, or as soon as reasonably possible. The written notice must identify the Covered Person and the nature of the injury or illness. **Failure to provide notice within 12 months following the end of the Plan Year during which the first loss occurred for which benefits arising out of such injury or illness may be claimed shall invalidate the claim.** However, this time limit shall not apply where the reason for the delay was the failure of a third party provider to supply evidence necessary to provide the notice or because of some other circumstance outside the Covered Person's control.

The Plan Administrator, upon receiving the notice required by the Plan, will provide the claimant with any forms necessary for filing a proof of loss. If the Plan Administrator does not provide the necessary forms within 15 days after receiving such notice, the claimant can meet the requirements of the Plan regarding proof of loss by submitting (within the time frame fixed in the Plan for filing proofs of loss) written proof of the occurrence, character, and extent of the loss for which the claim is made.

A claimant may appoint an authorized representative to act on his or her behalf in pursuing a benefit claim or in appealing an adverse benefit determination.

EXAMINATION AND RELEASE OF INFORMATION

The Plan Administrator shall have the right and opportunity to have a claimant examined whenever and as often as reasonably required during the pending of a claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where not forbidden by law. Further, as a condition of receiving benefits under the Plan, the claimant authorizes the release of all necessary vision information and records in order to process a claim.

INITIAL DECISION

The Plan Administrator will notify a claimant of the Plan's benefit determination as follows:

A. Urgent Care Claims. An urgent care claim is a pre-service claim for care or treatment to which the application of the time periods for making non-urgent care claim determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or would, in the opinion of a Physician with knowledge of the claimant's condition, subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. The Plan Administrator shall notify the claimant of the Plan's benefit determination regarding an urgent care claim within 24 hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or

payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant within 24 hours after receiving the claim of the information necessary to complete the claim. The claimant shall then be granted 48 hours to provide the information. The Plan Administrator shall notify the claimant of the Plan's benefit determination within 48 hours after the earlier of the receipt of the information or the end of the period granted the claimant to provide the information.

B. Pre-Service Claims. A pre-service claim is a claim for a benefit that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining care. The Plan Administrator shall notify the claimant of the Plan's benefit determination regarding a pre-service claim within 15 days after receipt of the claim. The Plan Administrator may extend this period one time for up to 15 days if it determines that such an extension is necessary owing to matters beyond its control. The Plan Administrator must notify the claimant, before the expiration of the initial 15-day period, of the circumstances requiring the extension and the date it expects to make a decision. If the extension is necessary because the claimant failed to submit the information required to decide the claim, the notice of the extension shall describe this required information, and the claimant will be granted 45 days from receipt of the notice to provide the information. The Plan Administrator will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.

C. Post-Service Claims. A post-service claim is a claim for a benefit that is not a pre-service claim or an urgent care claim. If the Plan Administrator denies a post-service claim, in whole or in part, it shall notify the claimant of the adverse determination within 30 days after receipt of the claim. The Plan Administrator may extend this period one time for up to 15 days, if it determines that such an extension is necessary owing to matters beyond its control. The Plan Administrator must notify the claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension and the date it expects to make a decision. If the extension is necessary because the claimant failed to submit the information required to decide the claim, the notice of extension shall describe this required information, and the claimant will be granted 45 days from the receipt of the notice to provide the information. The Plan Administrator will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.

D. Concurrent Care Claims. A concurrent care claim is a claim approved by the Plan Administrator for an ongoing course of treatment to be provided over a period of time or over a number of treatments. If the Plan Administrator reduces or

terminates that course of treatment (other than by Plan amendment or termination), it has issued an adverse benefit determination. The Plan Administrator will provide notice, in accordance with the Benefit Determination Notice section below, at least 30 days before reducing or terminating the course of treatment in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. The Plan Administrator shall decide any request to extend a course of treatment for urgent care as soon as possible and shall notify the claimant of its determination within 24 hours (if the claimant makes the claim to the Plan Administrator at least 24 hours before the expiration of the prescribed course of treatment for urgent care).

BENEFIT DETERMINATION NOTICE

The Plan Administrator will provide the claimant with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, and refer to the Plan provisions on which the determination is based. The notice will also describe the Plan's review procedures and related time limits, and will include a statement of the claimant's right to bring a civil action following an adverse benefit determination on review.

If the Plan Administrator based the adverse benefit determination upon an internal rule, guideline, protocol, or other similar criterion, the notice will state that the Plan Administrator relied upon this information and that it will provide a free copy of the same to the claimant upon request. If the Plan Administrator based the adverse benefit determination on a medically necessary, experimental treatment, or similar exclusion or limit, the notice will state that the Plan Administrator will provide an explanation of the determination free of charge to the claimant upon request.

APPEAL OF DENIAL

The claimant may request a review of an adverse benefit determination by submitting a written application to the Plan Administrator within 180 days following the denial of the claim. The claimant may submit written comments, documents, records, and other information relating to the claim. The Plan Administrator will consider the information without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the Plan Administrator will provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. For this purpose, a document, record, or other information is relevant if the Plan Administrator relied upon it in making the benefit determination; if it was submitted, considered, or generated in the course of making the benefit determination; or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The appeal procedure will provide for a review that does not defer to the initial adverse benefit determination. The appeal will be conducted by an appropriately named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment

(including a determination of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the appropriately named fiduciary will consult with a health care professional who has proper training and experience in the relevant field of medicine. The health care professional reviewing the appeal will not be the person who was consulted in the initial adverse benefit determination or a subordinate of that person. The Plan Administrator shall identify any experts it consulted on behalf of the Plan regarding a claimant's adverse benefit determination, whether or not it relied upon their advice.

In an appeal of an adverse benefit determination of an urgent care claim, the claimant may request an expedited appeal orally or in writing. All necessary information, including the Plan's determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or any other available, similarly expeditious method.

FINAL DECISION

The Plan Administrator shall make a decision regarding a request for review as follows:

A. Urgent Care Claims. The Plan Administrator shall notify the claimant of its determination on review of an urgent care claim within 72 hours after receipt of the claimant's request for a review of an adverse benefit determination.

B. Pre-Service Claims. There shall be two levels of appeal for pre-service claims. The Plan Administrator shall notify the claimant of its determination regarding a first-level appeal within 15 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level appeal to the Plan Administrator in writing within 60 days following the denial of the first level appeal. If the claimant submits a second appeal, the Plan Administrator shall notify the claimant of its determination regarding a second-level appeal within 15 days after receipt of the claimant's request of a second-level review of an adverse benefit determination.

C. Post-Service Claims. There shall be two levels of appeal for post-service claims. The Plan Administrator shall notify the claimant of its determination regarding a first-level appeal within 30 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level appeal to the Plan Administrator in writing within 60 days following the denial of the first level appeal. If the claimant submits a second appeal, the Plan Administrator shall notify the claimant of its determination regarding a second-level appeal within 30 days after receipt of the claimant's request of a second-level review of an adverse benefit determination.

The Plan Administrator shall provide a claimant with written or electronic notification of its determination on review. The notice shall include the same information that was required in the notification of the initial adverse benefit determination. The decision of the Plan Administrator on appeal shall be final and binding.

LEGAL PROCEEDINGS

No action at law or in equity shall be brought by a claimant to recover a claim on the Plan before the exhaustion of remedies provided under the Claim Procedure provisions of the Plan, nor shall such action be brought at all, unless brought by the last day of the Plan Year after the Plan Year in which the claimant was provided with a written notice denying the final level of Plan appeal concerning the claim.

NO INTEREST

The Plan shall not be required to pay interest on any claim for Plan benefits regardless of when paid.

ESCHEAT

If a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check shall be dishonored.

SPECIAL RULES

Covered Persons will be provided with the following additional rights with respect to claims and appeals:

A. A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan.

B. In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale of the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

C. The Plan cannot base decisions regarding the hiring, compensation, termination or promotion of a claims adjudicator, medical expert, or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

D. Certain benefit determination notices and appeal notices may be required to be provided in a language other than English if a minimum number of Participants are literate only in that other language. Further, the notices must include additional information such as information sufficient to identify the claim involved, the denial code and its corresponding meaning and any standard used in denying the claim, and a description of the available internal appeals and external review processes.

PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Subject to obtaining written certification pursuant to the Certification of the Plan Sponsor provision (see below), the Plan may disclose PHI to the Plan Sponsor provided that the Plan Sponsor does not use or disclose that PHI except for the following purposes:

A. To perform Administrative Functions for the Plan.

B. To obtain premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan.

C. To modify, amend, or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner inconsistent with 45 CFR §164.504(f).

CONDITIONS OF DISCLOSURE

The Plan Sponsor agrees to the following in regard to any PHI:

A. To not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

B. To ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

C. To not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

D. To report to the Plan any known use or disclosure of the information that is inconsistent with the uses or disclosures permitted.

E. To make a Covered Person's PHI available when he or she requests access in accordance with 45 CFR § 164.524.

F. To make a Covered Person's PHI available when he or she requests an amendment to same, and to incorporate any amendments to that PHI in accordance with 45 CFR § 164.526.

G. To make available the information required to provide an accounting of disclosures of PHI to a Covered Person upon request in accordance with 45 CFR § 164.528.

H. To make its internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services in order to determine compliance by the Plan with the HIPAA privacy rules.

I. To return or destroy all PHI received from the Plan if the PHI is still maintained in any form, if feasible, and to retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

J. To ensure that the adequate separation between the Plan and the Plan Sponsor, required in 45 CFR § 164.504(f)(2)(iii), is satisfied and that terms set forth in the applicable provision below are followed.

To be compliant with the HIPAA security standards, the Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/termination information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, the Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. The Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

CERTIFICATION OF PLAN SPONSOR

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.

PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan may disclose Summary Health Information to the Plan Sponsor provided that the Plan Sponsor uses such Summary Health Information only for the following purposes:

A. To obtain premium bids from health plan providers to provide health coverage under the Plan.

B. To modify, amend, or terminate the Plan.

ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR

The Plan Sponsor will provide access to PHI to the employees or classes of employees listed in its HIPAA privacy policies and procedures. The Plan Sponsor will restrict the access to and use of PHI by these individuals to the Administrative Functions that the Plan Sponsor performs for

the Plan. In the event any of these individuals do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Sponsor will impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. The Plan Sponsor will impose such sanctions progressively (e.g., an oral warning, a written warning, time off without pay, and termination), if appropriate, and commensurate with the severity of the violation.

To comply with the HIPAA security rule, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION

Pursuant to 45 CFR 164.504(f)(1)(iii), the Plan may disclose information on whether an individual is enrolled in or has terminated from the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

In accordance with the HIPAA privacy rules, the Plan Sponsor authorizes and directs the Plan to disclose PHI to stop-loss carriers, excess-loss carriers, or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess-loss coverage related to benefit claims under the Plan.

OTHER USES AND DISCLOSURES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

HYBRID ENTITY

This provision only applies to the extent to which the Plan provides any non-health benefits such as (but not limited to) disability benefits or group term life insurance benefits. The Plan is a separate legal entity whose business activities include functions covered by the HIPAA privacy rules as well as functions not covered by those rules. As a result, the Plan is a "hybrid entity" as that term is defined in the HIPAA privacy rules. The Plan's covered functions are its health benefits ("health care component"). All other benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA privacy rules with respect to the health care component (the health benefits) of the Plan.

PARTICIPANT NOTIFICATION

Participants shall be notified of the Plan's compliance with the HIPAA privacy rules in a Notice of Privacy Practices.

PLAN ADMINISTRATOR

The Plan Administrator is charged with the administration of the Plan. The Plan Administrator shall have the discretionary authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The Plan Administrator shall exercise its discretion in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the Plan Administrator shall have the discretionary authority to construe and interpret the terms of the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. The Plan Administrator may delegate all or a portion of its duties under the Plan to one or more authorized officers and/or an administrative committee.

AMENDMENTS AND TERMINATION

The Plan Sponsor reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

A. Subject to any applicable collective bargaining agreement, the Plan Sponsor shall have the right to amend this Plan at any time, in whole or in part, to take effect retroactively or otherwise. No amendment may retroactively reduce claims for any Covered Expenses that were incurred before the amendment unless necessary to conform the Plan to the requirements of the Code, regulations issued under the Code, and any other applicable laws or regulations.

B. Subject to any applicable collective bargaining agreement, the Plan Sponsor reserves the right at any time to terminate the Plan by action of the Board of Directors or other similar governing body of the Plan Sponsor.

In addition, the Plan shall automatically terminate upon the occurrence of any of the following events:

A. The liquidation or discontinuance of the business of the Plan Sponsor.

B. The adjudication of the Plan Sponsor as bankrupt.

C. A general assignment by the Plan Sponsor to or for the benefit of one or more of its creditors.

D. The merger or consolidation of the Plan Sponsor to another entity that is the surviving entity.

E. The consolidation or reorganization of the Plan Sponsor.

F. The sale of substantially all of the assets of the Plan Sponsor, unless the successor or purchasing entity adopts the Plan within 90 days thereafter.

If termination occurs, the Plan shall pay all benefits for Covered Expenses incurred before the termination date. Covered Persons shall have no further rights under the Plan.

FREE CHOICE OF PHYSICIAN

The Covered Person shall have free choice of any legally qualified Physician or surgeon.

WORKER'S COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law or regulation to which it is subject, that provision is deemed amended to conform to such law or regulation.

FAILURE TO ENFORCE

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at any other time, nor will such failure affect the right to enforce any other provision.

ENTIRE REPRESENTATION / NO ORAL MODIFICATIONS

This single document sets forth the terms of the Plan and the Summary Plan Description and it supersedes all other documents. Any other descriptive or interpretive materials (such as benefit summaries) shall not change the terms of the Plan as set forth in this document. Further, the terms of the Plan may not be modified by any oral statements made by the School District or any of its directors, officers, Employees, agents, or authorized representatives, including, but not limited to, the Claim Administrator.

NO VESTING

There is no vested right to current or future benefits under this Plan. A Covered Person's right to benefits is limited to any Plan assets and to Covered Expenses incurred and submitted within the time limits set forth in the Claims Procedure provision and incurred and submitted before the earliest of the following:

A. An amendment to the Plan that limits or terminates such benefits.

B. Termination of the Plan.

C. Termination of coverage or participation.

NON-ASSIGNABILITY

The benefits payable under the Plan to a Covered Person are specific to the Covered Person and may be received only by the Covered Person. No benefits of the Plan shall be assigned to any person, corporation, entity, or party except for assignment to the federal government in accordance with back-up withholding laws or except as provided in accordance with any assignment of rights as required by a state Medicaid program and in accordance with any state law that provides that the state has acquired the rights to payment with respect to a Covered Person. Any other attempted assignment shall be void. However, the Plan reserves the right to make payment of benefits, in its sole discretion, directly to a provider of services or the Covered Person. The Plan reserves the right, in its sole discretion, to refuse to honor the assignment of any claim to any person, corporation, entity, or party. This section shall not be interpreted to prevent direct billing for Covered Expenses by a provider to the Plan Administrator.

NO EMPLOYMENT RIGHTS

The establishment and maintenance of this Plan shall not be construed as conferring any legal rights on any Employee to be continued in the employ of the School District, nor shall this Plan interfere in any way with the right of the School District to discharge any Employee.

COVERED PERSONS' RIGHTS

Except as may be required by law, the establishment of this Plan and the Trust, if any, shall not be construed as giving any Participant or Dependent any equity or other interest in the assets, business, or affairs of the School District; or the right to question or complain about any action taken by its officers, directors, or stockholders or about any policy adopted or followed by the School District; or the right to examine any of the books and records of the School District. The rights of all Participants and Dependents shall be limited to their right to receive payment of their benefits from the Plan when the same becomes due and payable in accordance with the terms of the Plan.

ACTS OF PROVIDERS

Nothing contained in this Plan shall confer upon a Covered Person any claim, right, or cause of action, either at law or in equity, against this Plan for the acts of any provider (e.g., Physician) from which the Covered Person receives services or care while covered under this Plan.

RECOVERY OF OVERPAYMENT

If the Plan pays benefits that should not have been paid under the Plan or pays benefits in excess of what should have been paid under the Plan, the Plan Administrator shall have the right to recover such payment or excess from any individual, insurance company, or other third-party payer, provider, or any other organization to or for whom the payment was made. Recovery may be in the form of an offset against future amounts owed under the Plan, by a lump-sum refund payment, or by any other method as the Plan Administrator, in its sole discretion, may require.

ACCEPTANCE / COOPERATION

Accepting benefits under the Plan means that the Covered Person has accepted the Plan's terms and shall be obligated to cooperate with the Plan Administrator's requests to help protect the Plan's rights and carry out its provisions.

DEFINITIONS

Certain words and phrases used in this Plan are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Where these terms are used elsewhere in the Plan with the meanings assigned to them below, the terms usually will be capitalized, and where these terms are used with their common, non-technical meanings, the terms usually will not be capitalized (except when necessary for proper grammar).

ACTIVELY AT WORK

The term "Actively at Work" means the active expenditure of time and energy in the service of the School District. A Participant shall be deemed Actively At Work on each day of a regular paid vacation and on a regular non-working day on which the Participant is not totally disabled, if the Participant was Actively At Work on the last preceding regular working day.

ADMINISTRATIVE FUNCTIONS

The term "Administrative Functions" means activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Administrative Functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-benefits, such as vision and dental. PHI for these purposes may not be used by or between the Plan or Business Associates in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Administrative functions specifically do not include any employment-related functions.

BUSINESS ASSOCIATE

The term "Business Associate" means a person or entity who does the following:

A. Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.).

B. Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

CALENDAR YEAR

The term "Calendar Year" means a period of time beginning with January 1 and ending on the following December 31.

CHANGE IN STATUS

The term "Change in Status" means any of the following:

A. An event that changes the Employee's legal marital status, including marriage, death of the Employee's spouse, divorce, legal separation (if recognized by the state in which the individuals reside), and annulment.

B. An event that changes the number of an Employee's dependents, including birth, adoption, placement for adoption, and death of a dependent.

C. An event affecting the employment status of the Employee, the Employee's spouse, or the Employee's dependent; including termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status that affects an individual's eligibility for benefits.

D. An event that causes an Employee's dependent to satisfy or cease to satisfy the requirement(s) for coverage owing to the attainment of a specified age, student status, or any similar circumstance.

E. A change in the place of residence of the Employee, the Employee's spouse, or the Employee's dependent.

CLAIM ADMINISTRATOR

The term "Claim Administrator" means the person or firm, if any, retained by the Plan Administrator to handle the processing, payment, and settlement of benefit claims and other duties specified in a written administration agreement. If there is no Claim Administrator (for any reason, including circumstances caused by the termination or expiration of the Administration Agreement with the initial Claim Administrator), or if the term is used in connection with a duty not expressly assumed by the Claim Administrator in a signed writing, the term shall mean the Plan Administrator.

CLOSE RELATIVE

The term "Close Relative" means the spouse, parent, brother, sister, child, or in-laws of a Covered Person.

COBRA

The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (see Section 4980B of the Code and Sections 601 et seq. of the Employee Retirement

Income Security Act of 1974 [ERISA], as amended). See Consolidated Omnibus Budget Reconciliation Act of 1985.

CODE

The term "Code" means the Internal Revenue Code of 1986, as amended.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

The term "Consolidated Omnibus Budget Reconciliation Act of 1985" means federal legislation that gives workers and their families who lose their health benefits the right to choose to continue the benefits provided by their group health plan for limited periods of time under certain circumstances. In the context of a governmental employer, this term means the parallel continuation coverage provisions of the Public Health Service Act. See COBRA.

COSMETIC PROCEDURE

The term "Cosmetic Procedure" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness, injury, or disease.

COVERED EXPENSES

The term "Covered Expenses" means expenses incurred by a Covered Person for any medically necessary treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan. Covered Expenses are incurred on the date that any medically necessary treatments, services, or supplies are provided to a Covered Person.

COVERED PERSON

The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan. This term includes Participants and their eligible Dependents.

DEDUCTIBLE

The term "Deductible" means a specified dollar amount of Covered Expenses that must be incurred during a year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and in this Plan.

DEPENDENT

The term "Dependent" means the following:

A. The Participant's legal spouse who is a resident of the same country in which the Participant resides. The spouse must have met all of the requirements of a valid marriage contract in the state of marriage of the parties.

B. A child who meets all of the following conditions:

1. May be identified in one of the following categories:

   a. The Participant's natural child, the Participant's legally adopted child, or a child who is being placed for adoption with the Participant.

   b. A stepchild of the Participant or a child who has been placed under the legal guardianship of the Participant and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code.

   c. A child to whom the Participant is obligated to provide health care coverage under an order or judgment of a court of competent jurisdiction and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code.

2. Is a resident of the same country in which the Participant resides.

3. Is unmarried.

4. Is 25 years of age or younger. Coverage will continue to the end of the Calendar Year in which the Dependent becomes 25 years of age. This requirement is waived if the child is at least 25 years of age and is a Full-Time Student. The age requirement above is also waived for any child who is developmentally disabled or who has a physical handicap(s) before age 25, who is incapable of self-sustaining employment, and who could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code. Proof of incapacity must be furnished to the satisfaction of the Plan Administrator upon request, and the Plan Administrator may request additional proof from time to time.

5. For Children 19 Years of Age or Older: Is dependent on the Participant for a majority of their support.

C. The Participant's Sponsored Dependent. For purposes of this Plan, a Sponsored Dependent is a member of the Participant's family, either by blood or by marriage, who qualifies as a Participant's "dependent" for tax exemption purposes under Section 152 of the Code, who was declared as a Participant's "dependent" on the Participant's federal tax return for the preceding tax year, and who is continuing in that "dependent" status for the current tax year. A child cannot be covered as a Sponsored Dependent when the child is no longer eligible for coverage as a dependent child.

D. A child for whom the Participant is obligated to provide health care coverage under a QMCSO, notwithstanding the above.

NOTE: If both parents are Employees of the School District, children will be covered under this Plan as Dependents of only one parent.

The Participant may be asked to certify the status of the persons for whom the Participant is claiming Dependent status, and benefits shall be terminated and the Participant shall be asked to reimburse the Plan if it is discovered that he/she has provided false information.

The term "Dependent" excludes these situations:

A. A spouse or former spouse who is legally separated or divorced from the Participant, pursuant to a valid separation or divorce in the state granting the separation or divorce.

B. Any person who is covered under this Plan as an individual Participant.

C. Any person who would otherwise qualify as a Dependent, but who is not properly enrolled in the Plan.

DEPENDENT COVERAGE

The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an illness or injury of a Dependent or for routine preventive care for a Dependent.

EMPLOYEE

The term "Employee" means a teacher employed by the School District.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The term "Employee Retirement Income Security Act of 1974" means a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. See ERISA.

ERISA

The term "ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended, Section 3(1), 29 U.S.C. §1002(1). See Employee Retirement Income Security Act of 1974.

FAMILY

The term "Family" means a Participant and any Dependent(s).

FAMILY AND MEDICAL LEAVE ACT OF 1993

The term "Family and Medical Leave Act of 1993" means a federal law that provides certain employees with unpaid, job-protected leave each year, the duration of which is pre-determined by the federal government. It also requires that their group health benefits be maintained during the leave. See FMLA.

FMLA

The term "FMLA" means the Family and Medical Leave Act of 1993, Public Law 103-3 (February 5, 1993), 107 Stat. 6 (29 U.S.C. 2601 et seq.). See Family and Medical Leave Act of 1993.

FULL-TIME STUDENT

The term "Full-Time Student" means a Participant's Dependent child who is enrolled in and regularly attends a secondary school, college, or university, or a vocational/technical school in which completion of course work culminates in a licensed vocation. The educational institution must be accredited by the state where it is located and operate on a system of academic years or subdivisions of years, i.e., semesters or trimesters.

Eligibility for a Full-Time Student shall continue during any period classes are not in session (e.g., summer break) if the child was a Full-Time Student during the immediately preceding academic term and will be a Full-Time Student in the following academic term. The child is not required to enroll and regularly attend classes offered during a break.

If a Dependent child is enrolled in and regularly attends more than one qualifying educational institution, as described above, the total credit hours the student carries from all institutions must equal or exceed the full-time credit hours required by the institution with the least stringent policy.

The Dependent child must attend for the minimum number of credit hours required by that secondary school, college, university, or vocational/technical school in order to maintain full-time status. However, if the child experiences a serious injury or illness that prevents him or her from maintaining full-time status, coverage under the Plan will be temporarily extended in accordance with Public Law 110-381 (Michelle's Law) if all of the following requirements are met:

A. The Dependent child was enrolled in the Plan on or before the date on which he or she ceased to be a Full-Time Student.

B. The loss of Full-Time Student status would have otherwise caused the Dependent child's coverage under the Plan to terminate.

C. The Dependent child's attending Physician provides to the Plan Administrator written certification stating that the reduction in course hours is medically necessary and caused by a serious injury or illness.

If all of the above requirements are met, coverage will be extended until the earliest of the following dates:

A. One year after the date on which the child ceased to be a Full-Time Student.

B. One year after the date on which the reduction in course hours began.

C. The date on which the reduction in course hours is no longer medically necessary.

D. The date on which the Dependent child's medical condition no longer constitutes a serious injury or illness.

E. The date on which the Dependent child's coverage would otherwise terminate under the Plan (for example, because of the attainment of the Plan's limiting age).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The term "Health Insurance Portability and Accountability Act of 1996" means a federal law that limits the use of pre-existing condition exclusions, waiting periods, and health status exclusions; eliminates certain discriminatory exclusions, such as for self-inflicted injuries; and promulgates administrative simplification provisions. See HIPAA.

HIPAA

The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended (Public Law 104-191). See Health Insurance Portability and Accountability Act of 1996.

LIFETIME

The term "Lifetime" means the time a person is actually a Covered Person in this Plan, including any amendment or restatement of this Plan. The term "Lifetime" is not intended to suggest benefits before the effective date of an individual or after the termination of an individual or of the Plan.

MEDICARE

The term "Medicare" means the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," and that includes parts A and B of Subchapter XVIII of the Social Security Act as amended from time to time.

MOTOR VEHICLE

The term "Motor Vehicle" means a car or other vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular power that has more than two wheels. Motor Vehicle does not include a motorcycle, a moped, or any "off-road vehicle" (ORV) or "all-terrain vehicle" (ATV).

OBRA 1993

The term "OBRA 1993" means the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66 (August 10, 1993). See Omnibus Budget Reconciliation Act of 1993.

OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The term "Omnibus Budget Reconciliation Act of 1993" means a federal law that adds a provision to COBRA's tax code rules regarding pediatric vaccine coverage. See OBRA 1993.

ORTHOPTICS; VISION THERAPY

The terms "Orthoptics" and "Vision Therapy" mean the science of correcting defects in a person's simultaneous use of both eyes (binocular vision) through administration of vision therapy aids and/or eye muscle exercises.

PARTICIPANT

The term "Participant" means a person who is or was directly employed and compensated for services by the School District, who meets the other eligibility requirements, and who is properly enrolled in the Plan.

PARTICIPANT COVERAGE

The term "Participant Coverage" means coverage included under this Plan providing benefits payable as a consequence of an injury or illness of a Participant or for routine preventive care for a Participant.

PHI

See Protected Health Information.

PHYSICIAN

The term "Physician" means a legally licensed medical doctor or optometrist to the extent that he/she, within the scope of his/her license, is permitted to perform services provided in this Plan.

PLAN

The term "Plan" means the Vision Benefits Plan for Sparta Area Schools, as periodically amended.

PLAN ADMINISTRATOR

The term "Plan Administrator" means **SPARTA AREA SCHOOLS**, who 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.

PLAN SPONSOR

The term "Plan Sponsor" means **SPARTA AREA SCHOOLS.**

PLAN YEAR

The term "Plan Year" means the 12-month period that begins on September 1 and ends on the following August 31. This time period is used for purposes of determining annual benefit-based accumulators, Form 5500 reporting (if required), and compliance with laws impacting the Plan.

PROTECTED HEALTH INFORMATION

The term "Protected Health Information" means information that is created or received by the Plan or a Business Associate and relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care to a Covered Person, or the past, present, or future payment for the provision of health care to a Covered Person. Also, the information identifies the Covered Person or there is a reasonable basis to believe the information can be used to identify the Covered Person (whether living or deceased). The following components of a Covered Person's information will enable identification:

- Names
- Street address, city, county, precinct, ZIP code
- Dates directly related to a Covered Person's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death
- Telephone numbers, fax numbers, and electronic mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The term "Qualified Medical Child Support Order (QMCSO)" means an order pursuant to OBRA 1993 and applicable state law that requires the Plan to provide health coverage to a participating Employee's child. A QMCSO may either be obtained under state domestic relations law or may be initiated by a court or state administrative agency pursuant to applicable state law. The Plan Administrator shall develop procedures to determine whether an order submitted to the Plan constitutes a QMCSO pursuant to OBRA 1993 and applicable state law.

SCHOOL DISTRICT

The term "School District" means **SPARTA AREA SCHOOLS.**

SPECIAL ENROLLMENT PERIOD

The term "Special Enrollment Period" means the period for an individual with special enrollment rights to make enrollment elections under the Plan. The circumstances under which an individual has special enrollment rights are described in the Participant Enrollment and Dependent Enrollment sections and are prescribed by HIPAA and federal regulations issued pursuant to HIPAA.

SUMMARY HEALTH INFORMATION

The term "Summary Health Information" means information that may be individually identifiable health information. It summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom Plan Sponsor has provided health benefits under the Plan. The information described in 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information may be aggregated to the level of five-digit ZIP codes.

USUAL AND CUSTOMARY

The term "Usual and Customary" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, supplies, or equipment that do not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any complications or unusual circumstances that require additional time, skill, or expertise.

NO RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA, does not apply to this Plan. The fact that the Plan may, in some respects, conform to the requirements of ERISA, or include provisions often found in plans that are subject to ERISA, shall not be interpreted or construed to mean that the Plan is intended to comply with ERISA, or that Employees, Participants, or beneficiaries have any rights under ERISA. The preceding statement also pertains to other federal laws that do not apply to the Plan.

RULES OF CONSTRUCTION

This Plan shall be construed in accordance with the Code and, where not pre-empted, the laws of the state of Michigan.

The use of the singular includes the plural where applicable and vice versa. The headings do not limit or extend the provisions of the Plan. Capitalized terms, except where capitalized solely for grammar, have the meaning provided in the Plan. Errors cannot cause the Plan to provide a benefit that a Covered Person is not otherwise entitled to under the Plan. If a provision is unenforceable in a legal proceeding, the provision shall be severed solely for purposes of that proceeding and the remaining provisions of the Plan shall remain in full force.

Sparta Area Schools has caused this amended and restated Plan to be effective as of 12:01 a.m. local time, **January 1, 2012.**

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