



Group Dental and Vision Program Summary Plan Description



Employees of Participating School Districts of EdCare

Revised October 2011



The Healthy Choice





AMENDMENT & SUMMARY OF MODIFICATIONS

Effective Date: October 1, 2014

Effective **October 1, 2014**, Edcare Group hereby amends the Dental and Vision Summary Plan Description (Restated October 1, 2011).

Description of Benefits; Summary of the Edcare Group Dental and Vision Program Benefit Plan (Page 12)

- a child who is under age 26 (i. e., through age 25). The child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed.
- An eligible "child" is one who has a relationship with the Employee (e.g., a son, daughter, stepson or stepdaughter of the Employee, a legally adopted child, a child who is placed with the Employee for legal adoption, or a foster child). An eligible child also includes one for whom coverage is required due to a Qualified Medical Child Support Order.
- An eligible child who is currently under age 26, who meets the above criteria but who is not currently enrolled will be provided with an opportunity to enroll (a "special enrollment right").
- Because this is a non-grandfathered Plan, the Plan cannot refuse dependent coverage to an eligible adult child, even if they are eligible for their own employer-sponsored group health coverage.

THE EDCARE GROUP

BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE

DENTAL AND VISION BENEFITS

NOTE: THESE BENEFITS ARE PART OF "THE EDCARE GROUP HEALTH BENEFITS PLAN"

RESTATED: OCTOBER 1, 2011

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DENTAL BENEFIT SUMMARY

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with CVDP - an organization or "Network" of dental providers. When obtaining dental care services, a Covered Person has a choice of using a CVDP Network provider or a non-Network provider. A list or directory of the CVDP Network providers will be given to Plan participants without charge.

Because CVDP Network providers have agreed to provide services to Covered Persons at negotiated rates, when a Covered Person uses a CVDP Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of the maximum fee allowance. The "maximum fee allowance" is the contracted CVDP fee.

NOTE: Services of Non-Network providers will be paid at the CVDP negotiated rates.

SCHEDULE OF DENTAL BENEFITS

PLAN MAXIMUMS		
Calendar Year Maximum Benefit (non-orthodontia)	\$1,500	
Orthodontia Maximum Benefit	\$1,250	
Accidental Injury Benefits, per Calendar Year	\$1,000	
Plan benefits for each Covered Person will not exceed the maximums shown above.		
Orthodontia benefits do not apply to the Calendar Year Maximum Benefit. The Orthodontia Maximum Benefit applies to all periods a person is covered under the Plan (lifetime).		
Any services that would be covered under other benefit categories (see Preventive and Basic & Prosthodontic Services, etc., below) will instead be eligible for Accidental Injury Benefits when they are provided for conditions caused directly by external, violent and accidental means. Once the accident benefit is exhausted, additional benefits may be available up to the other benefit maximums shown. Coverage and frequency allowance are subject to the limitations and exclusions of each category.		
ELIGIBLE DENTAL EXPENSES	Covered Person Pays	Plan Pays
Accidental Injury Benefits	-0-	100%
Any dental services or supplies that would be covered under other benefit categories (see Preventive and Basic & Prosthodontic Services, etc. in the list of Eligible Dental Expenses) will instead be eligible for Accidental Injury Benefits when they are provided for conditions caused directly by external, violent and accidental means and incurred within 180 days of the date of the accident. Once the accident benefit is exhausted, additional benefits may be available but coverage and frequency allowances are subject to the limitations and exclusions of each category. Accidental injury benefits will be paid in accordance with the negotiated CVDP fee schedule.		
Preventive & Basic Services – see NOTES on next page		
1 st Calendar Year of Coverage	30%	70%
2 nd Calendar Year of Coverage	20%	80%
3 rd Calendar Year of Coverage	10%	90%
4 th Calendar Year of Coverage & Thereafter	-0-	100%
Limits applicable to certain Preventive & Basic Services:		
<ul style="list-style-type: none"> - replacement of crowns, inlays, onlays and veneer restorations are limited to once per tooth per 5-year period, provided the existing restoration cannot be made serviceable; - replacement of an amalgam or resin composite on a tooth is limited to once per 2-year period. Coverage is limited to the cost of an amalgam filling on a molar tooth; - one prophylaxis (cleaning), debridement procedure or periodontal maintenance procedure and topical fluoride application (under age 18) is covered in a 6-month period; - therapeutic topical fluoride varnish treatment is covered once per 3-month period for assessed high caries risk patients without an age restriction; - sealants are limited to children under age 16 and includes any repair or replacement within a 3-year period. For adults, 		

DENTAL BENEFIT SUMMARY, continued

sealants are limited to caries-free first and second molars without a previous restoration;

- unless a special need is shown, a full-mouth X-ray series or a panoramic X-ray is limited to once per 5-year period;
- routine bitewing X-rays are limited to 1 set per 6-month period for Dependent children under age 18 and 1 set per 12-month period for adults age 18 and over upon demonstrated necessity.

NOTES: In a Covered Person's first year of coverage, 70% of Eligible Expenses will be paid. The percentage will increase by 10% in each year thereafter if the Covered Person visits the Dentist during the current Calendar Year. If the Covered Person does not visit the Dentist in a Calendar Year, the percentage payable remains at the level reached during the previous year.

If a Covered Person loses eligibility and then again becomes covered, benefits will restart at 70%.

If an Employee and his eligible Dependent transfer to another Member District that has the same dental program, his percentage share for dental services will remain the same, as long as there is no break (month(s) in which he is ineligible) in coverage during the transition.

Prosthodontic Services	50%	50%
Orthodontia	50%	50%

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES AND DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental treatment is needed (i.e., where the proposed course of treatment will cost more than \$300), the Plan Sponsor recommends that a pre-treatment estimate be obtained prior to the treatment being performed. Emergency treatments, oral evaluations (including prophylaxis or debridement and dental X-rays) will be considered part of the "extensive dental treatment" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending Dentist complete a statement listing the proposed dental treatment and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the Dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and Dentist an opportunity to consider alternate treatment options that may be equally satisfactory and less costly. Where alternative treatment options exist, the Plan will provide benefits for the least expensive, professionally acceptable treatment.

Most Dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimate.

If a pre-treatment estimate is not obtained prior to the treatment being performed, the Plan Sponsor reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTE: A PRE-TREATMENT ESTIMATE IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME THE SERVICES ARE ACTUALLY INCURRED.

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SAVING MONEY ON DENTAL BILLS

A Plan participant can keep his dental expenses down by:

- comparing the fees of different Dentists;

- using a CVDP Dentist;

- having his Dentist obtain predetermination from the Contract Administrator for any treatment over \$300 – see **Dental Pre-Treatment Estimate** above;

- visiting his Dentist regularly for checkups;

- following his Dentist's advice about regular brushing and flossing;

- not putting off treatment until there is a major problem; and

reviewing their treatment statement for error. The dental plan requires that an Employee pay a percentage share of dental costs, as reflected in the **Dental Benefit Summary**. Some Dentists advertise that they will accept dental benefit payments as "payment in full." Unless the Employee pays its percentage share of the dental charges, benefit fraud may exist which increases the total plan expenses. Plan participants can help to keep these dental benefits intact by avoiding such schemes.

ELIGIBLE DENTAL EXPENSES

ACCIDENTAL INJURY BENEFIT (see the **Dental Benefit Summary** for information)

PREVENTIVE & BASIC SERVICES: 70-100%

Biopsy / Tissue Exam - Biopsy and examination of oral tissue.

Consultation - Consultation and evaluation by a Dentist upon referral by the patient's attending Dentist.

Crowns / Inlays / Onlays / Veneers - Initial placement of a metal, porcelain or resin composite indirect restoration on a tooth with extensive and/or significant caries and where the tooth cannot be satisfactorily restored with a resin composite or an amalgam restoration. See the **Dental Benefit Summary** for limits that apply to these restorations.

Replacement of a crown, inlay, onlay or veneer, if the existing restoration is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on veneer or facing restorations. Crowns placed for periodontal splinting are not covered.

Diagnostic Casts - Diagnostic casts, limited to once, per case, in conjunction with orthodontic treatment.

Endodontia - Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Evaluations / Examinations - One (1) comprehensive evaluation/examination per Dentist/dental office per lifetime, unless there are significant changes in the patient's medical or dental status, or three or more years have elapsed since the last dental treatment.

Periodic evaluations are limited to two (2) every 12 months, which includes all evaluations, specialist consultations, and office visits for observation within the frequency limits.

Extractions - see "Oral Surgery"

Fillings, Non-Precious - Amalgam, synthetic, plastic or resin restorations, including pins to retain a filling restoration when necessary.

Resin composite and amalgam restorations, including pins necessary for retention on a molar tooth.

Fluoride - Topical application of stannous or sodium fluoride for persons under age 18. See the **Dental Benefit Summary** for limits that apply to procedures that involve a prophylaxis, debridement or periodontal maintenance procedure.

One therapeutic topical fluoride varnish treatment, per 3-month period, for a patient of any age for assessed high caries risk.

Oral Surgery - Extraction of teeth, including simple extractions and surgical extraction, and removal of impacted teeth.

Deep sedation/general anesthesia or intravenous conscious sedation/analgesia, when given as part of a covered oral surgery procedure and determined to be medically necessary.

Palliatives - Emergency treatment for the relief of dental pain.

Pathology - Diagnostic laboratory services performed to assist in the diagnosis of oral disease.

ELIGIBLE DENTAL EXPENSES, continued

Periodontia - Surgical and non-surgical treatment of teeth and their supporting structures. See the **Dental Benefit Summary** for limits that apply to periodontal maintenance and debridement procedures..

Prophylaxis - see the **Dental Benefit Summary** for frequency limits.

Sealants - Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars which are free of decay or prior restoration. See the **Dental Benefit Summary** for limits that apply to sealants.

Space Maintainers - A fixed or removable appliance to retain the space left by a prematurely lost primary or "baby" tooth, preventing the movement of adjacent teeth in persons under the age of 16. Coverage is limited to one appliance per 36-month benefit period.

X-rays - Routine dental X-rays for diagnostic purposes, including "full mouth" X-rays or a panoramic X-ray, and bitewing X-rays. See the **Dental Benefit Summary** for frequency limits that apply to dental X-rays.

PROSTHODONTIC SERVICES: 50%

Prosthetics - Initial placement of a full or partial denture, or a fixed bridge, replacing a functioning tooth or teeth extracted while the individual is a covered person. The allowance for the prosthetic includes necessary adjustments within the six (6) months following installation. Extraction of third molars is not covered.

Replacement of, or addition of teeth to, an existing full or partial removable denture or bridgework or fixed bridge, but only if the existing denture or bridge is at least five (5) years old and cannot be made serviceable, unless it is determined that there has been such an extensive loss of remaining teeth or change in the supporting tissues that the existing appliance cannot be made satisfactory.

NOTE: If an implant is done in conjunction with a covered prosthodontic appliance (e.g., to support a denture or fixed bridge), the Plan will provide benefits for the appliance that would have been placed without the implant involvement. No benefits will be provided for the implant procedure and implant-related procedures.

Relining / Rebasing / Repairs, Etc. - see the **Dental Limitations and Exclusions**

ORTHODONTIA: 50%

Services or supplies for the correction of bite or malocclusion or for the alignment or repositioning of teeth, including:

initial consultation, models, and other diagnostic services;

initial banding or placement of orthodontic appliance(s);

periodic adjustments; and

retainers.

If a program of orthodontic treatment is begun before a Covered Person's effective date of coverage, the Plan's payments will begin with the first payment due to the Dentist following the individual's effective date.

Orthodontia benefits will stop when the first payment is due to the Dentist following either a person's termination of coverage or if treatment is ended for any reason before it is completed.

NOTE: X-rays and extractions that may be necessary for orthodontic treatment are not covered by orthodontic benefits, but may be eligible for benefits under the coverage category for "Preventive & Basic Services."

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Analgesia & Non-conscious Sedation

Appliances - Items intended for sport or home use, such as athletic mouthguards or habit-breaking appliances.

Congenital or Developmental Conditions - Treatment related to conditions which are the result of hereditary or developmental defects, including, but not limited to: cleft palate, jaw malformations, congenitally missing teeth and teeth that are discolored or malformed.

Cosmetic Dentistry - Treatment provided for cosmetic purposes, except when necessitated by an Accidental Injury.

Porcelain molar or maxillary second and third molar crowns.

Crowns placed for periodontal splinting.

Customized Prosthetics - Precision or semi-precision attachments, stress breakers, personalization or customized prosthetics.

Overdentures are considered to be customized but an alternate benefit (e.g., the benefit available for either a full or partial denture) may be available to defray the costs of the overdenture.

Excess & Unnecessary Care - Duplicate prosthetic devices or appliances.

Services which are not recommended by a Physician or Dentist or which are determined to be not medically or dentally necessary.

Experimental Procedures - Services which are considered experimental or which are not approved by the American Dental Association.

Grafting – Grafting tissues from outside the mouth to tissues inside the mouth.

Hospital Expenses – Charges made by any hospital or other surgical or treatment facility, including additional fees charged by the Dentist for treatment in any such facility.

Implants – Implant placement, the removal of implants, and including any procedure or treatment related to the placement or removal of an implant.

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.

Medical / Dental Necessity - Treatments or procedures which are not recommended by a Dentist or Physician (practicing with the scope of their license) or which are deemed to not be dentally or medically necessary.

Medical Expenses - Any dental services or treatment to the extent to which coverage is provided under any medical or other coverages offered by the Plan Sponsor.

Myofunctional Therapy

Non-Professional Care - Services rendered by someone other than:

a Dentist (D.D.S. or D.M.D.);

a dental hygienist, X-ray technician or other qualified technician or assistant who is under the supervision of a Dentist; or

a Physician furnishing dental services for which he is licensed.

DENTAL LIMITATIONS AND EXCLUSIONS, continued

Occlusal Restoration - Procedures, appliances or restorations that are performed to:

restore tooth structure that has been lost due to abrasion, erosion, or abfraction;

rebuild or maintain chewing surfaces that have been damaged because tooth structure was lost due to teeth being out of alignment or occlusion;

stabilize teeth (e.g., periodontal splinting);

improve occlusion (e.g., equilibration).

Oral Hygiene Counseling, Etc. - Education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene instruction, plaque control, or tobacco cessation. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, floss, oral irrigation devices, and mouthrinses.

Orthognathic Surgery

Personalization or Characterization of Dentures

Prescription Medications - Prescription and non-prescription medications obtained in or outside of a dental office. This includes, but is not limited to, injections, analgesia, and non-intravenous conscious sedation and includes the use or intraoral antibiotics placed around teeth.

Prior to Effective Date / After Termination Date - Any single procedure, bridge, denture or other prosthodontic service that is started before a person is covered under these dental benefits. A "single procedure" is a dental procedure that has been assigned a separate procedure number. For example, a 3-surface amalgam restoration on a permanent tooth (procedure #2160) or a complete upper denture, including adjustments for a six-month period following installation (procedure #5110).

Any single procedure that is started after a person's coverage terminates.

Splinting - Appliances and restorations for splinting teeth.

TMJ / Jaw Joint Treatment - Any diagnostic procedure, treatment, device appliance, splint, occlusal guard, or occlusal adjustment related to Temporomandibular Joint Dysfunction (TMJ) syndrome.

- (See also *General Exclusions* section) -

VISION BENEFIT SUMMARY

VISION BENEFITS ARE ADMINISTERED BY VISION SERVICE PLAN AND IN ACCORDANCE WITH A CONTRACT BETWEEN VSP AND THE PLAN SPONSOR. THIS IS ONLY A SUMMARY OF THE BENEFITS. ANY QUESTIONS ABOUT THE VISION COVERAGE SHOULD BE DIRECTED TO VISION SERVICE PLAN AT (800) 877-7195.

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with Vision Service Plan (VSP) - an organization or "Network" of vision care providers. When obtaining vision care services, a Covered Person has a choice of using a VSP Network provider or a non-Network provider. A VSP Network doctor can be located on vsp.com or by calling 1-800-877-7195.

Because VSP Network providers have agreed to provide services to Covered Persons at negotiated rates, when a Covered Person uses a VSP Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of the maximum fee allowance. The "maximum fee allowance" is the contracted VSP fee.

SCHEDULE OF VISION BENEFITS - A

With regard to the benefits shown below (i.e., "VSP Network" and "Non-Network"), a Co-Pay is an amount the Covered Person pays. Other dollar amounts shown are the maximum benefits the plan will pay (e.g., benefits for single vision lenses for glasses is \$30 if a Non-Network provider is used).

ELIGIBLE VISION EXPENSES	VSP Network	Non-Network
Vision Exam, routine Primary EyeCare Routine Vision Exams are limited to 1 examination per 12-month period. Primary EyeCare is for diagnosis and treatment of eye conditions like pink eye, loss of vision, and monitoring of cataracts, glaucoma and diabetic retinopathy.	\$10 Co-Pay, then 100% \$20 Co-Pay	\$10 Co-Pay, then 100% to \$45 N/A
Prescription Lenses for Glasses, per pair: Single Vision Lined Bifocal Lined Trifocal Limited to 1 pair of lenses per 24-month period.	100% 100% 100%	100% to \$30 100% to \$50 100% to \$65
Contacts (in lieu of glasses, including disposable contacts), up to The contact lens benefit renews every 24-month period. The allowance includes the cost of contacts and the contact lens exam (fitting and evaluation). This exam is in addition to the eye exam to ensure proper fit of contacts. See NOTE below.	100% to \$130	100% to \$105
Frames, per pair up to Limited to 1 frame per 24-month period. See NOTE below.	100% to \$130	100% to \$70

SCHEDULE OF VISION BENEFITS - B

With regard to the benefits shown below (i.e., “VSP Network” and “Non-Network”), a Co-Pay is an amount the Covered Person pays. Other dollar amounts shown are the maximum benefits the plan will pay (e.g., benefits for single vision lenses for glasses is \$30 if a Non-Network provider is used).

ELIGIBLE VISION EXPENSES	VSP Network	Non-Network
<p>Vision Exam, routine</p> <p>Primary EyeCare</p> <p>Routine Vision Exams are limited to 1 examination per 12-month period.</p> <p>Primary EyeCare is for diagnosis and treatment of eye conditions like pink eye, loss of vision, and monitoring of cataracts, glaucoma and diabetic retinopathy.</p>	<p>\$10 Co-Pay, then 100%</p> <p>\$20 Co-Pay</p>	<p>\$10 Co-Pay, then 100% to \$45</p> <p>N/A</p>
<p>Prescription Lenses for Glasses, per pair:</p> <p>Single Vision</p> <p>Lined Bifocal</p> <p>Lined Trifocal</p> <p>Limited to 1 pair of lenses per 12-month period.</p>	<p>100%</p> <p>100%</p> <p>100%</p>	<p>100% to \$30</p> <p>100% to \$50</p> <p>100% to \$65</p>
<p>Contacts (in lieu of glasses, including disposable contacts), up to</p> <p>The contact lens benefit renews every 12-month period. The allowance includes the cost of contacts and the contact lens exam (fitting and evaluation). This exam is in addition to the eye exam to ensure proper fit of contacts. See NOTE below.</p>	<p>100% to \$130</p>	<p>100% to \$105</p>
<p>Frames, per pair up to</p> <p>Limited to 1 frame per 24-month period. See NOTE below.</p>	<p>100% to \$130</p>	<p>100% to \$70</p>

GENERAL EXCLUSIONS

No benefits will be payable under the Plan for:

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Late-Filed Claims - Claims which are not filed within any required time periods.

Work-Related Conditions - Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees

Unless otherwise agreed in writing between the Plan and a District, in order for an Employee to be eligible to participate in the Plan, he must be in full-time active employment for the Employer as defined by the District and entitled to receive dental and vision benefits under the Plan. Certain retirees may also be eligible to participate in the Plan in accordance with District guidelines and pursuant to a written agreement.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees

The Employee coverages of the Plan may be provided on a contributory or non-contributory basis (that is, the Employee may or may not share in the cost of coverage). Subject to completion of the necessary enrollment forms, an eligible Employee's coverage is effective upon completion of the probationary or waiting period requirement established by the District.

WARNING: NO EMPLOYEE MAY DECLINE COVERAGE OR FAIL TO ENROLL HIMSELF OR ELIGIBLE DEPENDENTS UNLESS HE COMPLETES AND SIGNS THE "WAIVER NOTICE" FORM PROVIDED BY THE EMPLOYER OR PLAN SPONSOR.

Eligibility Requirements - Dependents

Except as noted at the end of this provision, an eligible Dependent of an Employee is:

a legally married spouse. A "spouse" will mean a person of the opposite sex (i.e., not the same sex as the Employee). "Legally married" means a legal union (as defined by the Employee's state of residence) between one man and one woman as husband and wife;

a domestic partner, subject to the following criteria:

- the Employee and domestic partner have filed a declaration of Domestic Partnership with the Secretary of State of the State of California;
- the Employee and domestic partner must have a common residence. It is not necessary that the legal right to possess the residence be in both names;
- neither the Employee nor domestic partner may be married to someone else or be a member of another domestic partnership that has not been terminated, dissolved or annulled;
- the Employee and domestic partner must not be related by blood in any way that would prevent them from being married to each other in California;
- both the Employee and domestic partner must be at least 18 years of age;
- both the Employee and domestic partner must be capable of consenting to the domestic partnership; and
- either of the following must be true: (1) the Employee and domestic partner must be of the same sex, or (2) the domestic partner must be of the opposite sex and one or both persons must be over age 62 and also meet the eligibility criteria for Medicare benefits.

ELIGIBILITY AND EFFECTIVE DATES, continued

an unmarried child under age 19 who is primarily dependent on the Employee for support. For these purposes a "child" will include:

- a natural child;
- a stepchild;
- a child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends;
- notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law. A child whose coverage is subject to a court order need not be a Tax Code dependent of an Employee;

an unmarried student age 19 or over but less than 25, if such child meets the above Dependent child eligibility requirements except for age, and is in full-time school attendance (as defined by the school) at a qualified educational institution, and is a dependent of the Employee within the meaning of the Internal Revenue Codes and Regulations.

As used herein, the term "qualified educational institution" will mean high schools, junior colleges or other two-year colleges granting two-year degrees; universities or colleges granting four-year degrees or post-graduate degrees; proprietary schools such as business colleges, professional schools, and trade and technical schools - that are established as other than evening schools exclusively.

Cessation of full-time school attendance will terminate Dependent status with respect to the student EXCEPT that: (1) if cessation is due to school vacation, Dependent status will terminate on the date the school reconvenes if attendance does not resume, or (2) if cessation is due to disability which prevents full-time school attendance, Dependent status will terminate on the first day of the school's next regular session which follows the date established by a Physician's written statement to the Contract Administrator that the student is capable of full-time school attendance if attendance does not resume.

NOTES: An eligible Dependent does not include:

a spouse following legal separation or a final decree of dissolution of marriage or divorce;

any person who is on active duty in a military service, to the extent permitted by law.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents

The Dependent coverages of the Plan may be provided on a contributory or non-contributory basis. A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date (see the "Special Enrollment Rights" provision for details as well as instances when the loss of other coverage can allow a Dependent to be enrolled). Otherwise, a Dependent can be enrolled only in accordance with the "Open Enrollment" provision.

NOTE: A Dependent's coverage will not become effective prior to the Employee's effective date. Also, see "Newborn Children..." below for special provisions pertaining to newborns.

Special Enrollment Rights

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage under the Plan at a later date if:

he was covered under another group health plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event such as, but not limited to, the following:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted; and

the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

ELIGIBILITY AND EFFECTIVE DATES, continued

where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the date of marriage;

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 31 days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with other enrollment provisions of the Plan.

Court or Agency Ordered Coverage – In accordance with state and federal law, if the Plan receives a Medical Child Support Order (MCSO) from a state court or agency and such order is determined by the Plan to be a qualified order (QMCSO), the child shall be enrolled as of the earliest possible date following such determination.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Change in Status, Cost or Coverage – An Employee will be permitted to make Plan election changes when such changes are consistent with and made concurrently with changes allowed under the Plan Sponsor's Section 125 cafeteria plan due to a qualified change as permitted under Federal law. The effective date of the Plan changes will be concurrent with the effective date of the cafeteria plan changes, unless an earlier effective date would be allowed under the terms of one of the other subsections of this "Special Enrollment Rights" provision.

Open Enrollment

If an individual does not enroll when he is first eligible or if he allows coverage to lapse, he can enroll for dental and vision benefits later during Open Enrollment and coverage will be effective on the following October 1st.

NOTE: See "Special Enrollment Rights" for mid-year enrollment allowances.

Reinstatement / Rehire

If an Employee returns to active employment and eligible status immediately following an approved leave of absence taken in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA) and during the leave Employee discontinues paying his share of the cost of coverage, then the Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before his family or medical leave expires and the Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. See "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Dual Coverage

When a husband and wife are both enrolled for coverage as Employees under this Plan, each has the option to enroll eligible Dependents for coverage hereunder. The combined maximum contractual benefits to which both Employees are entitled hereunder will not exceed the aggregate of 100 percent of the Usual, Customary and Reasonable charge(s) for the Eligible Expense(s).

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

TERMINATION OF COVERAGE

Employee Coverage Termination

Except as noted, an Employee's coverage will terminate upon the earliest of the following:

termination of the Plan or Plan benefits as described herein;

termination of participation by the Employee;

the date the Employee becomes a full-time member of the armed forces of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year. For active duty in the military services of the United States such date will be the date of active duty on his/her "activation Orders." However, if the U.S. active duty call-up is for less than 30 days and is then extended, Plan coverage will continue until 12:00 midnight on the 30th day of active duty;

at the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section.

NOTES: Unused vacation days or severance pay following cessation of active work will not count as extending the period of time coverage will remain in effect.

An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.

Dependent Coverage Termination

Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

termination of the Plan or these Plan benefits or discontinuance of Dependent coverage under the Plan;

the date the Dependent becomes a full-time member of the armed forces of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;

at midnight on the last day of the month in which the Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

on the date the Employee requests that Dependent coverage be terminated or at the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.

TERMINATION OF COVERAGE, continued

NOTES: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.

- (See *COBRA Continuation Coverage*) -

EXTENSION OF COVERAGE PROVISIONS

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Handicapped Dependent Children

If an already covered Dependent child attains age 19, which would otherwise terminate his status as a "Dependent", and:

if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan; and

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap or disability which commenced prior to the attainment of such age; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained 19 and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit to the Contract Administrator proof of the child's incapacity within thirty-one (31) days of the child's attainment of such age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extensions of Coverage During Absence From Work

If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., he is absent due to an approved leave or a temporary layoff), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

on the date coverage terminates as specified in the Employer's personnel policies or other Employer communications, if any. Such documents are incorporated into the Plan by reference;

while Employee is absent from work during a temporary leave of absence granted by the member school District from which the Employee is employed;

twelve (12) consecutive months during an approved sabbatical leave of absence;

while Employee is on an non-FMLA employer-approved leave of absence for illness, employment will be deemed to continue provided such Employee's inability to return to work is certified annually by the District;

the end of the period for which the last contribution was paid, if such contribution is required;

the date of termination of this Plan.

NOTE: To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

EXTENSIONS OF COVERAGE, continued

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Continued coverage under the FMLA is allowed during up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child;
- the placement of a child with the Employee for adoption or foster care;
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition; or
- Employee's own serious health condition that makes him unable to perform the functions of his or her job.

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

Extension of Coverage During Labor Dispute

If an Employee fails to continue in active employment due to a labor dispute (e.g., a strike), Employee can arrange to continue coverage for up to six (6) months. This extension will cease, however, on the earlier of the following:

- at the beginning of the period for which Employee fails to make the required payment toward the cost of coverage to his collective bargaining unit representative;
- at the beginning of the period for which the representative fails to make the required cost of coverage payments to the Plan Sponsor or Contract Administrator;
- on the date Employee commences active employment with another employer;
- on any contribution due date when less than 75% of the affected Employees have elected to continue coverage under the terms of this provision;
- at the end of six (6) months following the cessation of active employment.

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

EXTENSIONS OF COVERAGE, continued

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage is the lesser of:

18 months (or 24 months for elections made on or after December 10, 2004); or

the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

Extension of Coverage for Certain Retirees

A Participating Employer District may offer extended coverage options for eligible retirees. The availability and terms and conditions of such extensions are as determined by each District or applicable law, including California Assembly Bill # 528 (AB528). A retiring Employee should contact his District offices for additional information.

Extension of Coverage for Disabled Certificated Employees

If a certificated Employee becomes disabled as result of injuries that are a direct consequence of a violent act and if the Employee receives disability benefits from CalSTRS, a Participating Employer District will offer the disabled Employee the opportunity to enroll in the Plan's medical benefits. The District may require the Employee to pay the full cost of such coverage. An Employee should contact his District offices for additional information.

- (See *COBRA Continuation Coverage*) -

CLAIMS PROCEDURES

VISION CLAIMS

Vision claims are handled directly by Vision Service Plan. Any inquiries regarding a vision claim should be directed to **Vision Service Plan at 1-800-877-7195**. This number is to be used for Network and non-Network claim inquiries.

DENTAL CLAIMS

CVDP Network Claims

CVDP dental providers will submit their bills directly to the Contract Administrator and the Contract Administrator will pay CVDP Dentists directly. The Contract Administrator's agreement with CVDP Dentists makes sure that a Plan participant will not be responsible to the Dentist for any expenses that are the Plan's responsibility.

NOTE: The Contract Administrator may deny payment of a CVDP claim if the claim is submitted more than six (6) months after the date services were provided. If a claim is denied due to a CVDP Dentist's failure to make a timely submission, the Plan participant is not liable to the Dentist for the amount that would have been payable, unless the Employee failed to advise the Dentist of his or his Dependent's eligibility at the time of treatment.

Non-Network Claims

If a Covered Person uses a non-Network provider, written proof of the dental claim must be furnished to the Contract Administrator within six (6) months after the date expenses are incurred. The claim should be sent to:

Administrative Solutions, Inc.
P.O. Box 5809
Fresno, CA 93755

If a Covered Person uses the services of a non-Network (non-CVDP) Dentist, Plan benefits will be paid directly to the Employee unless otherwise requested on the claim form. However, the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

If for any reason the Contract Administrator fails to pay a Dentist who is not a CVDP Dentist, the Plan participant may be liable for that portion of the cost.

Medicaid Reimbursement Rights

Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS QUESTIONS, ADJUDICATION, APPEALS & ARBITRATION

CVDP Questions

If a Plan participant has questions about the services he receives from a CVDP Dentist, it is recommended that he first discuss the matter with the Dentist. If he continues to have concerns, he can call the Contract Administrator's Quality Review department at (559) 256-1320. If appropriate, CVDP can arrange for the person to be examined by one of their consulting Dentists in the Plan participant's area of residence. If the consultant recommends that the treatment be replaced or corrected, CVDP will intervene with the original Dentist to either have the services replaced or corrected at no additional cost or to obtain a refund. In the latter case, the Plan participant is free to choose another Dentist to receive his full benefit.

Claims Denials and Appeal Procedures

The Contract Administrator will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for denial. If a Plan participant has a question or complaint regarding eligibility, denial of dental services or claims, the policies, procedures and operation of CVDP, or the quality of dental services performed by a CVDP Dentist, he may contact the Contract Administrator at the phone number shown above.

A Plan participant has sixty (60) days after he receives notice of a denial to file an appeal. If the appeal is made in writing, it must include the name of the patient, the name of the Plan Sponsor, the Employee's name and social security number or identification number and the Employee's telephone number. The appeal should also include a copy of the treatment form, notice of payment or denial, and any other relevant information. The complaint should be clearly explained and sent to:

**Administrative Solutions, Inc.
P.O. Box 5809
Fresno, CA 93755**

The Contract Administrator will review the complaint and will response within thirty (30) day unless more information or time is needed to resolve the matter. Additional time may be needed if the complaint is referred to a dental consultant or to a peer review committee of the local dental society. If a referral is necessary, a notice will be sent to the Claimant within 120 days after the complaint is received. However, a response will be made within five (5) days of receipt of a complain that involves imminent and serious threat to a patient's health.

If a Plan participant has completed the grievance process or if he has been involved in the grievance process for sixty (60) days, he may file a complaint with the Department of Corporations if the grievance has not been satisfactorily resolved.

A Plan participant may immediately file a complaint with the Department in an emergency situation.

The California Department of Corporations is responsible for regulating health care service plans. The Department has a toll-free number (1-800-400-0815) to receive complaints regarding health plans.

If a Plan participant has a grievance against the Plan, he should contact the Plan and use the Plan's grievance process. If he needs the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved, he may call the Department's toll-free telephone number.

Disputes relating to the Plan, including claims denials, may be settled by arbitration if they cannot be settled by this complaint process. Arbitration will follow the Commercial Rules of the American Arbitration Association. A Plan participant can begin the process by giving written notice to each party (e.g., CVDP and his Dentist) with whom he wants to arbitrate, explaining the dispute and the amount involved, if any, and his desired solution. He must then file two (2) copies of the notice with the Association's regional office in Los Angeles, or San Francisco, along with the fee required by the Association.

DEFINITIONS

When capitalized within, the following items will have the meanings shown below.

Benefit Document – A document that describes one (1) or more benefits of the Plan.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1.

Claimant - Any Covered Person for whom a claim is submitted for benefits under the Plan.

Contract Administrator - A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

Covered Person - A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** and **Continuation of Coverage Option (COBRA)** sections for further information.

Dependent - see **Eligibility and Effective Dates** section

Eligible Expense(s) - Expense which is (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Benefit Document.

Employee - see **Eligibility and Effective Dates** section

Employers - School Districts who are participating in the Plan

Fiduciary - A Fiduciary of the Plan has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Usual, Customary and Reasonable - A charge made by a provider which does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of dental or vision conditions comparable in severity and nature to the dental or vision condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

NOTE: With regard to charges made by a provider of service participating in a Network, Usual, Customary and Reasonable will mean the provider's negotiated rate.

GENERAL PLAN INFORMATION

Name of Plan:	The EdCare Group Health Benefits Plan
Plan Sponsor / Plan Administrator:	Fresno Area Self-Insurance Benefits Organization Joint Powers Agreement, dba: The EdCare Group
Participating Employer(s):	School Districts who are participating in the Plan
Plan Year:	October 1 through September 30
Privacy Officer / Contact Person: Phone Number:	Fowler USD Benefit Specialist (559) 834-2591
Plan Benefits Described Herein:	Self-Funded Dental and Vision Benefits
Type of Administration:	Contract Administration – see “Administrative Provisions” for additional information

FUNDING - SOURCES AND USES

Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Sponsor will, annually, evaluate the costs of the Plan and determine the amount to be contributed (if any) by each enrollee (i.e., Employee, retiree, Dependent, COBRA enrollee)

ADMINISTRATIVE PROVISIONS

Administration (type of)

The Plan benefits described herein are administered by one or more Contract Administrators under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator(s). A Contract Administrator is not an insurance company.

Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

reduce, modify or terminate retiree health care benefits under the Plan, if any;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Discrepancies

In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan.

However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

Misstatement / Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Physical Examination

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority

The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards & Intent to Comply

To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Termination for Fraud

An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Type of Plan

This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for eligible Employees of the Employer(s), their eligible Dependents, and Qualified Beneficiaries under COBRA.

This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan which, for the most part, is exempt from the requirements the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers

GENERAL PLAN INFORMATION, continued

Health Protection Act (NMHPA), and the Womens Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

This Plan is subject to the terms of collective bargaining agreement(s). A complete list of the bargaining units participating in the Plan may be obtained upon written request to the Plan Sponsor, and is available for examination by Covered Person and beneficiaries at the office of the Plan Sponsor. Covered Persons and beneficiaries may receive from the Plan Sponsor, upon written request, information as to whether a particular employee organization is participating in the Plan and, if the organization is participating, the address of such entity.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of his Dependents has a Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

COBRA CONTINUATION COVERAGE, continued

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification Responsibilities – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

COBRA CONTINUATION COVERAGE, continued

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

COBRA CONTINUATION COVERAGE, continued

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

the cost previously charged was less than the maximum permitted by law;

the increase is due to a rate increase at Plan renewal;

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes his coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than \$50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

in the case of a bankruptcy Qualifying Event with regard to a retiree, the maximum coverage period is to the date of the retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary's death;

for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee's death.

COBRA CONTINUATION COVERAGE, *continued*

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

COBRA CONTINUATION COVERAGE, continued

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Nonelecting TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's preexisting condition exclusion provision.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

FOR ADDITIONAL ASSISTANCE BEYOND THAT WHICH IS ADMINISTRATIVELY AVAILABLE THROUGH YOUR DISTRICT OFFICE, YOU MAY CALL ON THE FOLLOWING:

BROKERAGE OFFICE

BARTHULI & ASSOCIATES
2307 N. FINE AVENUE
FRESNO, CA 93727-1516

PH: (559) 453-2400
FAX: (559) 453-2420



Broker Services Provided By:

Barthuli & Associates Insurance Services, Inc.

2307 North Fine Avenue

Fresno, California 93727-1516

(559) 453-2400 • Fax (559) 453-2420

www.barthuli.com