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<table>
<thead>
<tr>
<th>SERVICE PROVIDED</th>
<th></th>
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<tbody>
<tr>
<td><strong>Exam</strong></td>
<td></td>
</tr>
<tr>
<td>One Exam every 24 months for Covered Persons aged 19 and older</td>
<td>$172</td>
</tr>
<tr>
<td>One Exam every 12 months for Cover Persons under age 19</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Hardware</strong></td>
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<tr>
<td><strong>Lenses</strong></td>
<td></td>
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<tr>
<td>One pair every 24 months for Covered Persons aged 19 and older</td>
<td></td>
</tr>
<tr>
<td>One pair every 12 months for Cover Persons under age 19</td>
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<tr>
<td>- Single Vision</td>
<td>$106</td>
</tr>
<tr>
<td>- Bifocal</td>
<td>$148</td>
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<tr>
<td>- Trifocal</td>
<td>$198</td>
</tr>
<tr>
<td>- Lenticular</td>
<td>$250</td>
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<tr>
<td><strong>Frames</strong> Limited to one (1) standard frame every 24 months</td>
<td>$ 94</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
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<tr>
<td>One pair every 24 months for Covered Persons aged 19 and older</td>
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<tr>
<td>One pair every 12 months for Cover Persons under age 19</td>
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<td>- Single Vision</td>
<td>$200</td>
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<tr>
<td>- Bifocal</td>
<td>$242</td>
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<td>- Trifocal</td>
<td>$292</td>
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</table>
# DENTAL SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>Class I</th>
<th>Class II</th>
<th>Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive &amp; Diagnostic Services</td>
<td>Restorative Services</td>
<td>Major Services</td>
</tr>
<tr>
<td>• Exams</td>
<td>• Extractions</td>
<td>• Inlays and Onlays</td>
</tr>
<tr>
<td>• Cleanings</td>
<td>• Fillings</td>
<td>• Crowns</td>
</tr>
<tr>
<td>• X-rays</td>
<td>• Palliative Emergency Treatment</td>
<td>• Implants</td>
</tr>
<tr>
<td>• Fluoride</td>
<td>• Space Maintainers</td>
<td>• Bridges</td>
</tr>
<tr>
<td>• Sealants</td>
<td>• Repair of Dentures and Bridges</td>
<td>• Dentures</td>
</tr>
<tr>
<td></td>
<td>• Oral Surgery</td>
<td>• Bruxism Splints and Nightguards</td>
</tr>
<tr>
<td></td>
<td>• Apicoectomy</td>
<td>• Periodontics</td>
</tr>
<tr>
<td></td>
<td>• Endodontics</td>
<td></td>
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<tr>
<td></td>
<td>• Periodontics</td>
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<td>• Inlays and Onlays</td>
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<td>• Implants</td>
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<td>• Bridges</td>
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<td>• Dentures</td>
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<tr>
<td></td>
<td>• Bruxism Splints and Nightguards</td>
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<tr>
<td></td>
<td>• Periodontics</td>
<td></td>
</tr>
</tbody>
</table>

## Percentage Paid for Class I, Class II and Class III Services:

<table>
<thead>
<tr>
<th></th>
<th>Class I</th>
<th>Class II</th>
<th>Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st year</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>2nd year</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>3rd year</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>4th year</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

In the first Calendar Year a Covered Person receives covered dental services, the Plan will pay 70 percent of Covered Expenses. For each succeeding Calendar Year in a row that a Covered Person receives covered dental services, the percentage will increase by 10 percentage points, up to a maximum of 100 percent. This means that in the 2nd year in a row that a Covered Person receives covered dental services, the Plan will pay 80 percent of Covered Expenses. In the 3rd year in a row, the Plan will pay 90 percent, and in the 4th year, 100 percent of Covered Expenses.

If in any Calendar Year a Covered Person fails to receive covered dental services, the percentage payable will remain at the same level. For each succeeding year in which a Covered Person fails to receive covered dental services, the percentage of Covered Expenses the Plan pays will decrease 10 percentage points, but never below 70 percent.

**NOTE:** The percentage the Plan pays for a Covered Person who becomes enrolled after July 1 in any Calendar Year will be increased by 10 percentage points at the beginning of the following Calendar Year whether or not covered dental services were received. However, the percentage the Plan pays in subsequent Calendar Years will either increase or decrease as described in previous paragraphs.

$1,500 per Covered Person per Calendar Year

All dental services are limited to a Usual, Customary & Reasonable (UCR) allowance.
INTRODUCTION

Lincoln County School District, hereinafter referred to as the "Company", as the Plan Sponsor, hereby establishes the benefits, rights and privileges which shall pertain to participating Employees, hereinafter referred to as "Participants" or "Covered Persons", and the eligible dependents of such Participants.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of eligible Vision and Dental expenses. This Plan Document will also serve as the Employee Booklet.

EFFECTIVE DATE

The Effective Date of the Plan is January 1, 2006.

PLAN SPONSOR

The Plan Sponsor is the Company, whose address and telephone number are: P. O. Box 1110, Newport, OR 97365, (541) 265-4422.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is the Company, whose street address and telephone number are: 459 S.W. Coast Highway, Newport, OR 97365, (541) 265-4422.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment, and in such case shall apply the amount of such payment to or for the benefit of such Participant, his spouse, adult child, guardian of a minor child, or other relative of a dependent of such covered Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan will not be deemed to constitute a contract of employment or give any Employee of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.
ELIGIBILITY

WHO MAY RECEIVE BENEFITS

Benefits are provided to eligible Employees of the Company and their covered dependents. The following is a description of the qualifications needed to be eligible.

In order for a dependent to be covered under the Plan, the Employee must also be enrolled in the Plan (except in the case of COBRA continuation coverage).

Individuals who are working in violation of U.S. immigration laws or those individuals who have made false representations of any kind in order to obtain employment are excluded from eligibility for participation in the Plan. Any loss of coverage resulting from this situation will not be a qualifying event for Continuation Coverage Rights under COBRA.

**Employees** – regular full-time or part-time (scheduled to work at least 15 hours per week), who have met the Waiting Period described in "When Coverage Begins".

Ineligible Employees are those in the substitute category.

**Retirees** – who are a) receiving benefits from PERS (Public Employee Retirement System) or from a similar public retirement plan offered by the school district, and b) were enrolled under this Plan for at least 24 consecutive months immediately prior to retirement (waived if retirement was due to a service related disability; a copy of the PERS disability determination is required).

**Spouse** – Spouse means the lawful spouse of an Employee or a Retiree, unless legally separated or divorced. Common law marriages are not recognized under this Plan. A spouse shall be a “dependent” for purposes of this Plan.

**Domestic Partner** – as defined by the Plan.

**Children** – Children include: Natural, legally adopted or children under legal guardianship - unmarried to their 26th birthday, if they are dependent on the Employee or Retiree for support. In the case of adoption, see also “Pre-Adoption Health Coverage” in the section titled FEDERAL LAWS AND REGULATIONS.

Step-children - unmarried, to their 26th birthday, if they are dependent on the Employee / Retiree and the Employee's Spouse / qualified Domestic Partner for more than 50% of their support or the Employee / Retiree and the Employee's Spouse / qualified Domestic Partner are required to provide health benefits pursuant to a court order.

Foster children are not eligible for coverage under this Plan.

Physically or mentally disabled children - unmarried children described above with no age limitation if: 1) they are dependent on the Employee / Retiree as defined by the IRS, 2) they are unable to be self-supporting because of a permanent physical or mental disability, 3) they are not covered by another group plan, and 4) medical verification is submitted as requested.

A child meeting the definition set forth above shall be a “dependent” under this Plan.

NOTES:

- If more than one parent is an Employee, children may be covered as dependents of either parent or both. If both parents elect to cover the children as dependents, benefits will be processed according to the Coordination of Benefits provision. Likewise, an Employee may be covered both as an Employee and a dependent.
- See additional Eligibility information in the “Qualified Medical Child Support Order” provisions in the section titled FEDERAL LAWS AND REGULATIONS.

EFFECTIVE DATE OF COVERAGE

HOW TO ENROLL

The Human Resources Office has enrollment forms, which must be properly completed within thirty-one (31) days of eligibility in order to enroll in this Plan.

New dependents of Employees must be enrolled in this Plan within thirty-one (31) days of marriage or other eligibility described in the section titled "Eligibility" (in the case of birth or adoption, within sixty [60] days of birth or adoption). If an Employee or dependent declined coverage by signing a "Waiver of Coverage" form, he may only enroll as allowed under Special Enrollment Provision.
CHANGES IN ENROLLMENT

The Human Resources Office must be notified immediately if any change occurs which affects eligibility to participate in this Plan.

WHEN COVERAGE BEGINS

Participant Coverage under the Plan shall become effective with respect to a Covered Person on the date of eligibility provided that written application for such coverage is made as provided in this Plan.

New Employees and their eligible dependents will be covered as follows:

- If the Employee begins work between the 1st and the 10th of the month, coverage begins on the 1st of the month immediately following. For example, if the Employee begins work on January 10th, coverage begins on February 1st.
- If the Employee begins work between the 11th and the last day of the month, coverage begins on the 1st of the next following month. For example, if the Employee begins work on January 31st, coverage begins on March 1st.

Newborn children and newly adopted children will be covered on the date of birth or adoption or upon meeting the eligibility requirements described in the section titled "Eligibility" if enrollment forms have been properly completed. New spouses, qualified Domestic Partners or step-children will be covered on the first of the month following the date of marriage/partnership or upon meeting the eligibility requirements described in the section titled "Eligibility" if enrollment forms have been properly completed. NOTE: In the case of adoption, see also “Pre-Adoption Health Coverage” in the section titled FEDERAL LAWS AND REGULATIONS.

All coverage will commence at 12:01 a.m. on the date such coverage is in effect.

REINSTATEMENT OF COVERAGE

Employees returning from an approved personal leave of absence within three (3) months from the date the leave began will be reinstated the first of the month coinciding with or next following return to work. Dependents covered on the date of leave and new dependents acquired during the leave are included in this provision. Prior coverage under this Plan will credit towards satisfaction of the Waiting Period.

SPECIAL ENROLLMENT PROVISIONS

HIPAA requires a group health plan to offer a Special Enrollment opportunity upon the exhaustion of COBRA continuation coverage, the loss of eligibility for coverage that is not COBRA continuation coverage, or the termination of Employer contributions toward coverage that is not COBRA continuation coverage. This Special Enrollment right is available to eligible Employees, dependents of eligible Employees, and dependents of COBRA qualified beneficiaries. Also, HIPAA requires a group health plan to offer a Special Enrollment opportunity to certain newly acquired spouses and dependents of Participants, and to Employees who have previously declined coverage but who have since acquired a new spouse or dependent.

Opportunity #1—Individuals Who Lose Coverage: For this Special Enrollment right to apply:

1. The Employee or dependent of an Employee must be eligible, but not enrolled, for coverage under the terms of this Plan, and when coverage under this Plan was previously offered, the Employee or dependent had coverage under any group health plan (or through health insurance). (An individual who initially declined enrollment even though he did not have other coverage, but then acquires other coverage and is again offered the opportunity to enroll in this Plan would also be eligible for Special Enrollment.)

2. The Employee or dependent must lose coverage under a group health plan or health insurance (including coverage under a state health benefits risk pool, a public health plan, or Medicaid).

3. The Employee or dependent must have lost health insurance or other group health plan coverage because:
   - The coverage was provided under COBRA, and the COBRA coverage was exhausted. Exhaustion includes the following:
     - The entire 18-, 29-, or 36-month COBRA period must be completed;
     - The Employer or other responsible entity (other than the COBRA individual) failed to remit premiums on a timely basis;
     - The individual no longer resides in the service area for an HMO (or similar program) and there is no other COBRA coverage available; or
     - The individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.
The coverage was non-COBRA coverage and (a) the coverage terminated due to loss of eligibility for coverage, or (b) Employer contributions for the coverage were terminated. “Loss of eligibility” includes (but is not limited to):

- Legal separation, divorce, cessation of dependent status, death of an Employee, termination of employment, reduction in the number of hours of employment;
- Coverage offered through an HMO in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area;
- Coverage offered through an HMO in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, and no other benefit package is available to the individual;
- A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

Loss of eligibility does not include (a) a loss resulting from the failure of the individual to pay premiums on a timely basis; (b) a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan); (c) a reduction of contributions or level of benefits; or (d) an increase in cost of coverage.

4. The Employee or dependent must request Special Enrollment in this Plan within thirty-one (31) days after a loss of coverage or the Employer’s cessation of contributions for such coverage. If the loss of eligibility is due to a situation in which an Employee incurs a claim that would meet or exceed a lifetime maximum on all benefits, the Employee must request Special Enrollment within thirty-one (31) days after a claim is denied because of the operation of the lifetime limit. If all other eligibility requirements are met, coverage will be effective on the first day following the loss of other coverage so that there is no lapse in coverage.

Opportunity #2—Acquisition of a New Dependent

1. In the case of a new dependent as a result of marriage/partnership, an Employee may enroll himself and his dependents, provided that the Employee requests Special Enrollment thirty-one (31) days after the date of marriage/partnership and all other eligibility requirements are met. Coverage will be effective on the first of the month following the date of marriage/partnership.

2. In the case of a new dependent as a result of birth, adoption, or placement for adoption, an Employee may enroll himself and his dependents, provided that the Employee requests Special Enrollment within sixty (60) days of birth, adoption, or placement for adoption. Coverage will be effective on the date of birth, adoption, or placement for adoption.

3. In the case of a dependent over the age of 18 whose coverage was previously terminated due to loss of dependent status, but who later fulfills the eligibility requirements under the section entitled “Who May Receive Benefits”, you may enroll this dependent only, provided that you request Special Enrollment within thirty-one (31) days after the dependent regains dependent status as defined by this Plan. Coverage will be effective on the first day of the month following the change in the dependent’s status.

NOTE: The Enrollment Date for anyone who enrolls under a Special Enrollment Provision is the first date of coverage. Thus, the time between the dates a special enrollee first becomes eligible for enrollment under this Plan and the first day of coverage is not treated as a Waiting Period.

OPEN ENROLLMENT PROVISION

You may also enroll or make coverage selection changes during the annual open enrollment period (provided all other eligibility requirements are met). The annual open enrollment is during the month of September for coverage to be effective October 1st.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant Coverage shall automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation Coverage Rights under COBRA or Family Medical Leave Act (FMLA):

1. The end of the next month following the date of termination of the Participant’s employment or layoff;
2. The end of the next month following the date the Participant ceases to meet the eligibility provisions of the Plan;
3. On the last day of the month through which contributions for coverage are paid;
4. On the date the Plan is terminated;

5. On the date the Participant dies; or

6. On the date the Participant enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days, except as allowed under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If employment is obtained by misrepresentation or fraud (including misrepresentation of immigration status in obtaining or maintaining employment), coverage is immediately lost under the Plan. Any such loss of coverage because of false representations in obtaining employment would be retroactive to the Employee’s original Effective Date. The loss of coverage resulting from this situation will not be a qualifying event for Continuation Coverage Rights under COBRA.

DEPENDENT TERMINATION

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

1. The end of the next month following the date the dependent ceases to be an eligible dependent under the Plan;

2. The end of the next month following the date of termination of the Participant’s coverage under the Plan;

3. The end of the next month following the date the Participant ceases to meet the eligibility provisions of the Plan;

4. On the last day of the month through which contributions for Dependent Coverage are paid;

5. On the date the Plan is terminated;

6. On the last day of the month in which the Participant dies; or

7. On the date the dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days.

RETIREE TERMINATION AND RETIREES’ DEPENDENT TERMINATION

1. Retiree coverage will end on the earliest of: a) the last day of the month in which the Retiree turns 65, or b) the first day of the month in which the Retiree becomes eligible for Medicare.

2. Coverage for a Retiree’s spouse will end on the earliest of: a) the last day of the month in which the spouse turns 65 or is granted a decree of divorce, or b) the first day of the month in which the spouse becomes eligible for Medicare.

3. Coverage for a Retiree’s dependent child will end on the last day of the month in which the child is otherwise no longer considered to be a dependent as defined or voluntarily terminates enrollment, either individually or through the early retiree.

4. If a Retiree and/or his covered dependents voluntarily terminate retiree coverage under this Plan, reenrollment under this Plan will not be possible.

RESCINDED COVERAGE

The Plan may rescind an Employee’s and/or his covered dependent's coverage from the beginning as never effective or may deny a claim at any time for fraud, material misrepresentation, or concealment by the Employee or his covered dependent in obtaining or attempting to obtain benefits under this Plan or for knowingly aiding or permitting such actions by another.

If the Plan rescinds coverage as described above, the Plan will retain contributions paid as liquidated damages and reserves the right to recover from the Employee or his covered dependent the benefits paid as a result of such wrongful activity that are in excess of the contributions paid.
FEDERAL LAWS AND REGULATIONS

HIPAA PRIVACY

NOTE: This section does not constitute the triennial HIPAA Privacy Notice. Contact the Plan Sponsor for a copy of the HIPAA Privacy Notice.

Lincoln County School District (the “Plan Sponsor”) sponsors the Lincoln County School District Vision & Dental Care Benefits Plan (the “Plan”). Members of the Company’s workforce have access to the individually identifiable health information of Plan Participants for the administrative functions of the Plan. When this health information is provided by the Plan to the Plan Sponsor, it is Protected Health Information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor’s ability to use and disclose Protected Health Information (PHI). The following HIPAA definition of PHI applies to this Plan Document:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted under this Plan Document or as otherwise required or permitted by HIPAA. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner inconsistent with 45 C.F.R. § 164.504(f).

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The following paragraphs generally explain COBRA coverage, when it may become available to you and your Family, and what you need to do to protect the right to receive it.

The Plan has two (2) components, Vision and Dental, and you may only elect to be enrolled in the combination of both of these components (not separately). COBRA (and the description of COBRA coverage contained in this Plan Document) applies only to the benefits offered under this Plan (that is, the Vision and the Dental components) and not to any other benefits offered by the Plan or by Lincoln County School District School District (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires—nothing in this Plan Document is intended to expand your rights beyond COBRA’s requirements.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below in the section entitled “Who Is Entitled to Elect COBRA?”

COBRA coverage may become available to “qualified beneficiaries”—After a qualifying event occurs and any required notice of that event is properly provided to Lincoln County School District, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under the “Qualified Medical Child Support Orders” provisions may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA COVERAGE UNDER THE HEALTH FSA COMPONENT

COBRA coverage is offered only in limited circumstances—COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered Employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Health FSA plan year.

Health FSA COBRA coverage lasts only until the end of the plan year—COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the Health FSA plan year.

All qualified beneficiaries are covered together under the Health FSA unless otherwise elected—Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each beneficiary has separate election rights and each could alternatively elect separate COBRA coverage to cover
that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact Lincoln County School District for more information.

_No Health FSA open enrollment_—Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

**WHO IS ENTITLED TO ELECT COBRA?**

We use the pronoun “you” in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

_Qualifying events for the covered Employee—_If you are an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

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

_Qualifying events for the covered spouse—_If you are the spouse of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happen:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

_Qualifying events for the covered spouse or covered Domestic Partner—_If you are the spouse or the Domestic Partner of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happen:

1) The Employee dies;
2) The Employee’s hours of employment are reduced;
3) The Employee’s employment ends for any reason other than his or her gross misconduct; or
4) You become divorced or legally separated from the Employee or your domestic partnership ends. Also, if your spouse/Domestic Partner (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation or end to the domestic partnership, and a divorce, legal separation or end to the domestic partnership later occurs, then the divorce, legal separation or end to the domestic partnership may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce, separation or end of the domestic partnership.

For purposes of these CONTINUATION COVERAGE RIGHTS UNDER COBRA, a covered Domestic Partner (as defined) will be treated as a covered spouse.

_Qualifying events for dependent children—_If you are the dependent child of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happen:

- Your parent-Employee dies;
- Your parent-Employee’s hours of employment are reduced;
- Your parent-Employee’s employment ends for any reason other than his or her gross misconduct; or
- You stop being eligible for coverage under the Plan as a “dependent child.”

Individuals who are working in violation of U.S. immigration laws or those individuals who have made false representations of any kind in order to obtain employment are excluded from eligibility for participation in the Plan. Any loss of coverage resulting from this situation will not be a qualifying event for continuation of coverage rights under COBRA.

_Electing COBRA after leave under the Family and Medical Leave Act (FMLA)—_Under special rules that apply if an Employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact Lincoln County School District for more information about these special rules.

_Special second election period for certain eligible Employees who did not elect COBRA—_Certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain Family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost). If you are an Employee or former Employee and you qualify for TAA or ATAA, CONTACT Lincoln County School District PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE ANY RIGHT THAT YOU MAY HAVE TO ELECT COBRA DURING A SPECIAL SECOND ELECTION PERIOD.
WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify Lincoln County School District of any of these three qualifying events.

You must notify the Plan Administrator of certain qualifying events by this deadline—For other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), a COBRA election will be available only if you notify Lincoln County School District in writing within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

You must notify the Plan Administrator of certain qualifying events by this deadline—For other qualifying events (divorce or legal separation of the Employee and spouse, the end of a domestic partnership, or a dependent child’s losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify Lincoln County School District in writing within sixty (60) days after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

No COBRA election will be available unless you follow the Plan’s notice procedures and meet the notice deadline—In providing this notice, you must use the Plan’s form entitled “Notice of Qualifying Event (Form & Notice Procedures),” and you must follow the procedures specified in the section below entitled “Notice Procedures for Notice of Qualifying Event.” If these procedures are not followed or if the notice is not provided in writing to Lincoln County School District during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA. (You may obtain a copy of the Notice of Qualifying Event [Form & Notice Procedures] from Lincoln County School District).

ELECTING COBRA COVERAGE

How to elect COBRA—To elect COBRA, you must complete the Election Form that is part of the Plan’s COBRA election notice and mail, hand deliver or fax it to Trusteed Plans Service Corporation. (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from Trusteed Plans Service Corporation.)

Deadline for COBRA election—If mailed, your election must be postmarked (and if hand-delivered or faxed, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Independent election rights—Each qualified beneficiary will have an independent right to elect COBRA. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan’s COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition Exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition Exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods.

COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred—see the section above entitled “COBRA Coverage Under the Health FSA Component.”

COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled “Termination of COBRA Coverage Before the End of the Maximum Coverage Period.”
Termination of employment or reduction of hours—Otherwise, when Plan coverage is lost due to the end of employment or reduction of the Employee’s hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

EXTENSION OF MAXIMUM COVERAGE PERIOD  (Not Applicable to Health FSA Component)

If the qualifying event that resulted in your COBRA election was the covered Employee’s termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Trusteed Plans Service Corporation of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. (The period of COBRA coverage under the Health FSA cannot be extended under any circumstances. (These extension opportunities also do not apply to a period of COBRA coverage resulting from a covered Employee’s death, divorce, or legal separation or a dependent child’s loss of eligibility.)

Disability extension of COBRA coverage—If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify Trusteed Plans Service Corporation in a timely fashion, all of the qualified beneficiaries in your Family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered Employee’s termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered Employee’s termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify Trusteed Plans Service Corporation of a qualified beneficiary’s disability by this deadline—The disability extension is available only if you notify Trusteed Plans Service Corporation in writing of the Social Security Administration’s determination of disability within 60 days after the latest of:

• the date of the Social Security Administration’s disability determination;
• the date of the covered Employee’s termination of employment or reduction of hours; and
• the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee’s termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered Employee’s termination of employment or reduction of hours in order to be entitled to a disability extension.

No disability extension will be available unless you follow the Plan’s notice procedures and meet the notice deadline—In providing this notice, you must use the Plan’s form entitled “Notice of Disability (Form & Notice Procedures),” and you must follow the procedures specified in the section below entitled “Notice Procedures for Notice of Disability.” If these procedures are not followed or if the notice is not provided in writing to Trusteed Plans Service Corporation during the 60-day notice period and within 18 months after the covered Employee’s termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. (You may obtain a copy of the Notice of Disability [Form & Notice Procedures] from Trusteed Plans Service Corporation.)

Second qualifying event extension of COBRA coverage—An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee’s termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Employee, divorce or legal separation from the covered Employee or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered Employee becomes entitled to Medicare.)
You must notify Trusteed Plans Service Corporation of a second qualifying event by this deadline—This extension due to a second qualifying event is available only if you notify Trusteed Plans Service Corporation in writing of the second qualifying event within 60 days after the later of: (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

No extension will be available unless you follow the Plan’s notice procedures and meet the notice deadline—In providing this notice, you must use the Plan’s form entitled “Notice of Second Qualifying Event (Form & Notice Procedures),” and you must follow the procedures specified in the section below entitled “Notice Procedures for Notice of Second Qualifying Event.” If these procedures are not followed or if the notice is not provided in writing to Trusteed Plans Service Corporation during the 60-day notice period, THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT. (You may obtain a copy of the Notice of Second Qualifying Event [Form & Notice Procedures] from Trusteed Plans Service Corporation.)

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

• any required premium is not paid in full on time;
• a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition Exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
• a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B and/or Part D) after electing COBRA;
• the Employer ceases to provide any group health plan for its Employees; or
• during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled “Extension of Maximum Coverage Period.” (Not Applicable to Health FSA Component.)

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify Trusteed Plans Service Corporation if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage—You must notify Trusteed Plans Service Corporation in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B and/or Part D) after electing COBRA; the Employer ceases to provide any group health plan for its Employees; or during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled “Extension of Maximum Coverage Period.” (Not Applicable to Health FSA Component.)

You must notify Trusteed Plans Service Corporation if a qualified beneficiary ceases to be disabled—If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify Trusteed Plans Service Corporation of that fact within 30 days after the Social Security Administration’s determination. You must use the Plan’s form entitled “Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures),” and you must follow the procedures specified below in the section entitled “Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability.” (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability [Form & Notice Procedures] from Trusteed Plans Service Corporation.)

You must notify Trusteed Plans Service Corporation if a qualified beneficiary ceases to be disabled—If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify Trusteed Plans Service Corporation of that fact within 30 days after the Social Security Administration’s determination. You must use the Plan’s form entitled “Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures),” and you must follow the procedures specified below in the section entitled “Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability.” (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability [Form & Notice Procedures] from Trusteed Plans Service Corporation.)

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

PAYMENT FOR COBRA COVERAGE

How premium payments must be made—All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the individual at the address specified on the Election Form that is part of the Plan’s COBRA election notice.
When premium payments are considered to be made—If mailed, your payment is considered to have been made on the date it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified on the Election Form. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise.

First payment for COBRA coverage—If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand delivered.) See the section above entitled “Electing COBRA Coverage.”

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue’s employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact Trusteed Plans Service Corporation using the contact information provided on the Election Form to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly payments for COBRA coverage—After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month’s COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Trusteed Plans Service Corporation will send monthly notices of payments due for these coverage periods (that is, Trusteed Plans Service Corporation will send a bill to you for your COBRA coverage—if you do not receive a notice of payment due for a coverage period (e.g., it is lost in the mail), it is your responsibility to pay your COBRA premiums on time).

Grace Periods for monthly COBRA premium payments—Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

Children born to or placed for adoption with the covered Employee during a period of COBRA coverage—A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The child’s COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other Family members of the Employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs—A child of the covered Employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Lincoln County School District during the covered Employee’s period of employment with Lincoln County School District is entitled to the same rights to elect COBRA as an eligible dependent child of the covered Employee.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)
KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your Family’s rights, you should keep Lincoln County School District and/or the COBRA Administrator informed of any changes in the addresses of Family members. If a covered dependent resides at a separate address, it is your responsibility to provide this dependent with a copy of this notice or any other COBRA notice.

You should also keep a copy, for your records, of any notices you send to Lincoln County School District and/or the COBRA Administrator, along with proof of mailing.

PLAN CONTACT INFORMATION

You may obtain information about the Plan and COBRA coverage on request from the COBRA Administrator, Trusted Plans Service Corporation, P.O. Box 1894, Tacoma, WA 98401-1894 or 6901 6th Avenue, Tacoma, WA 98406, (253) 564-5850.

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan’s most recent Plan Document (if you are not sure whether this is the Plan’s most recent Plan Document, you may request the most recent one from Lincoln County School District).

NOTICE PROCEDURES

Lincoln County School District (the Plan)

Notices Must Be Mailed, Faxed or Hand Delivered to:          COBRA Administrator
                  Trusted Plans Service Corporation
                  P.O. Box 1894 or 6901 – 6th Avenue
                  Tacoma, WA 98401-1894 or 98406
                  Facsimile: (253) 564-5881

NOTICE PROCEDURES FOR NOTICE OF QUALIFYING EVENT

Deadline for Notice of Qualifying Event—The deadline for providing this notice is 60 days after the later of (1) the qualifying event (i.e., a divorce or legal separation or a child’s loss of dependent status); and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

NOTICE PROCEDURES FOR NOTICE OF QUALIFYING EVENT

Deadline for Notice of Qualifying Event—The deadline for providing this notice is sixty (60) days after the later of (1) the qualifying event (i.e., a divorce, a legal separation or the end of a domestic partnership, or a child’s loss of dependent status); and (2) the date on which the covered spouse, the Domestic Partner (as defined), or a dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

How to provide Notice of Qualifying Event—You must mail, fax or hand deliver this notice to the individual at the address specified above. Your notice must be in writing (using the Plan’s form described below) and must be mailed, faxed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or hand delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

Required form and information for Notice of Qualifying Event—you must use the Plan’s form entitled “Notice of Qualifying Event (Form & Notice Procedures)” to notify Lincoln County School District of a qualifying event (i.e., a divorce or legal separation or a child’s loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Qualifying Event [Form & Notice Procedures] from Lincoln County School District.)

If you are notifying Lincoln County School District of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying Lincoln County School District that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days after the divorce or legal separation in accordance with these Notice Procedures for Notice of Qualifying Event and must in addition provide evidence satisfactory to Lincoln County School District that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.
NOTICE PROCEDURES FOR NOTICE OF DISABILITY

Deadline for Notice of Disability—The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration’s disability determination; (2) the date of the covered Employee’s termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the covered Employee’s termination of employment or reduction of hours.

How to provide Notice of Disability—You must mail, fax or hand deliver this notice to the COBRA Administrator at the address specified above. Your notice must be in writing (using the Plan’s form described below) and must be mailed, faxed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or hand delivered, your notice must be received by the COBRA Administrator at the address specified above no later than the deadline described above.

Required form and information for Notice of Disability—You must use the Plan’s form entitled “Notice of Disability (Form & Notice Procedures)” to notify the COBRA Administrator of a qualified beneficiary’s disability, and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Disability [Form & Notice Procedures] from the COBRA Administrator.)

Your Notice of Disability must include a copy of the Social Security Administration’s determination of disability.

NOTICE PROCEDURES FOR NOTICE OF SECOND QUALIFYING EVENT

Deadline for Notice of Second Qualifying Event—The deadline for providing this notice is 60 days after the later of (1) the date of the second qualifying event (i.e., a divorce or legal separation, the covered Employee’s death, or a child’s loss of dependent status); and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan).

How to provide Notice of Second Qualifying Event—You must mail, fax or hand deliver this notice to the COBRA Administrator specified above. Your notice must be in writing (using the Plan’s form described below) and must be mailed, faxed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or hand delivered, your notice must be received by the COBRA Administrator at the address specified above no later than the deadline described above.

Required form and information for Notice of Second Qualifying Event—You must use the Plan’s form entitled “Notice of Second Qualifying Event (Form & Notice Procedures)” to notify the COBRA Administrator of a second qualifying event (i.e., a divorce or legal separation, the covered Employee’s death, or a child’s loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Second Qualifying Event [Form & Notice Procedures] from the COBRA Administrator).

If you are notifying the COBRA Administrator of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

NOTICE PROCEDURES FOR NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT, OR CESSION OF DISABILITY

Deadline for Notice of Other Coverage—If you are providing a Notice of Other Coverage (a notice that a qualified beneficiary has become covered, after electing COBRA, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the qualified beneficiary.

Deadline for Notice of Medicare Entitlement—If you are providing a Notice of Medicare Entitlement (a notice that a qualified beneficiary has become entitled, after electing COBRA, to Medicare Part A, Part B and/or Part D), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

Deadline for Notice of Cessation of Disability—If you are providing a Notice of Cessation of Disability (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration’s determination.
**How to provide notices**—You must provide these notices to the COBRA Administrator at the address specified above. Your notice must be provided no later than the deadline described above.

**Information and form required**—You should use the Plan’s form entitled “Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)” to notify the COBRA Administrator of any of these events, and all of the applicable items on the form should be completed. (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability [Form & Notice Procedures] from the COBRA Administrator.)

**Additional information required for certain notices**—If you are providing a Notice of Other Coverage, your notice should include evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include a copy of the Medicare card showing the date of Medicare entitlement.

If you are providing a Notice of Cessation of Disability, your notice must include a copy of the Social Security Administration’s determination.

**UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

It is the intent of this Plan to comply with all provisions of the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Employees going into or returning from military service may elect to continue Plan coverage as mandated by USERRA. These rights apply only to eligible Employees and eligible dependents covered under the Plan before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

a. The 24-month period beginning on the date that Uniformed Service leave commences; or
b. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee’s share, if any, for the coverage.

A pre-existing condition Limitation may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, Plan Exclusions and Waiting Periods may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, military service.

There are time limits for reporting back to work upon release from the military as well as notice requirements. For further details, please contact the Human Resources Office.

**FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)**

Under the FMLA, eligible Employees are entitled to an unpaid leave of absence for up to twelve (12) weeks (married Employees who are both employed by the Company are eligible for a combined maximum of twelve [12] weeks leave) within a twelve (12) month period, provided the leave is for:

1. the birth of a son or daughter or to provide care for the newborn;
2. the placement with the Employee of a son or daughter for adoption or foster care;
3. a "serious health condition" of the Employee’s spouse, son, daughter or parent; or
4. a "serious health condition" of the Employee that makes the Employee unable to perform the function of his job.

A "serious health condition" exists whenever an Illness, Injury, impairment or mental condition involves Inpatient care or continuing care by a healthcare provider, as defined in Section 825.114 of the Family and Medical Leave Act of 1993.

An Employee is considered eligible, if:

1. the Employee has worked for the Company for at least twelve (12) consecutive months, and
2. has been employed for at least 1,250 hours of service during the twelve (12) month period immediately preceding the commencement of the leave, and
3. is employed at a work-site with fifty (50) or more Employees within a seventy-five (75) mile radius at other work-sites of the Company.
The twelve (12) month period is based on a twelve (12) month period measured forward from the date any Employee's first FMLA leave begins.

Generally, leave must be taken all at once. However, under certain circumstances, the leave may be taken intermittently or on a reduced leave schedule. If the leave is taken because of a birth or placement of a child for adoption or foster care, an Employee may take leave intermittently or on a reduced schedule only if the Company agrees.

Prior to taking Family leave, Employees must give the Company at least thirty (30) days advance notice of the intended leave dates or as much notice as is practical, whichever is less. In addition, the Employee may be required to provide certification for the Medical Necessity of the leave.

The FMLA requires the Company to continue group coverage during the FMLA leave. If the coverage is contributory, the Employee's share of the premiums will be due at the same time they would be made if by payroll deduction. Coverage will terminate if the Employee does not make the required premium contributions for coverage (if any) within thirty (30) days of the premium due date as described above.

Employees returning from leave as described under FMLA, and who choose not to continue their coverage, will have their coverage reinstated to the same level of benefits as if the leave had not taken place, or if the premium payments had not been missed. The Employee will not be required to satisfy a new Waiting Period or new Pre-Existing Condition Waiting Period.

This is a summary of the FMLA rules. For more information, please refer to the FMLA policy in the Employee handbook, or contact the Human Resources Office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

DOL guidance provides that a Plan must enroll an Employee involuntarily if the Employee’s enrollment is necessary for a child to have coverage that is required under a QMCSO. It follows that an Employee would also be unable to drop his or her coverage while a QMCSO is in effect if the Employee’s enrollment is necessary for a child to have coverage.

“Alternate Recipient” shall mean any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s eligible dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent.

“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant’s child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“National Medical Support Notice” or “NMSN” shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

“Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of “National Medical Support Notice”;

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2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
   b. Informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan’s default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this Section 4.05, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
   a. Whether the child is covered under the Plan; and
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

**PRE-ADOPTION HEALTH COVERAGE**

A child under the age of eighteen (18) is eligible for coverage from the time the child is placed for adoption in the home of a Plan Participant, and shall be treated in the same manner as a natural child of a Participant, even if the adoption has not become final.
VISION PLAN

The following are vision benefits under this program, which are subject to the Vision Plan Limitations and Vision Plan Exclusions shown below. Services may be received from the vision provider of your choice; there is no vision provider network.

COVERED VISION SERVICES

• Examinations, including contact lens fitting. Limited to one (1) vision examination every 24 months for Covered Persons 19 years of age or older, or one (1) vision examination every 12 months for Covered Persons under 19 years of age.

• Lenses. Limited to one (1) pair of standard size and quality white glass or white plastic lenses every 24 months for Covered Persons 19 years of age or older, or one every 12 months for Covered Persons under 19 years of age.

• Frames. Limited to one (1) standard frame every 24 months when necessary to accommodate newly prescribed lenses.

• Contact Lenses, if they are necessary after cataract surgery or if they are the only means to correct vision to 20/70 or better. Limited to one (1) pair of contact lenses every 24 months for Covered Persons 19 years of age or older, and one (1) pair every 12 months for Covered Persons under 19 years of age.

DisposaProceed contact lenses are subject to the contact lenses maximum as shown in the Vision Summary of Benefits and may be purchased throughout the applicable 12- or 24-month period as stated above.

If contact lenses are selected as an alternative to lenses and a frame, Covered Expenses are limited to the amount the Plan would have paid for regular lenses and a frame. The Plan will base payment on the type of contact lenses purchased (single, bifocal, or trifocal).

VISION PLAN LIMITATIONS

• The Covered Person is responsible for the difference between the provider's retail charge and the Plan's benefit payment.

• Coverage is limited to services provided by optometrists, ophthalmologists and opticians, to the extent that such services are within the scope of their license.

VISION PLAN EXCLUSIONS

• Treatment of eyes or special procedures such as orthoptics or vision training.

• Charges for fashion eyewear features such as flintglass, blended, coated, tinted (except tints #1 and #2), or oversize lenses.

• Additional charges for partially covered frames.

• Charges for prisms, prism segs, slab-off, and other special purpose vision aids.

• Replacement of lenses and frames, unless the Covered Person is otherwise eligible for benefits.
DENTAL PLAN

BENEFIT LIMITATION

All services are limited to a Usual, Customary and Reasonable (UCR) allowance (as defined) as determined by the Plan Administrator.

CALENDAR YEAR MAXIMUM

Dental benefits are payable at the Coinsurance level shown in the Dental Summary of Benefits up to the Calendar Year maximum amount listed in the Dental Summary of Benefits.

COINSURANCE

Coinsurance is the percentage share payable by the Covered Person on claims for which the Plan provides benefits at less than 100% of the allowed amount. As stated in the Dental Summary of Benefits, the following applies:

In the first Calendar Year a Covered Person receives covered dental services, the Plan will pay 70 percent of Covered Expenses. For each succeeding Calendar Year in a row that a Covered Person receives covered dental services, the percentage will increase by 10 percentage points, up to a maximum of 100 percent. This means that in the 2nd year in a row that a Covered Person receives covered dental services, the Plan will pay 80 percent of Covered Expenses. In the 3rd year in a row, the Plan will pay 90 percent, and in the 4th year, 100 percent of Covered Expenses.

If in any Calendar Year a Covered Person fails to receive covered dental services, the percentage payable will remain at the same level. For each succeeding year in which a Covered Person fails to receive covered dental services, the percentage of Covered Expenses the Plan pays will decrease 10 percentage points, but never below 70 percent.

NOTE: The percentage the Plan pays for a Covered Person who becomes enrolled after July 1 in any Calendar Year will be increased by 10 percentage points at the beginning of the following Calendar Year whether or not covered dental services were received. However, the percentage the Plan pays in subsequent Calendar Years will either increase or decrease as described in previous paragraphs.

ESTIMATE OF BENEFITS

If dental care is estimated to be over $500, ask the Dentist to complete and submit a pre-treatment estimate to the Claims Administrator. This will allow the Covered Person to know in advance exactly what procedures are covered, the amount this Plan will pay toward the treatment and their financial responsibility.

The estimate from the Claims Administrator will be based on the coverage available at the time the estimate is given. However, benefit payment will be based on coverage in effect at the time services are actually rendered and will always be subject to the eligibility provisions and Limitations of the Plan.

ALTERNATE TREATMENT

When there is more than one method of treatment for a dental condition, Covered Expenses will be limited to the treatment method with the lesser charge.

DENTAL PLAN EXPENSES INCURRED

For root canal therapy, an expense is considered Incurred at the time the pulp chamber is opened. For full or partial dentures, an expense is considered Incurred on the date on which the final impression is made. For fixed Bridges, Crowns, Inlays and Onlays, an expense is considered Incurred on the date on which teeth are prepared. All other expenses are considered Incurred at the time a service is rendered or completed, or a supply furnished.

Expenses are covered only if Incurred and completed while a Covered Person is covered under this Plan.

DENTAL PLAN LIMITATIONS

The following services will be considered an integral part of the entire dental service rather than a separate service: local anesthesia, bases, pulp caps, temporary dental services, study models/diagnostics casts, treatment plans and Occlusal Adjustments.
BENEFITS PROVIDED BY YOUR DENTAL PLAN

The following are Class I, Class II, and Class III covered dental benefits under this program, which are subject to the Limitations and Exclusions contained in this Plan. Services may be received from the dental provider of your choice; there is no dental provider network.

─ CLASS I ─

Covered PREVENTIVE & DIAGNOSTIC Benefits

- Oral Examinations.
- Prophylaxis.
- Topical Fluoride application. Limited to topical Fluoride application to the exposed tooth surfaces for Covered Persons age 22 or under.
- Sealants. Limited to the permanent teeth for enrollees age 17 and under.
- Periapical and Bitewing X-Rays; i.e., dental x-rays of the inside of the mouth.

─ CLASS II ─

Covered RESTORATIVE Benefits

- Extractions. The surgical removal or pulling of teeth.
- Fillings. Fillings of silver Amalgam, silicate, or plastic restorative material. If the Covered Person elects to have another more costly restorative material (such as gold), coverage is limited to the cost of a silver Amalgam filling. Multiple restorations of one surface and anterior restorations involving adjoining surfaces will be treated as a single filling.
- Palliative Emergency Treatment; i.e., Emergency treatment that is primarily for relief, not cure.
- Space Maintainers required to preserve the space between teeth because of premature loss of a primary tooth. The primary teeth are the first set of teeth, sometimes known as baby teeth.
- Repair of dentures and Bridges; i.e., the repair or reline of artificial teeth.
- Oral Surgery. Surgery for dental purposes pertaining to the gums, teeth, or tooth structure and treatment of fractures and dislocations.
- Apicoectomy. The surgical removal of the tip of the tooth root.
- Endodontics. The prevention, diagnosis, and treatment of disease and Injury of the tooth pulp, root, and surrounding tissue. This includes pulpotomy, pulp capping, and root canal treatment.
- Periodontic Services. Nonsurgical services of the connective tissues around and supporting the teeth. Surgical periodontal exams, gingival curettage, gingivectomy, osseous surgery including flap entry and closure, mucogingivoplasty surgery, and management of acute infection and oral lesions related to the tooth structure are covered.

Limitations

- Periodontal scaling and Root Planing, per quadrant, is limited to once in any 24-month period, based on the last date of service.
- General Anesthesia and I.V. Sedation are covered only when administered by a Dentist who meets the educational guidelines established by the appropriate State Dental Disciplinary Board in conjunction with a covered oral surgery procedure.

Exclusions

- Space maintainers used in orthodontics to create a space between the teeth.

─ CLASS III ─

Covered MAJOR Benefits

- Inlays and Onlays.
- Crowns, consisting of a casting procedure.
• Dental Implants, including attachment devices.
• Bridges, fixed and removable.
• Dentures, full and partial.
• Bruxism splints and Nightguards; i.e., appliances to reduce or prevent pain or damage from grinding of the teeth.
• Periodontal splints; i.e., appliances to stabilize the teeth in proper position during periodontal treatment.

Limitations
• For replacement of missing teeth with full or partial dentures, Covered Expenses are limited to the charge for the standard procedure.

Exclusions
• Covered Expenses do not include replacement of an existing denture, for any reason, less than five years after the date of the most recent replacement. This applies whether or not the Covered Person was enrolled under this Plan at the time of the initial placement.
• Personalized restoration, precision attachments, and special techniques are not covered.

DENTAL PLAN LIMITATIONS AND EXCLUSIONS
1. Services for Injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, or arising out of, or in the course of, any work for wage or profit;
2. Services which are provided to the eligible person by any federal, state or provincial government agency (except for Medicaid Coverage) or provided without cost to the eligible person by any municipality, county or other political subdivision;
3. Dental services (including medications) rendered for or in support of Cosmetic purposes, including complications resulting from Cosmetic surgery except if the surgery is performed to treat a disease, correct a functional disorder, or as the result of an accidental Injury;
4. Restorations or appliances Necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth;
5. Services or supplies for the treatment of jaw joint problems including, but not limited to: Temporomandibular Joint disorder or dysfunction, craniomandibular disorder, or other disorders of the joint linking the jawbone and skull and the complex of muscles, nerves or other tissues related to that joint;
6. Experimental and/or Investigational services or supplies. Experimental and/or Investigational services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are Experimental and/or Investigational, this Plan, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community in the State of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective;
7. Dental services started prior to the date the person became eligible for services under this Plan, or the Company-sponsored plan this Plan replaces;
8. Dental services completed after the person is no longer covered under this Plan;
9. Charges for completion of claim forms;
10. Appliances for periodontal splinting;
11. Services and supplies that are not Necessary for treatment of a dental Injury or disease or that are not recommended and approved by the licensed Dentist attending the patient;
12. Replacement of a tooth that was missing prior to the date the person became eligible for services under this Plan, or the Company-sponsored plan this Plan replaces (unless otherwise required by applicable law);
13. Charges for services rendered by any provider that is a Close Relative of the Covered Person, or that resides in the same household of the Covered Person;
14. Charges in excess of the Usual, Customary and Reasonable (UCR) charge for the services or supplies provided, or which exceed the UCR charges for the least costly plan of treatment when there is more than one accepted method of treatment for the dental condition;
26. Charges resulting from changing from one Dentist to another while receiving treatment, or from receiving care from more than one Dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one Dentist had performed all the required dental services;

27. Habit breaking appliances or supplies;

17. Orthodontic services, except extractions for orthodontic purposes;

18. Prescription drugs and fees for writing a prescription for medications;

19. 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;

20. Charges Incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining dental services, drugs, or supplies;

21. Services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner’s policy, or other similar type of coverage;

22. Services and supplies a Covered Person could have received in a Hospital or program operated by a government agency or authority, unless reimbursement under this Plan is otherwise required by law;

23. The treatment of any condition caused by or arising out of service in the armed forces of any country or from an insurrection;

24. Services and supplies a Covered Person receives while in the custody of any state or federal law enforcement authorities or while in jail or prison;

25. Any medication or supply distributed by a professional provider to be taken or used outside his or her office. These include, but are not limited to Fluoride rinse or mouthwash;

26. Any full or partial denture that is intended for placement in the mouth for less than twelve (12) months;

27. Gnathologic recordings of jaw movements and positions;

28. Study models of teeth and surrounding tissue for purposes of study and treatment planning;

29. Educational programs for Plaque control or to teach nutritional and oral hygiene techniques;

30. All other services not specifically included in this Plan as covered dental benefits or an exception to these Dental Plan Limitations and Exclusions.
CLAIMS PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan.

HEALTH CLAIMS

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are three types of claims: Pre-service (Urgent and Non-urgent) which apply to transplants only, and Post-service.

PRE-SERVICE CLAIMS

A "Pre-service Claim" is a claim for transplant benefits under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" is any claim for transplant benefits with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A Pre-service Claim is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator and includes the following information:

1. The proposed date of service;
2. The name, address, telephone number and tax identification number of the proposed provider of the services or supplies;
3. The proposed place where the services are to be rendered;
4. The diagnosis and procedure codes;
5. The anticipated amount of charges;
6. The name of the Plan or group number;
7. The name and Social Security Number of the covered Employee; and
8. The name of the patient.

POST-SERVICE CLAIMS

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan or group number;
7. The name and Social Security Number of the covered Employee; and
8. The name of the patient.
Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

**WHEN HEALTH CLAIMS MUST BE FILED**

Health claims must be filed with the Claims Administrator within twelve (12) months of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.** However, on termination of the Plan, final claims must be received within ninety (90) days of termination.

**TIMING OF CLAIM DECISIONS**

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims, of decisions that a claim is payable in full) within the following timeframes:

**Pre-service Urgent Care Claims:**
- If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

**Pre-service Non-urgent Care Claims:**
- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

**Post-service Claims:**
- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period. In that case, the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

**Extensions – Pre-service Urgent Care Claims.** No extensions are available in connection with Pre-service Urgent Care Claims.

**Extensions – Pre-service Non-urgent Care Claims.** The 15-day processing period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

**Extensions – Post-service Claims.** The 30-day processing period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

**Calculating Time Periods.** The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.
NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

The Plan Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental and/or Investigational), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Full and Fair Review of All Claims: In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate Named Fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or the Claims Administrator, information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which
   • A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
   • All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.
FIRST APPEAL LEVEL

Requirements for First Appeal: The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, the claimant may telephone the Claims Administrator as follows: Claims Manager, 1-800-426-9786, Ext. 211. To file an appeal in writing, the claimant’s appeal must be addressed as follows or faxed to the following number: Trusteed Plans Service Corporation, 6901 – 6th Avenue, Tacoma, WA 98406, FAX number: 253-564-5881, ATTN: Claims Manager.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/claimant;
2. The Employee/claimant’s social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal: The Plan Administrator shall notify the claimant of the Plan’s benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- Calculating Time Periods: The period of time within which the Plan’s determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal: The Plan Administrator shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan’s adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan’s review procedures and the time limits applicable to the procedures;
9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims;
10. The following statement: “All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.”

Furnishing Documents in the Event of an Adverse Determination: In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to ”Manner and Content of Notification of Adverse Benefit Determination on First Appeal” as appropriate.
SECOND APPEAL LEVEL

Adverse Decision on First Appeal: Requirements for Second Appeal: Upon receipt of notice of the Plan’s adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the adverse decision. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal: The Plan Administrator shall notify the claimant of the Plan’s benefit determination on review within the following timeframes:

- **Pre-service Urgent Care Claims:** As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.
- **Pre-service Non-urgent Care Claims:** Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
- **Post-service Claims:** Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
- **Calculating Time Periods:** The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal: The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; (ii) a description of the Plan's review procedures and the time limits applicable to the procedures; and (iii) for Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination: In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal to be Final: If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.
GENERAL PROVISIONS

ALTERNATE BENEFITS

Alternate benefits means payment for those services or supplies which are not otherwise Covered Expenses of the Plan, but that the Plan Administrator believes to be Medically Necessary and cost-effective. If the Plan Administrator approves payment for alternate benefits, the Covered Person will be notified of such approval and the duration of such approval.

The fact that alternate benefits are paid by the Plan shall not obligate the Plan to pay such benefits for other Covered Persons, nor shall it obligate the Plan to pay continued or additional alternate benefits for the same Covered Person. Payments for alternate benefits are Covered Expenses for all purposes under the Plan.

EXAMINATION

If necessary to assist in making a benefit determination, the Plan may request that the patient be examined by a Physician selected and paid by the Plan. If the patient chooses not to comply with this request, benefits will be denied.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan with respect to Covered Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

TIME LIMITATION

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Plan is existent, such limitation is hereby extended to agree with the minimum period permitted by such law.

FREE CHOICE OF PROVIDER

The Covered Person shall have free choice of any legally qualified Physician or surgeon and the Physician-patient relationship shall be maintained.

WORKER’S COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby deemed amended to conform to the minimum requirements thereto.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS

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

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.
FACILITY OF PAYMENT

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

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

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, all Covered Persons who are eligible for Medicare benefits will be entitled to benefits under this Plan in addition to Medicare. Employees who are actively at work and their eligible dependents will be considered to be covered under the Plan as primary payor of benefits and Medicare as secondary payor of benefits; however, in no event will this Plan pay benefits for more than the actual charges for services Incurred. If any Covered Person eligible for Medicare fails to enroll in Medicare, the benefits of this Plan will be paid as though he had enrolled.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Benefits Subject to This Provision  This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies  A Covered Person may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;

2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

3. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. If the Plan pays any medical or other benefits for the Injuries or Illness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.
The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

**Amount Subject to Subrogation or Reimbursement**  
*Any amounts recovered will be subject to Subrogation or Reimbursement.* In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys’ fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

“Another Party” shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person’s Injuries or Illness.

“Another Party” shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person’s own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner’s, renter’s or any other liability insurer; a workers’ compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

“Recovery” shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

“Subrogation” shall mean the Plan’s right to pursue the Covered Person’s claims for medical or other charges paid by the Plan against Another Party.

“Reimbursement” shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

**When a Covered Person Retains an Attorney**  
If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person’s attorney must recognize and consent to the fact that the Plan precludes the operation of the “made-whole” and “common fund” doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person’s attorneys’ fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person’s attorneys’ fees and costs. Attorneys’ fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

**When the Covered Person is a Minor or is Deceased**  
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor’s representative has access or control of the Recovery.

**When a Covered Person Does Not Comply**  
When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.

**AVAILABILITY OF BENEFITS**

Benefits quoted to providers are not a guarantee of claim payment. Claim payment will be dependent upon eligibility at the time of service and all terms and conditions of the Plan.

For a written pre-treatment estimate, a provider of service must submit to the Claim Administrator their proposed course of treatment, including diagnosis, procedure codes, place of service and proposed cost of treatment. In some cases, medical records or additional information may be necessary to complete the estimate of benefits.
The coordination of benefits provision is intended to prevent the payment of benefits which exceed Allowable Expenses. It applies when the Participant or any eligible dependent who is covered by the 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 plans pay reduced benefits. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed one hundred percent (100%) of Allowable Expenses. Only the amount paid by the 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 needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

COORDINATION OF BENEFITS DEFINITIONS

"Plan" as used in this Section will mean any plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

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

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

"Allowable Expenses" means any necessary item of expense, the charge for which is Usual, Reasonable and Customary, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

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

COORDINATION ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the Plans will pay benefits first. This is done by using the first of the following rules which applies:

1. A Plan with no coordination provision will determine its benefits before a Plan with a coordination provision.
2. A Plan that covers a person other than as a dependent will determine its benefits before a Plan that covers such person as a dependent.
3. When a claim is made for a dependent child who is covered by more than one Plan, the benefits as a dependent of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that year; except
   a. If both parents have the same birthday, the benefits of the Plan which covers the parent longer are determined before those of the Plan which covers the other parent for a shorter period;
b. If the other Plan does not have the rules stated in (3), but instead has the rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.

4. When the parents of a dependent child are divorced or separated, these are the rules for determining which Plan pays first:
   a. The Plan of the parent with custody, then
   b. The Plan of the spouse of the parent with custody, then
   c. The Plan of the parent without custody; then
   d. The Plan of the spouse of the parent without custody.

5. When the parents of a dependent child are divorced or separated and there is a decree establishing financial responsibility for medical expenses of the dependent child, benefits as a dependent of the parent with financial responsibility are determined before benefits as a dependent of the parent without financial responsibility.

6. A Plan that covers a person as a laid off Employee, a retired Employee or a dependent of such Employee will determine its benefit after the Plan that does not cover such person as a laid off Employee, a retired Employee or a dependent of such Employee. If one of the Plans does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

7. When the above rules do not establish an order, benefits are determined first under the Plan that covers the person for the longest period of time.

EXCHANGE OF INFORMATION

This Plan and other plans may exchange information needed in order to coordinate benefits. No consent or notice is required. Covered Persons must furnish needed information.
PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services.

Plan Administrator  An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to a Covered Person’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator  The duties of the Plan Administrator include the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a Covered Person’s rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the Plan Documents and all other records pertaining to the Plan;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by applicable law;
- To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan’s administration.

Amending and Terminating the Plan  The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of the Covered Person are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.
DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.

AMALGAM

“Amalgam” means a mostly silver filling often used to restore decayed teeth.

BITEWING X-RAY

“Bitewing X-Ray’ is an x-ray that reveals the condition of the top visible part of the upper and lower molar teeth.

BRIDGE

“Bridge” means a replacement for a missing tooth or teeth. The Bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

CALENDAR YEAR

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

CLAIMS ADMINISTRATOR

“Claims Administrator” means the person or firm retained by the Plan Administrator who is responsible for performing certain ministerial functions for the Plan.

CLOSE RELATIVE

“Close Relative” means the spouse, parent, brother, sister, child, aunt, uncle or grandparent of the Covered Person or the Covered Person's spouse.

COBRA

“COBRA” means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COMPANY

“Company” means Lincoln County School District and any participating subsidiaries or affiliates.

COSMETIC

“Cosmetic” means a procedure performed or a service or supply provided solely for the improvement of a Covered Person's appearance rather than for the restoration of bodily function.

COVERED EXPENSES

“Covered Expenses” means the Usual, Customary and Reasonable charges for Necessary or Medically Necessary treatments, services, or supplies that are listed as a covered benefit of the Plan.

COVERED PERSON

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

CROWN

“Crown” is that portion of the human tooth covered by enamel.
DENTIST

“Dentist” means a person duly licensed to practice Dentistry by the governmental authority having jurisdiction over the licensing and practice of Dentistry in the locality where the service is rendered.

DEPENDENT COVERAGE

“Dependent Coverage” means eligibility under the terms of the Plan for benefits payable as a consequence of Covered Expenses Incurred for an Illness or Injury of a properly enrolled dependent.

DOMESTIC PARTNER

“Domestic Partner” is an individual with whom the Employee has united in a serious, committed relationship. Such relationship is intended as a consideration of life partnership between the Employee and his spousal equivalent and such relationship has been maintained for at least six (6) months. The following criteria are required to establish the relationship:

1. The Employee must file an Affidavit of Domestic Partnership with the Personnel Department;
2. The two parties are each other’s sole Domestic Partner and intend to remain so indefinitely;
3. Neither of the parties is legally married;
4. They are at least 18 years of age (or are emancipated minors as recognized under Oregon law) and mentally competent to consent to the partnership;
5. They are not related by blood to a degree of closeness that would prohibit legal marriage in the State of Oregon;
6. They reside together in the same residence for at least six (6) months and intend to do so indefinitely;
7. They are jointly responsible for each other’s common welfare and financial obligations;
8. At least six (6) months have elapsed since benefits coverage was terminated on a previously covered Domestic Partner; and
9. They understand that as Domestic Partners they are subject to the same thirty-one (31) day notice requirements set forth in the Plan as are all other Employees and dependents who are covered by or applying for benefits.

If there is any change in the Domestic Partner relationship, the Human Resources Department must be notified within thirty-one (31) days of such change by filing a Statement of Termination of Domestic Partnership. A copy must be mailed to the other party by the party authorizing such action. A subsequent Affidavit of Domestic Partnership cannot be filed for a twelve (12) month period following the termination, unless it is filed within thirty-one (31) days for the same Domestic Partner.

EMERGENCY

“Emergency” means an Illness or Injury of sudden, acute onset resulting in a life-threatening situation requiring immediate Physician and Hospital attention. Examples of a medical Emergency are heart attacks or suspected heart attacks, coma, loss of respiration, stroke, acute appendicitis, etc.

EMPLOYEE

See definition of Covered Person.

EMPLOYER

See definition of Company.

ENDODONTICS

“Endodontics” is that branch of Dentistry that deals with the diagnosis and treatment of diseases of the dental pulp and tissues around the root end.

ENROLLMENT DATE

“Enrollment Date” is the earlier of: a) the first day of coverage, or b) if there is an eligibility Waiting Period for benefits, the first day of the eligibility Waiting Period.

EXCLUSIONS

“Exclusions” means services and charges not covered under this Plan.
EXPERIMENTAL AND/OR INVESTIGATIONAL

The Plan Administrator or its designee has the discretion and authority to determine if a medical, surgical, diagnostic, psychiatric, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for preauthorization under the Plan’s utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

1. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.

2. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical or scientific literature on the subject, or a preponderance of such literature published in the United States and written by experts in the field; that shows that recognized medical or scientific experts classify the service or supply as Experimental and/or Investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
   - authoritative peer reviewed medical or scientific writings that will be considered include the following publications or sources of publications:
     - “United States Pharmacopoeia Dispensing Information”;
     - “American Hospital Formulary Service”;
     - “American Medical Association (AMA), Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, or similar publications of the AMA;
     - specialty organizations recognized by the AMA;
     - the National Institutes of Health (NIH);
     - the Center for Disease Control (CDC);
     - the Agency for Health Care Policy and Research (AHCPR)
     - opinions of other agency review organizations, e.g. ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries;
     - the American Dental Association (ADA), with respect to dental services or supplies;

3. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is approved by the FDA as an “investigational new drug for treatment use”; or classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease” as that term is defined in FDA regulations; or approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

4. The prescribed service or supply is available to the Covered Individual only through participation in Phase I or Phase II clinical trials; or Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

FAMILY

“Family” means a Participant and his eligible dependents.

FLUORIDE

“Fluoride” is a substance which when topically applied or applied to drinking water is effective in resisting tooth decay.

GENERAL ANESTHESIA

“General Anesthesia” is a drug or gas which produces unconsciousness and insensitivity to pain.

HIPAA

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), which was enacted as part of a broad Congressional attempt at incremental health care reform. HIPAA required the Department of Health and Human
Services to create standards for the electronic exchange, privacy and security of health information. The “HIPAA Privacy Rule” grants health care consumers a greater level of control over the use and disclosure of personally identifiable health information. In general, health care providers, health plans, and clearinghouses are prohibited from using or disclosing health information except as authorized by the patient or specifically permitted by the regulation.

HOSPITAL

“Hospital” means an institution that meets all of the following conditions:
1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient’s expense;
2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses;
5. It qualifies as a Hospital, a psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
6. It is a provider of services under Medicare; and
7. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

ILLNESS

“Illness” means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

IMPLANT

“Implant” is a graft or insert set firmly onto or deeply into the Alveolar area prepared for its insertion. It may support a Crown or Crowns, a Bridge abutment, a partial denture, or a complete denture.

INURRED

“Incurred” means the time or date a service or supply is actually provided to a Covered Person. With respect to a course of treatment or procedure that includes several stages or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

INJURY

“Injury” means trauma or damage to the Covered Person’s body from an external force.

INLAY

“Inlay” is a dental filling shaped to the form of a cavity and then inserted and secured with cement.

I.V. SEDATION

“I.V. Sedation” is a form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

LIMITATIONS

“Limitations” are restrictions such as age, period of time covered and Waiting Periods, which may limit coverage or benefits under this Plan.
MEDICALLY NECESSARY or MEDICAL NECESSITY

“Medically Necessary” or “Medical Necessity” means a medical service or supply that:

1. is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it; and
2. is determined by the Plan Administrator or its designee to meet all of the following requirements:
   • It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
   • It is not provided primarily for the convenience of the patient, Physician, Hospital, Health Care Provider, or health care facility;
   • It is an “appropriate” service or supply given the patient’s circumstances and condition; and
   • It is a “cost-efficient” supply or level of service that can be safely provided to the patient; and
   • It is safe and effective for the Illness or Injury for which it is used.

A medical service or supply will be considered to be “appropriate” if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is (a) as likely to result in information that could affect the course of treatment and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient’s overall health condition.
2. It is care or treatment that is (a) as likely to produce a significant positive outcome and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient’s overall health condition.

A medical service or supply will be considered to be “cost-efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses Incurred in connection with the service or supply.

The fact that the Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.

A hospitalization or confinement to a Skilled Nursing Facility or other specialized health care facility will not be considered to be Medically Necessary if the patient’s Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

MEDICARE

“Medicare” means the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act", and which includes Parts A, B and D and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79), as amended from time to time.

NAMED FIDUCIARY

“Named Fiduciary” means the Company, as the Plan Administrator.

NECESSARY

“Necessary” in regards to dental treatment means that, as determined by the Claims Administrator:

1. There is a condition which requires treatment; and
2. The service or supply used to treat the condition is:
   A. Required;
   B. Generally professionally accepted as the usual, customary and effective means of treating the condition in the United States;
   C. Approved by regulatory authorities such as the American Dental Association;
   D. Not performed mainly for the convenience of the patient or the provider of dental services;
   E. Not conducted for research purposes; and
   F. The most appropriate level of services that can be safely provided to the patient.

All of these criteria must be met; merely because a Dentist recommends or approves certain care does not mean that it is Necessary.

NIGHTGUARD

“Nightguard” is an appliance used to treat the unconscious habit of gnashing or grinding teeth during the sleeping period or at times of stress.
OCCLUSAL ADJUSTMENT

“Occlusal Adjustment” is a modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the Temporomandibular Joints and the structure supporting the teeth.

ONLAYS

“Onlay” is a restoration of the contact surface of the tooth that covers the entire surface.

PARTICIPANT

“Participant” means an eligible Employee of the Company and who meets the qualifications as stated in this Plan.

PARTICIPANT COVERAGE

“Participant Coverage” means coverage hereunder providing benefits payable as a consequence of an Injury or Illness of a Participant.

PERIODONTICS

“Periodontics” is that branch of Dentistry that deals with the prevention and treatment of diseases of the bone and soft tissues surrounding the teeth.

PHYSICIAN

“Physician” means legally licensed medical or dental providers, including but not limited to: Advanced Registered Nurse Practitioner A.R.N.P., Certified Nurse Midwife C.N.M. if an A.R.N.P./C.N.M., Alcoholism Treatment and Drug Addiction Facility, Ambulatory Surgical Center, Audiologist, Birthing Center, Chiropractor D.C., community mental health center including those persons with the designation M.S.W., Dentist D.D.S. or D.M.D., Dietician D., R.D. or C.D., Durable Medical Equipment Supplies, Home Health Agency, Home Infusion Therapist, Hospice, Hospital, Laboratory, Licensed Practical Nurse L.P.N., Certified Nutritionist C.N., Occupational Therapist O.T., Optometrist O.D., Osteopathic Physician Assistant O.P.A., Physical Therapist P.T., Physician and Surgeon M.D. or D.O., Physician Assistant P.A., Podiatrists D.P.M., Psychologist, Radiologic Technologists, Registered Nurse R.N., Respiratory Care Practitioners, Skilled Nursing Facility, Speech Therapist S.T., and Surgical Assistant R.N., to the extent that same, within the scope of their license, are permitted to perform services provided in this Plan.

A Physician shall not include the Covered Person, any Close Relative of the Covered Person, or one who resides in the same household as the Covered Person.

PLAN

“Plan” means this Lincoln County School District Vision & Dental Care Benefits Plan.

PLAN DOCUMENT

“Plan Document” means this Plan Document and Summary Plan Description.

PLAN SPONSOR

“Plan Sponsor” means the Company.

PLAQUE

“Plaque” is flat masses of bacteria and debris on tooth surfaces.

PROPHYLAXIS

“Prophylaxis” is the control of dental and oral diseases by preventive measures, especially the mechanical cleaning of the teeth.

QUALIFIED BENEFICIARY

“Qualified Beneficiary” means a covered Employee or dependent who is eligible to continue coverage under the Plan in accordance with applicable provisions of COBRA due to a COBRA qualifying event.
RESTORATIVE
“Restorative” means a process used to replace a lost tooth or part, or the diseased portion of one, by artificial means as with a filling, Crown, Bridge or denture designed to restore proper dental function.

ROOT PLANING
“Root Planing” is a procedure done to smooth roughened root surfaces.

TEMPOROMANDIBULAR JOINT (TMJ)
“Temporomandibular Joint” is the joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

A Temporomandibular Joint disorder has one or more of the following characteristics: pain in the musculature associated with the Temporomandibular Joint, internal derangements of the Temporomandibular Joint, arthritic problems with the Temporomandibular Joint, or an abnormal range of motion or limitation of motion of the Temporomandibular Joint.

USUAL, CUSTOMARY AND REASONABLE (UCR)
“Usual, Customary and Reasonable” is the lesser of the provider’s usual charge for the same services or supplies in the absence of insurance coverage and the charge customarily billed to private patients for the same or similar services or supplies by providers in the same geographic location (the same zip code region).

WAITING PERIOD
A “Waiting Period” is the time between the first day of employment in an eligible class and the first day of coverage under the Plan.
1. Name of Plan:  
Lincoln County School District Vision & Dental Care Benefits Plan

2. Employer Identification Number (EIN) Assigned by the Internal Revenue Service:

   EIN:  93-6000627

3. Type of Plan:
   Self-Funded Vision and Dental Plan

4. Type of administration:
   Contract administration with the Claims Administrator. The funding for the benefits is derived from the funds of the Plan Sponsor (and contributions made by covered Employees, if any). The Plan is self-insured.

5. Name, business address and telephone number of the Plan Sponsor:
   Lincoln County School District  
   459 S.W. Coast Highway  
   Newport, OR 97365  
   (541) 265-4422

6. Name, business address and telephone number of the Plan Administrator (Named Fiduciary):
   Lincoln County School District  
   459 S.W. Coast Highway  
   Newport, OR 97365  
   (541) 265-4422

7. Name and address for service of legal process:
   Same as shown in #5.

8. Name, business address and telephone number of the Claims Administrator:
   Trusteed Plans Service Corporation  
   P.O. Box 1894  
   Tacoma, Washington 98401-1894  
   (253) 564-5850

9. The date of the end of the year for purposes of maintaining the Plan's fiscal records:  June 30th

10. Participating Employers:  Lincoln County School District