
**DENTAL PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**CHARLESTON COMMUNITY UNIT SCHOOL DISTRICT #1
EMPLOYEE BENEFITS PLAN**

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INTRODUCTION

This document is a description of Charleston Community Unit School District #1 Employee Benefits Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Covered Persons against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, exclusions, limitations, timeliness of COBRA elections, pre-authorizations, lack of medical necessity, lack of timely filing of Claims or lack of coverage. These provisions are explained in summary fashion in this document and additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service is incurred on the date the service is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Limitations and Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing Claims and the Claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Covered Persons' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Covered Person should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage on the date of hire the day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer for that work.
- (2) is in a class eligible for coverage.
- (3) Has been employed as an Active Employee during the Waiting Period.

Eligible Classes of Dependents. A "Dependent" is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried Children from birth to the limiting age of 26 years. When the Child reaches the limiting age, coverage will end on the end of the month in which the Child reaches the limiting age. If the Child does not maintain full-time status or graduates, coverage closes independent of limiting age.

Full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Child" or "Children" shall include each unmarried child, who is not eligible for health benefits through employment and who is less than twenty-six (26) years old including: the Employee's natural children; legally adopted children; children for whom the Employee is the legal guardian; children related to the Employee by blood or marriage; foster children who live with the Employee, in the Employee's household, in a regular parent-child relationship and are dependent on the Employee for support (as defined under Section 152 of the Internal Revenue Code and Federal Tax Regulations applicable to such section); children for whom the Employee has court-ordered legal custody; children for whom the Employee or the Employee's Spouse is required to provide health care coverage pursuant to a QMCSO and who are unmarried and dependent on the Employee or the Employee's Spouse for support and maintenance; and children for whom the Employee is the proposed adoptive parent who are residing with the Employee and dependent on the Employee for support and maintenance during the waiting period prior to the adoption becoming final. In the case of a foster child or any other child that is not the Employee's or the Employee's Spouse's natural child, a regular parent-child relationship does not exist if either of the child's natural parents also resides with the Employee or the Employee's Spouse.

A Covered Person under this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the Child must be dependent upon the covered Employee for over one-half of his support during the Plan Year. A special rule applies in the case of a Child of divorced parents, legally separated parents or parents who lived apart at all times of the year or during the last six months of the calendar year. The Child will be considered

dependent upon the Employee for over one-half of his support if the Child is in the custody of the Employee and/or the other parent for more than one-half of the year and the Child is dependent upon one and/or both parents for more than one-half of his support for the year. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent Child who reaches the limiting age and is totally disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's total disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their Children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Charleston Community Unit School District #1 shares the cost of Employee and Dependent coverage under the Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed, and returned with the enrollment application.

The level of Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

TIMELY ENROLLMENT

Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his Dependents (including his Spouse) because of other dental insurance or group dental plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the Employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the Employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Charleston Community Unit School District #1, 410 West Polk Street Charleston, IL 61920.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:
 - (a)** The Employee or Dependent was covered under a group dental plan or had dental insurance coverage at the time coverage under this Plan was previously offered to the individual. Special Enrollment will also be available to an Employee that declines coverage without having coverage under another plan and subsequently enroll in other coverage and loses that coverage. However, the Employee must have had an opportunity for initial enrollment or Special Enrollment under this Plan but again chose not to enroll.
 - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated.
 - (d)** The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (e)** For purposes of these rules, a loss of eligibility occurs if:
 - (i)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees).
 - (ii)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (iii)** The Employee or Dependent has a 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).

- (iv) The Employee or Dependent has a 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.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

- (a) The Employee is a Covered Person under this Plan (or has met the Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of loss of coverage, the date of the loss of prior coverage upon completion and return the enrollment/change form in a timely manner and payment of any required premiums for such new coverage;
- (c) in the case of a Dependent's birth, as of the date of birth; or
- (d) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Enrollment Pursuant to Termination of Medicaid or CHIP Coverage.

Subject to the conditions set forth below, an Employee who is eligible but not enrolled, or the Dependents of such eligible Employee, if eligible but not enrolled, may enroll in the Plan if either of the following two conditions are satisfied.

- (1) Termination of Medicaid or CHIP Coverage. The eligible Employee or Dependent may enroll if the eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.
- (2) Eligibility for Employment Assistance Under Medicaid or SCHIP. The eligible Employee or Dependent may enroll if the eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under the Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

An eligible Employee and/or his or her Dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the eligible Employee or Dependent is determined to be eligible for the premium assistance.

Coverage shall become effective on the first day of the month following the month in which the Plan received the request for special enrollment under this section.

ENROLLMENT OF DEPENDENT PURSUANT TO A QMCSO

If the Plan Administrator receives a QMCSO, as determined by the Plan Administrator, for an eligible Dependent, the effective date shall be the later of (a) the date of the QMCSO, or (b) thirty (30) days prior to the date the QMCSO was received by the Plan Administrator. If the Employee is not enrolled in the Plan, the Plan Administrator shall enroll the Employee as of the same effective date as the eligible Dependent and the Employee shall be responsible for any required Employee contributions.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The date the covered Employee's eligible class is eliminated.
- (3) The end of the month in which the covered Employee ceases to be in one of the eligible classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (5) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect or may immediately terminate coverage.
- (6) If an Employee misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Employee and covered Dependents upon thirty-one (31) days written notice from the Plan.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: 6 months after the date on which the person becomes disabled.

For leave of absence or layoff only: 6 months after the date on which the person was laid off or began his leave of absence.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, pre-existing conditions limitations or exclusions and the Waiting Period will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy the Waiting Period or any pre-existing condition limitation or exclusion.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the

following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or the Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or the Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of Dependent status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) At the end of the month in which a Dependent Child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may either void coverage for the Dependent for the period of time coverage was in effect or may immediately terminate coverage.
- (7) If a Dependent misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Dependent upon thirty-one (31) days written notice from the Plan.

If a Covered Person's coverage is terminated as described above, coverage for completion of a dental procedure (except for Orthodontia Services) requiring two or more visits on separate days will be extended for at least 90 days after the Covered Person's termination date in order for the procedure to be finished. The procedure must be started prior to the Covered Person's termination date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed.

SCHEDULE OF BENEFITS

Out of Network Benefits

Usual and Customary Rate at 90thile of Ingenix

Annual Deductible

For each Covered Person – \$50.00 In and Out-of-Network. The maximum Annual Deductible per family is three (3) times the individual Deductible.

Annual Maximum

The total amount of benefits that will be paid in a Calendar Year is \$1,500 per Covered Person for In and Out-of-Network. Benefits for Orthodontia do not count to the Annual Maximum.

ORTHODONTIC BENEFIT

Orthodontic Maximum

The total amount of benefits that will be paid over the total course of a lifetime is \$1,000 per Dependent Child under age 19 on the date orthodontic treatment begins.

Orthodontia Services

If covered, the Plan will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under the Plan. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured unless the person was receiving benefits under the prior plan. Benefits will be offset by any amounts already paid under the prior plan. The Plan considers orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

The Plan will pay the Coverage percentage shown in the Schedule of Benefits after any required deductible for orthodontic services has been satisfied. The maximum benefit payable to each Covered Person for orthodontic services is shown in the Schedule of Benefits. Those Covered Persons who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

Exclusions and Limitations

Coverage for services and supplies is not provided for any of the following:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery (subrogate with medical insurance);
- Miofunctional therapy (TMJ);
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;

Payment of Benefits

Benefits will be pro-rated and paid out over a twenty-four (24) month period.

Provider services started after the Covered Person's coverage terminates are not covered. Covered benefits in accordance with the Summary Plan Document in effect at the time coverage terminates will continue for 60 days if the orthodontist is receiving monthly payments or until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist is receiving payments on a quarterly basis. All other provisions of the Summary Plan Document apply to the Orthodontic benefit.

BENEFIT DESCRIPTION	In-Network Coverage Percentage	Out of Network Benefit	Waiting period
Diagnostic I			
Periodic Oral Evaluation	100%	100%	0
Limited Oral Evaluation-Problem Focused	100%	100%	0
Oral evaluation-Pt. under 3 yrs. old & counseling w/primary caregiver	100%	100%	0
Comprehensive Oral Evaluation	100%	100%	0
Detailed Extensive Oral Evaluation-Problem Focused-By Report	100%	100%	0
Comprehensive Periodontal Eval - New/Exist Pt	100%	100%	0
Intraoral-Complete Series Including Bitewings	100%	100%	0
Intraoral-Periapicals	100%	100%	0
Bitewings	100%	100%	0
Vertical Bitewings-7 to 8 Films	100%	100%	0
Panoramic Film	100%	100%	0
Diagnostic II			
Intraoral-Occlusal Film	80%	80%	0
Extraoral Films	80%	80%	0
Pat/Lat Skull & Facial Bone Survey Film	80%	80%	0
Cephalometric Film	80%	80%	0
Oral/Facial Images	80%	80%	0
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities	80%	80%	0
Pulp Vitality Tests	80%	80%	0
Diagnostic Casts	80%	80%	0
Preventive			
Prophylaxis	100%	100%	0
Topical Application of Fluoride Not Including Prophylaxis-Child	100%	100%	0
Sealant-Per Tooth	100%	100%	0

Space Maintainer	100%	100%	0
Restorative I			
Amalgam Restorations	80%	80%	0
Resin Restorations (Anterior)	80%	80%	0
Composite Resin Restorations (Posterior)	80%	80%	0
Inlays & Onlays			
Inlay-Metallic	50%	50%	0
Onlay-Metallic	50%	50%	0
Inlay-Porcelain/Ceramic	50%	50%	0
Onlay-Porcelain/Ceramic	50%	50%	0
Inlay-Composite/Resin	50%	50%	0
Onlay-Composite/Resin	50%	50%	0
Restorative II			
Crown-Resin	50%	50%	0
Crown-Porcelain	50%	50%	0
Crown-3/4 Cast	50%	50%	0
Crown-Full Cast	50%	50%	0
Crown-Titanium	50%	50%	0
Recement Inlay	50%	50%	0
Recement Crown	50%	50%	0
Prefabricated Stainless Steel Crown	50%	50%	0
Sedative Filling	50%	50%	0
Core Build-Up, Including Any Pins	50%	50%	0
Pin Retention/Tooth, In Addition to Restoration	50%	50%	0
Post and Core In Addition to Crown	50%	50%	0
Endodontics			
Pulp Cap (Excluding Final Restoration)	80%	80%	0
Therapeutic Pulpotomy (Excluding Final Restoration)	80%	80%	0

Gross Pulpal Debridement	80%	80%	0
Pulpal Therapy	80%	80%	0
Root Canal-Anterior (Excluding Final Restoration)	80%	80%	0
Treatment of Root Canal Obstruction-Non-Surgical Access	80%	80%	0
Incomplete Endodontic Therapy-Inoperable or Fractured Tooth	80%	80%	0
Internal Root Repair of Perforation Defects	80%	80%	0
Retreatment Previous Root Canal Therapy-Anterior **	80%	80%	0
Apexification/Recalcification	50%	50%	0
Apicoectomy/Periradicular Surgery	50%	50%	0
Retrograde Filling-Per Root	50%	50%	0
Root Amputation-Per Root	50%	50%	0
Hemisection-Including Root Removal, Not Including Root Canal	50%	50%	0
Periodontics			
Gingivectomy or Gingivoplasty	80%	80%	0
Gingival Flap Proc	80%	80%	0
Apically Positioned Flap	80%	80%	0
Clinical Crown Lengthening-Hard Tissue	80%	80%	0
Osseous Surgery (Including Flap Entry and Closure)	80%	80%	0
Bone Replacement Graft	50%	50%	0
Guided Tissue Regeneration-Resorbable Barrier per Site	50%	50%	0
Pedicle Soft Tissue Graft Procedure	50%	50%	0
Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	50%	50%	0
Subepithelial Connective Tissue Graft Procedures	50%	50%	0
Periodontal Scaling and Root Planing	80%	80%	0
Full Mouth Debridement to Enable Periodontal Evaluation and Diagnosis	80%	80%	0
Periodontal Maintenance Procedures Following Active Therapy	80%	80%	0
Prosthodontics (removable)			
Complete Denture	50%	50%	0

Immediate Denture	50%	50%	0
Partial Denture-Resin Base (Clasp/Rests)	50%	50%	0
Partial Denture-Metal Frame with Resin Base	50%	50%	0
Removable Unilateral Partial Denture-One Piece Cast Metal	50%	50%	0
Adjust Complete and Partial Dentures	50%	50%	0
Repair Complete and Partial Dentures	50%	50%	0
Replace Missing or Broken Teeth-Complete Denture (Each Tooth)	50%	50%	0
Add Tooth to Existing Partial Denture	50%	50%	0
Add Clasp to Existing Partial Denture	50%	50%	0
Replace All Teeth & Acrylic - Cast Metal Frame	50%	50%	0
Rebase Complete and Partial Denture	50%	50%	0
Relines Partial and Complete Denture	50%	50%	0
Interim Complete Denture	50%	50%	0
Interim Partial Denture	50%	50%	0
Tissue Conditioning	50%	50%	0
Prosthodontics (fixed)			
Abutment supported porcelain/ceramic crown	50%	50%	0
Abutment supported porcelain fused to metal crown	50%	50%	0
Abutment supported cast metal crown	50%	50%	0
Abutment supported Crown Titanium	50%	50%	0
Implant supported porcelain/ceramic crown	50%	50%	0
Implant supported porcelain fused to metal crown	50%	50%	0
Implant supported metal crown	50%	50%	0
Pontic-Cast	50%	50%	0
Pontic-Porcelain	50%	50%	0
Pontic-Porcelain/Ceramic	50%	50%	0
Retainer-Fixed Prosthesis	50%	50%	0
Crown-Porcelain/Ceramic	50%	50%	0

Crown-Retainer-Porcelain	50%	50%	0
Crown-Retainer 3/4 Cast	50%	50%	0
Crown-Retainer-Full Cast	50%	50%	0
Recement Fixed Partial Denture	50%	50%	0
Post and Core/Addition to Bridge Retainer	50%	50%	0
Core Buildup for Retainer, Including Any Pins	50%	50%	0
Coping-Metal	50%	50%	0
Oral Surgery			
Simple Extraction	80%	80%	0
Surgical Removal of Erupted Tooth	80%	80%	0
Removal of Impacted Tooth-Soft Tissue	80%	80%	0
Surgical Removal of Residual Tooth Roots (Cutting Procedure)	50%	50%	0
Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons	50%	50%	0
Biopsy of Oral Tissue	50%	50%	0
Brush biopsy	50%	50%	0
Alveoloplasty	50%	50%	0
Incision and Drainage Abscess-Intraoral Soft Tissue	50%	50%	0
Frenulectomy (Frenectomy/Frenotomy) Separate Procedure	50%	50%	0
Frenuloplasty	50%	50%	0
Excision of Hyperplastic Tissue/Per Arch	50%	50%	0
Surgical reduction of fibrous tuberosity	50%	50%	0
Orthodontics			
Limited Ortho	50% LTM	50% LTM	0
Interceptive Ortho	50% LTM	50% LTM	0
Comprehensive Orthodontic Treatment	50% LTM	50% LTM	0
Adjunctive Services			
Palliative (Emergency) Treatment-Dental Pain-Minor Procedure	80%	80%	0
Local Anesthesia	80%	80%	0

Deep Sedation/General Anesthesia	80%	80%	0
IV Conscious Sedation/Analgesia	80%	80%	0
Consultation (by Other than Practitioner Providing Treatment)	80%	80%	0
Occlusal Adjustment	80%	80%	0

DENTAL BENEFITS

All benefits will be paid after the Covered Person satisfies the Waiting Period and an Annual Deductible up to an Annual Maximum. All benefits are subject to the Exclusions and Limitations set forth in this Summary Plan Document.

Benefit amounts will vary depending on whether the Covered Person obtains services from a Network Provider or from a Provider that is not part of the Network.

In-Network Benefits

Plan will pay a percentage of the charge by the Network Provider for each covered service, up to the actual charge. The percentage, by procedure classification, is set forth in the Schedule of Benefits. For example, if Plan pays 80% for a covered service, the Covered Person pays the remaining balance of 20% of the In-Network Provider's fee for that Covered Service.

The Covered Person is responsible for paying the remaining balance of the charge (only up to the Provider's negotiated fee) and may be required to remit payment at the time of service. Billing arrangements are between the Covered Person and the Provider.

Network Providers are set forth in the Plan's provider directory. Covered Persons should confirm continued participation of a provider in the Network before receiving services. The Network has both general dentists and specialists to provide services.

Out-of-Network Benefits Option

You may receive Covered Services from Non-Participating Providers. If You seek services from a Non-Participating Provider, You are responsible for ensuring that the Non-Participating Provider complies with the Plan's Utilization Management Policies. You must in certain situations receive Pre-authorization from the Plan prior to receiving a Covered Service (check Your Schedule of Benefits or call the Member Service Department to determine when Covered Services require Pre-authorization). Under the Out-of-Network option, the Covered Services may be delivered in or out of the Plan's service area.

Coverage for Covered Services provided by Non-Participating Providers is limited to the Usual and Customary rate less applicable Coinsurance and Deductibles. The Usual and Customary rate is a rate established by the Plan based upon data provided by Ingenix. You may call customer service at the telephone number listed on Your identification card to find out the Usual and Customary rate for a particular dental procedure code.

If the amount You are charged for a service is equal to or less than the Out-of-Network rate, the charges should be completely covered by Your Out of Network benefit, except for any Deductible and Coinsurance payments You must make. However, if the amount You are charged is in excess of the Out-of-Network rate for a particular service, You must pay the excess. For example, assume Your Coinsurance is 20%, the dentist's bill is \$150 and the Out-of-Network rate is \$100. In this example, The Plan would pay \$80, You would pay Coinsurance of \$20 plus the \$50 in actual charges that exceeds the Out-of Network Rate. Payments for charges in excess of the Out-of-Network rate do not count towards Your annual Out-of-Pocket Maximum.

Benefit percentages are set forth in the Schedule of Benefits by procedure classification. Benefits are calculated using an Out of Network Rate. The Out of Network Rate is a rate established by The Plan based upon data provided by Ingenix. You may call customer service at the telephone number listed on Your identification card to find out the Out of Network Rate for a particular dental procedure code.

If a Covered Person obtains services from a Provider that is not part of the Network, the Covered Person may be required to remit payment in full at the time services are rendered. The Covered Person or the provider can then submit a Claim to Claims Administrator for Out-of-Network Benefits under the Plan.

Pre-authorization

Pre-authorization **is required** for the following procedure types:

Inlays, Onlays, Crowns
Root canals, Root canal retreatment
Periodontal Surgery
Periodontal scaling and root planning
Full dentures, partial dentures, fixed bridges
Implants
Third molar extractions
Complete occlusal adjustments

Documentation, including diagnostic quality radiographs, periodontal charting and other appropriate visual or written narrative should be sent with proposed treatment. If treatment is done without prior Pre-authorization approval, and documentation is submitted with a Claim, such Claim may not be paid.

Predetermination of Benefits

If the charge for any treatment is expected to exceed \$500, it is STRONGLY suggested that a dental treatment plan be submitted to the Plan by Your dentist for review before treatment begins. This process is called predetermination and is separate and different from Pre-authorization. This may be helpful to estimate both the benefits available and Your anticipated out of pocket expense. Predetermination is optional and not a requirement for use of benefits

The proposed services will be reviewed and a predetermination of benefits statement will be issued to the Covered Person or the Provider detailing the benefits that will be covered by the Plan. The predetermination is good for 180 calendar days.

Payment will be subject to the Plan benefits (e.g. Annual Maximums), limitations and exclusions in force at the time the Claim is submitted. Predetermination of benefits is also subject to the Alternate Benefit Provision immediately below.

Alternate Benefit Provision

Many dental problems can be resolved in more than one way. If: 1) The Plan determines that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, the Plan may use the less expensive alternative benefit to determine the amount payable under the Plan. For example: When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, the Plan may base its benefit on the amalgam filling which is the less expensive alternative benefit. This is the case whether a Participating Provider or Non-participating Provider performs the service.

Services Performed Outside The United States of America

Any claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Service, as defined; (2) be supplied in English; and (3) **use American Dental Association (ADA) codes** or provide a narrative of the services received. The benefit will be based on the Out-of-Network rate for the Group's zip code.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis. The term "Active Employee" does not include independent contractors, temporary employees or part-time employees.

Allowable Charge is the allowable amount the Plan pays, less any applicable coinsurance or deductibles. The allowable charge for services from Network Providers is equal to the standard fees, as developed by us or our agent, paid to Network Providers in the geographic area where the expenses are incurred. The allowable charge for services from Non-Participating Providers is equal to the Usual and Customary Charges at 90% of Ingenix.

Annual Deductible means the amount set forth in the Schedule of Benefits which each Covered Person must pay each year before benefits will be paid. The maximum Annual Deductible per family is three (3) times the individual Deductible as set forth in the Schedule of Benefits.

Annual Maximum means the total amount of benefits that will be paid in a year as set forth in the Schedule of Benefits to the Covered Person. Benefits for Orthodontia do not count to the Annual Maximum.

Benefit Year means the 12 months following the effective date of the Plan.

Calendar Year means January 1st through December 31st.

Claim means any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims.

Claims Administrator is Group Dental Service, Inc., dba Coventry Dental, 111 Rockville Pike, Rockville, MD 20850.

Coinsurance means a specified percentage of the Allowable Charge that You must pay as a condition of the receipt of certain services as provided under the Plan. Specific Coinsurance amounts are listed in the Schedule of Benefits. In some circumstances, the Maximum Allowable Charge will be more than the charges the Provider has billed for the Covered Services. In these cases, You will still be responsible for Coinsurance based on the Allowable Charge.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Service means a procedure listed in the attached Schedule of Benefits. If a procedure is not listed, it will not be covered under the Summary Plan Document. All procedures are subject to the Exclusions and Limitations set forth in this Summary Plan Document.

Covered Person means a person covered under the Plan.

Deductible means the amount a Covered Person must pay toward Covered Services under the Plan before the Plan begins paying for services. This Summary Plan Document lists the Deductible that applies to You.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Charleston Community Unit School District # 1.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental/Investigational means drugs or procedures not recognized by the United States Food and Drug Administration, the United States Public Health Service, Medicare, and the Dental Director as universally accepted treatment.

Maximum Allowable Charge is equal to the standard fees, as developed by us or our agent, paid to Network Providers in the geographic area where the expenses are incurred.

Member Service Department means the Company's Member Service Department, which includes services for Covered Persons. The number for the Member Service Department is located on Your ID card.

Network Providers refers to dentists that have contracted with Coventry Dental or partners of Coventry Dental to charge negotiated fees for each Covered Service.

Non-Participating Provider refers to providers that have not directly or indirectly executed an agreement with Coventry Dental or partners of Coventry Dental to participate in its network.

Out-of-Network refers to the payment level for services received from a Non-Participating Provider as designated in the Schedule of Benefits.

Plan means Plan Name, which is a benefits plan for certain Employees of Employer and is described in this document.

Plan Administrator is Charleston Community Unit School District #1.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pre-authorization means approval by the Company that is required for payment for certain services to be performed. Pre-authorization does not guarantee payment if the Covered Person is not covered at the time the service is provided. Pre-authorization does not guarantee payment at the In-Network benefit level for services rendered by Non-Participating Providers.

Provider means a practitioner of dentistry duly licensed by the State Board of Dental Examiners acting within the scope of his license. Provider does not include: the Covered Person or the Covered Person's Spouse; or the Covered Person or the Covered Person Spouse's child, parent, brother, sister, or a person living with the Covered Person.

Prudent Layperson means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

Qualified Medical Child Support Order ('QMCSO') means an order from a court of competent jurisdiction or a state agency stating that the Eligible Person is responsible for providing coverage under the Plan. You should contact Your Plan Administrator for answers to any questions You have with respect to a QMCSO.

Schedule of Benefits means a schedule of covered benefits, fully discussed in this Summary Plan Document, which delineates the Covered Person's Coinsurance, Deductibles, out-of-pocket maximums, and other benefit limitations. The Schedule of Benefits is included with this Summary Plan Document.

Usual & Customary Rate is a rate established by the Plan based upon data provided by Ingenix.

Utilization Management Policies means the evaluation of the appropriateness, medical need and efficiency of the proposed dental care service procedures. Such procedures include Pre-authorization, pre-determination and alternate benefit provisions.

Waiting Period means the time each Covered Person must be enrolled under the Plan before benefits will be paid for each classification of services as set forth in the Schedule of Benefits.

You/Your means a Covered Person covered under this Summary Plan Document

PLAN LIMITATIONS AND EXCLUSIONS

No benefits are payable under the Plan for procedures and services unless such procedures or services are listed as covered in the Schedule of Benefits. All benefits are subject to the following exclusions and limitations and frequency limits:

General

1. Coverage is limited to those services set forth in the Schedule of Covered Procedures. If a service is not listed, it is not included and is not covered.
2. Treatment to restore tooth structure lost due to attrition, erosion, abfraction or abrasion is not covered.
3. Where two or more professionally acceptable dental treatments for a dental condition exist, the Plan bases reimbursement on the least expensive alternative treatment (LEAT).
4. Services furnished solely for cosmetic reasons are not covered.
5. Any services related to implants including implant removal, repair, restoration or placement.
6. Fees related to broken appointments, preparing or copying dental reports, duplication of x-rays, itemized bills or claim forms are not covered.
7. Treatment for injuries or conditions covered by Workers' Compensation or employer liability laws, and treatment provided without cost to the covered Person by any municipality, county, or other political subdivision is not covered. This exclusion does not apply to any treatment covered by Medicaid or Medicare.
8. Treatment as a result of, civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime is not covered.
9. Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth is not covered.
10. Examination, evaluation and treatment of temporomandibular joint (TMJ) pain dysfunction is not covered.
11. Treatment of jaw fractures or orthognathic surgery is not covered.
12. Consultations and/or evaluation for non-covered services is not covered.
13. Services and/or appliances that alter the vertical dimension or alter, restore or maintain the occlusion including, but not limited to full mouth rehabilitation, splinting, appliances or any other method is not covered.
14. Removal and replacement of clinically acceptable material or restorations with alternative materials, for any reason except the pathological condition of the tooth or teeth, is not covered.
15. Replacement of fixed or removable bridges or orthodontic appliances that have been lost, stolen or damaged due to patient abuse or misuse is not covered
16. Periodontal splinting of teeth by any method is not covered.
17. Analgesia, anxiolysis, inhalation of nitrous oxide or non-intravenous sedation is not covered.
18. Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature is not covered.
19. Any outpatient facility, surgicenter facility, or inpatient hospital facility and associated facility charges, services and supplies is not covered
20. House, extended care facility calls, hospital calls, office visits for observation (during regularly scheduled hours) when no other services are provided, office visits after regularly scheduled hours or case presentations is not covered.
21. Drugs obtainable with or without a prescription are not covered.
22. Fees for equipment sterilization, OSHA or other regulatory agency requirements or mandates, infection control, and medical waste disposal is not covered
23. Treatment that is not described by the most recent (current edition) of the American Dental Association (ADA) CDT (current dental terminology) book is not covered.
24. Any treatment covered under an individual or group medical plan, auto insurance, no fault auto insurance or uninsured motorist policy to the extent permitted by state statute is not covered.

Diagnostic & Preventive

25. Oral evaluation (comprehensive or periodic) and prophylaxis, including scaling and polishing is limited to twice per year. Comprehensive oral evaluation is limited to Once per thirty six (36) months.
26. Bitewing x-rays are limited to once every twelve (12) months.
27. Full mouth x-rays (complete intraoral series) are limited to once every thirty six (36) months.
28. When a combination of x-rays (i.e. ten or more periapical x-rays or panoramic x-ray with bitewing x-rays) is done on the same date of service where the reimbursement meets or exceeds the reimbursement for

- full mouth x-rays, the plan reimbursement and benefit allocation will be based on full mouth x-rays.
29. Prophylaxis if performed on the same date of service with periodontal treatment is not covered.
 30. For Eligible Covered Dependents (age 14 and under) fluoride once every twelve (12) months.
 31. Sealants for Eligible Covered Dependents (age 14 and under) once per 1st and 2nd permanent molar once every thirty six (36) months.
 32. Space maintainers for Eligible Covered Dependents (age 14 and under) once per lifetime per space.

Restorative

33. Amalgams and Composites are limited to one restoration allowed per surface every thirty six (36) months.
34. Core Build Ups are limited to once every eighty-four (84) months.
35. Post and Cores are limited to once every eighty-four (84) months.
36. Crowns, inlays and onlays are limited to once per tooth per eighty-four (84) months following date of final cementation.
37. Core build ups, post and cores, crowns, inlays or onlays treatment on teeth exhibiting poor periodontal prognosis are not covered.
38. Reimbursement for post and cores, crowns, inlays or onlays will be based on the date of final cementation.

Endodontics

39. Root canals are limited to once per tooth per lifetime. Re-treatment of root canal is limited to not more than once per tooth per lifetime and not sooner than twenty four (24) months after the initial root canal for the same tooth.
40. Reimbursement for root canal treatment will be based upon the date of the final fill.
41. Endodontic treatment on teeth exhibiting poor periodontal prognosis is not covered.
42. Intentional endodontic treatment on teeth for the express purpose providing for restorative treatment (i.e. crown) where there is no sign of injury or disease is not covered.

Periodontics

43. Periodontal surgery is limited to once per quadrant per thirty six (36) months.
44. Crown lengthening is limited to once per tooth per lifetime. This procedure is not covered when done on the same date as a restoration on the same tooth.
45. Periodontal scaling and root planing is limited to once per quadrant every twenty-four (24) months.
46. Full mouth gross debridement is limited to once per thirty six (36) months.
47. Periodontal maintenance is limited to two per twelve (12) month period following active periodontal treatment (excluding gross debridement).
48. Gingeectomy/gingivoplasty or anatomical crown exposure is not covered when done on the same date as a restoration on the same tooth.
49. Bone grafting or guided tissue regeneration an extraction site or with endodontic surgical procedures is not covered.

Prosthodontics Removable & Fixed

50. Full dentures, partial dentures and fixed bridges are limited to once every eighty four (84) months. The eighty four month period shall be measured from the date on which the appliance was seated, whether paid for under the provisions of this Policy, under any prior dental care contract or by the Member.
51. Full dentures, partial dentures and fixed bridges are not covered for any person under the age of 18.
52. Retreatments, Relines, Rebases, Replacements, or Repairs are not covered within six (6) months of the date of final insertion of the full or partial denture. Benefits for denture repair will be limited to no more than half the cost of the Provider fee for a new denture.
53. Relines and rebases of existing removable dentures no more than once per thirty-six (36) month period.
54. Replacement of all teeth and acrylic on cast metal framework is limited to once per thirty-six (36) month period.
55. Interim complete dentures and interim partial dentures may not be replaced for a twelve (12) month period.
56. Reimbursement for full dentures, partial dentures and fixed bridges will be based upon the date of final insertion or cementation.

Oral & Maxillofacial Surgery

57. Extractions of 3rd (wisdom teeth) molars under age 16 are not covered.

Orthodontics

58. Orthodontia coverage – limited to Lifetime Maximum. Orthodontics for cosmetic reasons is not covered.

Adjunctive General Services

59. Palliative treatment is covered as a separate benefit only if no other service other than exam and x-rays were done during the visit. Palliative treatment may only be rendered on an emergency basis for the relief of pain and cannot be billed as a separate charge if the underlying dental problem is corrected on the same date of service.
60. General anesthesia or intravenous conscious sedation is covered for a maximum of one hour.
61. Consultations performed by a General Dentist or Specialist are not covered if the dental procedure is performed on the same date of service by that General Dentist or Specialist. Consultation should already be included with the dental procedure.

CLAIM PROVISIONS

HOW TO SUBMIT A CLAIM

A dental provider or other authorized representative may file a Claim or an appeal on Your behalf. All references in this section to "Covered Person" will include an authorized representative. Claims Administrator may require proof that a person is Your authorized representative.

Notice of Claim - Written notice must be given within 60 days after treatment or as soon as reasonably possible. Notice should include the Covered Person's name, address and group number. Claims Administrator may not invalidate or reduce a Claim if it is shown that it was not reasonably possible to give notice within 60 days and notice was given as soon as was reasonably possible.

Claim Forms - Claims Administrator will provide Claim forms for filing Proof of Loss to each claimant or to the Employee for delivery to the claimant. If Claims Administrator does not provide the Claim forms within 15 days after Notice of Claim is received, the claimant is considered to have complied with the requirements of the Plan as to Proof of Loss if the claimant submits within the time fixed by the Plan for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the Claim is made.

Proof of Loss - Written proof, satisfactory to the Plan, must be given to the Plan within 60 days after the date of loss. If that is not reasonably possible, the Plan will not deny or reduce any Claim if proof is furnished as soon as reasonably possible except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

Time of Payment of Claims - Benefits payable under the Plan for any loss will be paid not more than 30 days after written receipt of Proof of Loss. The Plan reserves the right to request x-rays, narratives and other diagnostic information, as the Plan sees fit, to determine benefits.

How To Submit Claims: - Claims submitted to Claims Administrator must identify the treatment rendered using the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. The Plan reserves the right to request x-rays, narratives and other diagnostic information, as the Plan sees fit to determine benefits.

Overpayment Recovery: Claims Administrator reserves the right to deduct from any benefits properly payable under the Plan the amount of any payment that has been made:

1. in error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under the Plan within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under this Plan or any other plan or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Plan made by a Covered Person if Claim payments previously were made with respect to a Covered Person.

Payment of Claims - All benefits will be paid to the Covered Person unless assigned by the Covered Person to the Provider. Only one Claim amount will be paid for each Covered Service. Any benefits unpaid at the time of the Covered Person's death will be paid in one lump sum to the first surviving class of the following classes of persons:

- a) wife or husband;
- b) children;

- c) mother and father;
- d) sisters and brothers.

If there is no surviving member of any of the above classes, the benefits will be paid to the Covered Person's estate.

Legal Actions - No legal action for reimbursement of a claim for payment for services may be initiated prior to the exhaustion of the Plan's appeals procedures. No legal action for reimbursement of a claim for payment for services may be initiated more than three (3) years after the expiration of the date of service of the Claim at issue.

CLAIMS REVIEW PROCEDURE

The following is a description of how the Plan processes claims for benefits. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If You have any questions regarding this procedure, please contact the Claims Administrator.

Informal Inquiry Process

Most complaints begin as an informal inquiry. Covered Persons should direct informal inquiries to the Plan via the Health Plan Customer Services Department Monday through Friday from 8:00 a.m. to 5:00 p.m. at the telephone number listed below:

Toll-free: 1-866-690-4908

A customer service associate will review, research and resolve the inquiry. The Covered Person will be informed of the resolution within thirty (30) days. At the time of resolution, if the decision is adverse to the Covered Person, the Covered Person will be advised of his/her right to request a formal complaint. Covered Persons also have the right to bypass the informal inquiry procedures and immediately file a formal complaint.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting physician or Provider, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A physician or Provider with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician or Provider, an individual acting on behalf of the Plan applying the judgment of a Prudent Layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours

Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Claims Administrator and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Pre-authorization.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for dental services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	60 days

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- (7) If the adverse benefit determination is based on the medical necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) was relied upon in making the benefit determination;
- (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- (3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- (4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by the Claims Administrator who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/Investigational, or not medically necessary or appropriate, the Claims Administrator shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Review of appeals shall be concluded within the following time frames:

- Urgent Care Appeals – Within thirty-six (36) hours after receipt of the appeal. The Claims Administrator will notify the Covered Person and/or the authorized representative verbally and will provide written notice within thirty-six (36) hours after receipt of the appeal.
- Pre-service Appeals - within fifteen (15) days of the request for appeal.
- Post-service Appeals - within thirty (30) days of the request for appeal.

The Claims Administrator will advise the Covered Person or authorized representative of the determination in writing giving the reason for the decision.

[Other Appeal Rights

As a participant or beneficiary of an employee welfare benefit plan under ERISA, Covered Persons may have the right to bring a civil action under ERISA Section 502(a). Covered Persons may exercise this right to recover benefits due under the Plan, enforce the Covered Person's rights under the Plan, or to clarify rights to future benefits under the terms of the Plan. Covered Persons must exhaust the internal appeal process before bringing a civil action under ERISA Section 502(a).

COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) will apply when a Covered Person is covered for dental benefits under more than one Plan. For purposes of this section, "Plan" is defined below under Plans Considered for COB.

If this COB provision applies, the Order of Benefit Determination Rules below should be looked at first. Those rules determine whether this Plan is a Primary Plan or a Secondary Plan. A "Primary Plan" means the Plan that pays benefits or provides services first under the rules. A "Secondary Plan" is any Plan that is not a Primary Plan. When there are more than two Plans covering the Covered Person, this Plan may be: a Primary Plan as to one or more other Plans; and a Secondary Plan as to a different Plan or Plans.

If this Plan is:

1. a Primary Plan, COB will not apply and benefits will not be reduced; or
2. a Secondary Plan, COB will apply, and benefits may be reduced so that the total payment from all Plans will not exceed 100% of total Allowable Expenses. This reduction is described under Effect on Benefits below.

Plans Considered for COB

"Plan" is any of the following that provides benefits or services for or because of dental care or treatment:

1. group; blanket or franchise insurance; or other group type coverage, whether insured or uninsured;
2. union welfare plans; employer organization plans; or labor management trustee plans; or
3. coverage under a governmental plan; or coverage required or provided by law. This does not include benefits payable under any state plan under:
 - a. Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or
 - b. any plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Each contract or other arrangement for coverage under 1. through 3. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Plan" will not include:

1. individual or family policies; or individual or family subscriber contracts; this includes: prepayment; service; group practice; or individual practice coverage;
2. school accident type coverage; or
3. guaranteed renewable individual intensive care or specified disease policies.

Order Of Benefit Determination Rules

General

When there is a basis for a Claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Plan; and
2. both those rules and this Plan's COB Rules require that this Plan's benefits be determined before those of the other Plan.

Rules

This section determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the individual as an employee, covered person or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the individual as a Dependent.
2. Dependent Child/Parents not Separated or Divorced. Except as stated in Rule 3., when this Plan and another Plan cover the same child as a Dependent of different individuals, called "parents":
 - a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year;
 - b. but, if both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time;
 - c. however, if the other Plan:
 - i. does not have this "birthday rule"; but
 - ii. has a rule based upon the gender of the parent; and

if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
3. Dependent Child/Parents Separated or Divorced. If two or more Plans cover a child as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. first, the Plan of the parent with custody of the child;
 - b. then, the Plan of the spouse of the parent with the custody of the child; and
 - c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state:

- a. that one of the parents is responsible for the health care expense of the child; and
- b. the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms,

the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any:

- a. Claim Determination Period; or
- b. Plan Year;

during which any benefits are actually paid or provided before the entity has the actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan which covers the individual as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers the individual as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule 4. is ignored.
5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, person or subscriber longer are determined before those of the Plan which covered the employee, person or subscriber for the shorter term.

Effect on Benefits

COB applies to this Plan when, in accordance with the Order of Benefit Determination Rules, this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Plan may be reduced under this COB provision. Such other Plan or Plans are referred to as "the other Plans" immediately below.

Reduction In This Plan's Benefits

The benefits of this Plan will be reduced when the sum of:

1. the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
2. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

"Allowable Expense" means an expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means the year defined in the Schedule of Benefits. However, it does not include any part of a year during which an individual has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. Claims Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. Claims Administrator need not tell, or get the consent of, any individual to do this. Each Covered Person claiming benefits under the Plan must give Plan Administrator any facts it needs to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under this Plan. Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Claims Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. the individuals it has paid or for whom it has paid;
2. the insurance companies; or
3. the other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Group, Inc. Employee Benefits Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Covered Person would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for Dependent status under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue Your group health coverage will affect Your rights under federal law. First, You can lose the right to avoid having pre-existing condition limitations or exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help You avoid such a gap. Second, if You do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to You, You will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition limitations or exclusions. Finally, You should take into account that You have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if You get COBRA continuation coverage for the maximum time available to You.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If You have questions about these new tax provisions, You may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the Employee,
- (3) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (4) enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), You or someone on Your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that You provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver Your notice to the person, department or firm listed below, at the following address:

Charleston Community Unit School District #1

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state:

- the **name of the plan or plans** under which You lost or are losing coverage,
- the **name and address of the Employee** covered under the Plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, Your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If You or Your Spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later 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 made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions or limitations of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier). The Qualified Beneficiary must immediately notify the Plan Administrator of any such enrollment in Medicare. The notice must be provided as described in the Notice Procedures above.
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) 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
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact the Plan Sponsor. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District

Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

ERISA INFORMATION: RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Charleston Community Unit School District #1 Employee Benefits Plan is the benefit plan of Charleston Community Unit School District #1, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Charleston Community Unit School District #1 to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Charleston Community Unit School District #1 shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Covered Person's rights.
- (4) To prescribe procedures for filing a Claim and to review Claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS.

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT.

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR.

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN COVERED PERSONS RIGHTS UNDER ERISA. Covered Persons in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Covered Persons shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Covered Person, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or Dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Covered Person's claim for a benefit is denied or ignored, in whole or in part, the Covered Person has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Covered Person up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in state or federal court.

In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons and their beneficiaries. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent the Covered Person from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Covered Person has any questions about the Plan, he or she should contact the Plan Administrator. If the Covered Person has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Covered Person should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Charleston Community Unit School District #1 Employee Benefits Plan

PLAN NUMBER:

TAX ID NUMBER: 37-6002687

PLAN EFFECTIVE DATE: 1/1/2010

PLAN YEAR ENDS: 12/31

EMPLOYER INFORMATION

Charleston Community Unit School District #1

PLAN ADMINISTRATOR

Charleston Community Unit School District #1

NAMED FIDUCIARY

The Employer
Charleston Community Unit School District #1

AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator
Charleston Community Unit School District #1

CLAIMS ADMINISTRATOR

Coventry Dental

BY THIS AGREEMENT, Charleston Community Unit School District #1 Employee Benefits Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Charleston Community Unit School District #1 on or as of the day and year first below written.

By _____
Charleston Community Unit School District #1

Date _____

Witness _____

Date _____

HIPAA PRIVACY AMENDMENT

CHARLESTON COMMUNITY UNIT SCHOOL DISTRICT #1 EMPLOYEE BENEFITS PLAN

BY THIS AGREEMENT, Charleston Community Unit School District #1 Employee Benefits Plan, the medical plan(s) (herein called the "Plan") is hereby amended as follows, effective as of 1/1/2010.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the Employer is amending the Plan as follows:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
 - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
 - (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
 - (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
 - (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

SCHEDULE I

The following members of Charleston Community Unit School District #1's workforce are designated as authorized to receive Protected Health Information from Charleston Community Unit School District #1 Employee Benefits Plan ("the Plan") in order to perform their duties with respect to the Plan:
Jim Littleford

IN WITNESS WHEREOF this Agreement has been executed on behalf of Charleston Community Unit School District #1, effective January 1, 2010.

By _____
Charleston Community Unit School District #1

Witness _____

HIPAA SECURITY AMENDMENT

CHARLESTON COMMUNITY UNIT SCHOOL DISTRICT #1 EMPLOYEE BENEFITS PLAN

BY THIS AGREEMENT, Charleston Community Unit School District #1 Employee Benefits Plan, the medical plan(s) (herein called the "Plan") is hereby amended as follows, effective as of 1/1/2010.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the Employer is amending the Plan as follows:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

IN WITNESS WHEREOF this Agreement has been executed on behalf of Charleston Community Unit School District #1, effective on January 1, 2010.

By _____
Charleston Community Unit School District #1

Witness _____