El Centro Elementary School District

(Classified Employees)

DENTAL & VISION BENEFITS

PLAN DOCUMENT &

SUMMARY PLAN DESCRIPTION

REVISED MARCH 2022

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (i.e., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form or Means of Notification - Notification of the Qualifying Event must be made in writing. Notice may be made on INFINISOURCE'S election form. The form is available, without cost, from the Employer's Human Resources office.

Content - Notification must include an adequate description of the Qualifying Event or disability determination. In the case of a disability determination, a copy of the Social Security Administration determination of disability must be included. The Qualified Beneficiary must also provide any additional information as the Plan deems necessary for making the appropriate determination with regard to the notice.

Delivery of Notification - Notification must be received by INFINISOURCE (the COBRA administrator) by mail, by fax or online as follows:

Mail: P.O. Box 949 ***or*** 15 East Washington Street, Coldwater, MI 49036-0949

Fax: 1-517-279-9420

Online: www.benefitsolved.com

The toll-free phone number for assistance with COBRA questions is 1-800 -594-6957.

Time Requirements for Notification - In the case of a divorce, legal separation or a child losing dependent status, notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide notice through the Summary Plan Description or the Plan Sponsor's General COBRA notice. If notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event or (4) the date the covered Employee or Qualified Beneficiary is advised of the notice obligation through the SPD or the Plan Sponsor's General COBRA notice. Also, notice must be provided within the 18-month COBRA coverage period.

The Plan will not reject an incomplete notice as long as the notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

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IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Plan participant may obtain additional information about Plan coverage of a treatment, procedure, preventive service, etc. from the office who handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will give you a better understanding of the benefits and provisions.

SOLICITUD DE INFORMACIONES EN ESPAÑOL

(Spanish Language Offer of Assistance)

Este documento está escrito en ingles y contiene un resumen de los derechos y beneficios de su plan de seguro. Si ud. tiene dificultad en comprender cualquier parte de este documento, comuniquese con los administradores de la:

Navia Benefit Solutions
PO Box 5809
Fresno, CA 93755

El horario de la oficina es: las ocho de la mañana hasta las cuatro de la tarde, lunes a viernes. Ud. tambien puede llamar a la oficina del administrador del plan de seguro a este teléfono: (559) 256-1320 para pedir ayuda.

DENTAL BENEFIT SUMMARY
BASIC OPTION

NETWORK AND NON-NETWORK PROVIDERS

The Plan Sponsor has contracted with "Networks" of dental providers. Network providers have agreed to provide dental services at negotiated rates. Lists or directories of the Network providers will be given to Plan participants without charge.

When obtaining dental care services in the United States, a Covered Person has a choice of using a provider who is participating in the First Dental Health Network (FDH) or any other Covered Provider of his choice (a Non-Network provider). For in-Mexico services, a First Dental Health (AMEXUS) Network provider or a participating dental laboratory must be used.

When a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of "Usual, Customary and Reasonable." The Schedule of Dental Benefits (below) may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible.

SCHEDULE OF DENTAL BENEFITS

BENEFIT MAXIMUMS	
Calendar Year Maximum	$1000*
Orthodontia Lifetime Maximum	$1000 *
TMJ Lifetime Maximum	$500
Benefits for each Covered Person will not exceed the maximums shown above. Orthodontia benefits do not apply to the Calendar Year Maximum. The Orthodontia Maximum applies to all periods a child is covered under the Plan. Benefits for Eligible Dental Expenses that are related to treatment of TMJ (i.e., disorders of the temporomandibular joint) are subject to both the Calendar Year Maximum and the TMJ Lifetime Maximum.	
ANNUAL DEDUCTIBLES	
Individual Deductible	$25
Family Maximum Deductible	$75

*Married employees that each cover their dependents on the ECESD's Plan; benefit maximums will be doubled for those dually covered dependents. maximums will be doubled.

ELIGIBLE DENTAL EXPENSES	**FDH Network** (Stateside)	**Non-Network** (Stateside)	**AMEXUS Network** (Mexico)
Diagnostic & Preventive Services	100%†	80%†	100%†

Diagnostic & Preventive Services include the following, some of which are limited by age or frequency as shown below. See the **Eligible Dental Expenses** section for further detail:

- Biopsy / pathology
- Consultation
- Diagnostic casts
- Exams and cleanings, limited to 2 exams/cleanings per Calendar Year
- Fluoride, limited to 2 applications per Calendar Year
- Palliatives
- Sealants, limited to children under age 14
- Space maintainers
- Study models
- X-rays. Full mouth series or panoramic X-ray, limited to once per 5-year period. Routine bitewings, limited to 2 sets per Calendar Year for children under age 18 and 1 set per Calendar Year for persons age 18 and over.

Basic Services	70% - 100%††	60%	70% - 100%††

Basic Services include the following. See the **Eligible Dental Expenses** section for further detail:

- Anesthesia
- Casts
- Crowns
- Endodontia
- Fillings
- Injections
- Oral surgery / extractions
- Periodontal
- Visits, non-routine

ELIGIBLE DENTAL EXPENSES	**FDH Network** (Stateside)	**Non-Network** (Stateside)	**AMEXUS Network** (Mexico)
Major Services	50%	40%	50%
Major Services include the following. See the **Eligible Dental Expenses** section for further detail: • Implants • Prosthodontics (dentures & bridges) • Repairs, recementings, relines, etc.			
Orthodontia	50% To $1000 Lifetime	50% To $1000 Lifetime	50% To $1000 Lifetime
Orthodontia benefits are limited to a maximum 24-month treatment program.			

† Annual Deductible does not apply.

†† The 70% benefit will apply to benefits provided during a person's first Calendar Year (or partial year) of coverage. The percentage increases by 10% each consecutive year the member is enrolled on the benefit plan to a maximum benefit of 100%. If coverage is terminated and later resumed, benefits restart at the 70% benefit level.

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

DENTAL BENEFIT SUMMARY
BUY-UP OPTION

NETWORK AND NON-NETWORK PROVIDERS

The Plan Sponsor has contracted with "Networks" of dental providers. Network providers have agreed to provide dental services at negotiated rates. Lists or directories of the Network providers will be given to Plan participants without charge.

When obtaining dental care services in the United States, a Covered Person has a choice of using a provider who is participating in the First Dental Health Network (FDH) or any other Covered Provider of his choice (a Non-Network provider). For in-Mexico services, a First Dental Health (AMEXUS) Network provider or a participating dental laboratory must be used.

When a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of "Usual, Customary and Reasonable." The Schedule of Dental Benefits (below) may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible.

SCHEDULE OF DENTAL BENEFITS

BENEFIT MAXIMUMS	
Calendar Year Maximum	$1500*
Orthodontia Lifetime Maximum	$1500 *
TMJ Lifetime Maximum	$500

Benefits for each Covered Person will not exceed the maximums shown above.

Orthodontia benefits do not apply to the Calendar Year Maximum. The Orthodontia Maximum applies to all periods a child is covered under the Plan.

Benefits for Eligible Dental Expenses that are related to treatment of TMJ (i.e., disorders of the temporomandibular joint) are subject to both the Calendar Year Maximum and the TMJ Lifetime Maximum.

ANNUAL DEDUCTIBLES	
Individual Deductible	$25
Family Maximum Deductible	$75

*Married employees that each cover their dependents on the ECESD's Plan; benefit maximums will be doubled for those dually covered dependents. maximums will be doubled.

ELIGIBLE DENTAL EXPENSES	**FDH Network** (Stateside)	**Non-Network** (Stateside)	**AMEXUS Network** (Mexico)
Diagnostic & Preventive Services	100%†	80%†	100%†

Diagnostic & Preventive Services include the following, some of which are limited by age or frequency as shown below. See the **Eligible Dental Expenses** section for further detail:

- Biopsy / pathology
- Consultation
- Diagnostic casts
- Exams and cleanings, limited to 2 exams/cleanings per Calendar Year
- Fluoride, limited to 2 applications per Calendar Year
- Palliatives
- Sealants, limited to children under age 14
- Space maintainers
- Study models
- X-rays. Full mouth series or panoramic X-ray, limited to once per 5-year period. Routine bitewings, limited to 2 sets per Calendar Year for children under age 18 and 1 set per Calendar Year for persons age 18 and over.

Basic Services	70% - 100%††	60%	70% - 100%††

Basic Services include the following. See the **Eligible Dental Expenses** section for further detail:

- Anesthesia
- Crowns
- Endodontia
- Fillings
- Injections
- Oral surgery / extractions
- Periodontal
- Visits, non-routine

ELIGIBLE DENTAL EXPENSES	**FDH Network** (Stateside)	**Non-Network** (Stateside)	**AMEXUS Network** (Mexico)
Major Services	50%	40%	50%
Major Services include the following. See the **Eligible Dental Expenses** section for further detail: • Inlays, Onlays & Cast Resoration • Implants • Prosthodontics (dentures & bridges) • Repairs, recementings, relines, etc.			
Orthodontia	50% To $1500 Lifetime	50% To $1500 Lifetime	50% To $1500 Lifetime
Orthodontia benefits are limited to a maximum 24-month treatment program.			

† Annual Deductible does not apply.

†† The 70% benefit will apply to benefits provided during a person's first Calendar Year (or partial year) of coverage. The percentage increases by 10% each consecutive year the member is enrolled on the benefit plan to a maximum benefit of 100%. If coverage is terminated and later resumed, benefits restart at the 70% benefit level.

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

DENTAL PRE-TREATMENT ESTIMATE

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

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

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

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

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

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

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies listed below, which are: (1) incurred while a person is covered under the Plan and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

- Appliance or modification of an appliance, on the date the final impression is taken;
- Crown, inlay, onlay or gold restoration on the date the tooth is prepared;
- Root canal therapy, on the date the pulp chamber is opened; or
- Any other service, on the date the service is rendered.

NOTE: Many dental conditions can be properly treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment which is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition. This restriction will not apply, however, to "white" (plastic or composite) fillings.

DIAGNOSTIC & PREVENTIVE SERVICES

Biopsy / Pathology – Oral biopsy and tissue examination.

Consultation - Consultation by a dental specialist upon referral by the patient's attending dentist.

Diagnostic Casts - Plaster or stone model of teeth and adjoining tissue (study model)

Exams & Cleanings, Routine - Oral examinations and routine cleaning and polishing of the teeth.

Fluoride - Topical application of stannous or sodium fluoride.

Palliatives - Emergency treatment for the relief of dental pain.

Prophylaxis - see "Exams & Cleanings, Routine"

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

Space Maintainers - Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

X-rays - Dental X-rays for diagnostic purposes, as well as routine "full mouth" X-rays or a panoramic X-ray and routine bitewing X-rays.

BASIC SERVICES

Anesthesia - General anesthesia when administered in connection with oral surgery.

NOTE: Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are not covered. Such services should be included in the cost of the procedure itself.

Crowns – Initial placement of a crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

Replacement of a crown if: (1) the existing crown is at least five years old, (2) it is determined that replacement is required because the restoration is unsatisfactory as a result of poor quality of care or (3) the tooth has experienced extensive loss or changes to tooth structure or supporting tissue since the prior placement.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on veneer or facing (i.e., "tooth-colored") restorations. Crowns placed for periodontal splinting are not covered.

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

Extractions - see "Oral Surgery"

Fillings, Non-Precious – Initial placement of an amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

NOTE: Replacement of an existing restoration is not covered for any purpose other than active tooth decay.

Injections - Injection of antibiotic drugs.

Oral Surgery - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Periodontal - Treatment of the gums and tissues of the mouth, including periodontal prophylaxes.

NOTE: Periodontal prophylaxes (cleanings) are subject to the frequency allowance for routine cleanings (see "Diagnostic & Preventive Services" in the **Dental Benefit Summary**).

Visits, Etc. – Office visits for observation, office visits after regularly-scheduled hours, treatment of unusual post-surgical complications and limited occlusal adjustment.

MAJOR SERVICES

Implants - Implants inserted into bone or soft tissue in the jaw to anchor an artificial tooth, a permanent bridge or a denture

Inlays, Onlays & Cast Restorations – Initial placement of an inlay, onlay or cast restoration when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration.

Replacement of an inlay, onlay or cast restoration, if: (1) the existing restoration is at least five years old, (2) it is determined that replacement is required because the restoration is unsatisfactory as a result of poor quality of care or (3) the tooth has experienced extensive loss or changes to tooth structure or supporting tissue since the prior placement.

Prosthodontics – Initial placement of a full or partial denture or bridge. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

Addition of teeth to an existing bridge or denture to replace newly-extracted teeth.

Replacement of an existing full or partial denture or bridgework, but only if:

- Existing denture or bridgework is at least five (5) years old; or
- There has been such an extensive loss of remaining teeth or a change in supporting tissue that the existing appliance cannot be made satisfactory.

Repairs & Adjustments - Repair or re-cementing of crowns, inlays, bridgework or dentures or the relining of dentures. Adjustments for prosthetics, but only after six (6) months from placement.

ORTHODONTIA

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

- Initial consultation, models, x-rays and other diagnostic services;
- Initial banding or placement of orthodontic appliances);
- Periodic adjustments;
- Retainers.

Orthodontia benefits will begin upon submission of proof that the orthodontia treatment program has begun. Payments will be divided into equal installments, based upon the estimated number of months of treatment and will be paid over the treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is shown in the "Plan Maximums" in the **Dental Benefit Summary**. This maximum applies to the entire period(s) a person is covered under the Plan.

If orthodontic treatment begins before an individual becomes eligible for coverage, benefits will begin with the first payment due to the dentist following the individual's coverage effective date.

Orthodontia benefits will cease when the first installment is due following either a loss of eligibility or if treatment is ended for any reason before it is completed.

NOTE: X-rays and extractions that might be necessary for orthodontia treatment are not covered under the orthodontia benefits but may be covered as Diagnostic and Preventive or Basic Services.

Repair or replacement of an orthodontic appliance is <u>not</u> covered.

The Plan provides coverage for standard orthodontic treatment. If a Covered Person selects specialized appliances or procedures for aesthetic reasons, coverage will be limited to the cost of a standard treatment plan. the patient is responsible for excess costs.

DENTAL LIMITATIONS AND EXCLUSIONS

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

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

Congenital or Developmental Conditions - Treatment of congenital (hereditary) or developmental (following birth) malformations such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

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

NOTE: Excess charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic is not covered on a tooth posterior to the second bicuspid but will be considered "cosmetic." This restriction does not apply to non -precious fillings.

Customized Prosthetics - Precision or semi-precision attachments, overdentures or customized prosthetics.

Discoloration Treatment - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Care - Services which exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) which would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

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

Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

Hospital or Facility Expenses – Services or supplies provided by a hospital or other surgical or treatment facility or any additional fees charged by a dentist for treatment in any such facility.

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

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

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

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

- Dentist (D.D.S. or D.M.D.);
- Dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist;
- Physician furnishing dental services for which he is licensed.

Occlusal Restoration - Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

- Altering the vertical dimension;
- Replacing or stabilizing tooth structure lost by attrition;
- Realignment of teeth;
- Gnathological recording or bite registration or bite analysis;
- Occlusal equilibration or periodontal splinting.

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

Personalization or Characterization of Dentures

Prescribed Drugs – Prescribed drugs or applied therapeutic drugs.

Prior to Effective Date / After Termination Date - Courses of treatment which were begun prior to the Covered Person's effective date, including crowns, bridges or dentures which were ordered prior to the effective date.

Dental services or supplies provided after termination of coverage, except as expressly allowed.

Splinting - Appliances and restorations for splinting teeth.

Temporary Restorations & Appliances - Excess charges for temporary restorations and appliances. The Eligible Expenses for the permanent restoration or appliance will be the maximum covered charge.

*- (See also **General Exclusions** section) -*

VISION BENEFIT SUMMARY

NETWORK AND NON-NETWORK PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of vision providers. The Network is Medical Eye Services (MES). Network providers have agreed to provide care at negotiated rates. Lists or directories of the Network providers will be given to Plan participants without charge.

When obtaining vision care services, a Covered Person has a choice of using a provider who is participating in the Network or any other Covered Provider of his choice (a Non-Network provider).

Since Network providers have agreed to provide services to Covered Persons at negotiated rates, when a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of "Usual, Customary and Reasonable". The Schedule of Vision Benefits (below) may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible.

SCHEDULE OF VISION BENEFITS

ELIGIBLE VISION EXPENSES	MES Network	Non-Network
Annual Deductible **Eye Examination**	$10 100%	$10 100% to $40
Limited to 1 exam per 12-month period.		
Contacts (in lieu of glasses)	100%	100% to $210
Benefits for necessary contacts are limited to $210 and are available every 12-month period. "Necessary" contacts are those: (1) following cataract surgery, (2) when visual acuity cannot be corrected to 20/70 in the better eye except through the use of contacts or (3) necessitated by anisometropia or certain conditions of keratoconus. Benefits for other contacts are limited to $105 per 24-month period.		

ELIGIBLE VISION EXPENSES	MES Network	Non-Network
Frames, per pair	100% to $150	100% to $80
Limited to 1 standard frame per 24-month period.		
Lenses for Glasses		
Single Vision	100%	100% to $30
Bifocals	100%	100% to $50
Trifocals	100%	100% to $65
Lenticular	100%	100% to $125
Limited to 1 pair of lenses per 12-month period.		

THIS IS ONLY A SUMMARY. SEE THE **VISION LIMITATIONS AND EXCLUSIONS** SECTION FOR MORE INFORMATION.

VISION LIMITATIONS AND EXCLUSIONS

Except as expressly stated below, no vision coverage will be provided for:

Ancillaries – Contact lens insurance or care kits.

Coated or Laminated Lenses - Excess charges for anti-reflective coatings or lamination.

Cosmetic Supplies - Excess charges for beveled, faceted or oversize lenses, no -line bifocals, two pairs of glasses in lieu of bifocals unless prescribed, etc.

Duplicate - Duplicate or spare eyeglasses, lenses or frames.

Employment-Required Services - Any eye examination or any corrective eyewear which is required by an employer as a condition of employment.

Medical or Surgical Treatment of the Eye - Medical or surgical treatment of the eye or vision services or supplies which are covered under any other plan of coverage offered by the Plan Sponsor.

Non-Professional Care - Vision exams performed other than by a licensed ophthalmologist or optometrist.

Orthoptics - Services or supplies in connection with orthoptics, vision training or other special procedures.

Non-Prescription Lenses - Lenses which do not correct refractive error (plano lenses) or which are not obtained upon prescription by an ophthalmologist, optometrist or optician.

Refractive Surgery, Etc. - Surgery to correct refractive error.

Repair or Replacement - Repair of lenses or frames.

Replacement of lost, stolen or broken lenses or frames or when there is no prescription change (except in accordance with the allowable frequencies shown in the benefit summary).

Subnormal Vision Aids

Sunglasses, Etc. - Excess charges for sunglasses (tint other than No. 1 or 2) or photosensitive lenses.

*- (See also **General Exclusions** section) -*

GENERAL EXCLUSIONS

No benefits will be payable under the Plan for:

Excess Charges - Charges in excess of the Usual, Customary and Reasonable fees.

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

Late-Filed Claims - Claims which are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay or is not billed or would not have been billed in the absence of coverage under this Plan. However, this exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies - Any services, care or supplies not specifically listed as Eligible Expenses.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof).

Outside United States - Charges incurred outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining such services, drugs or supplies.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the plan which this Plan replaces.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse or a parent, brother, sister or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Telecommunications - Advice or consultation given by or through any form of telecommunication.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications there from or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

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

COORDINATION OF BENEFITS (COB)

IF COVERED BY ECESD

Married employees that each cover their dependents on the ECESD's Plan; benefit maximums will be doubled for Calendar Year and Orthodontia for those dually covered dependents.

IF COVERED BY OTHER PLANS

Benefits provided under the Plan are subject to an industry-standard Coordination of Benefits (COB) provision.

Briefly, the intent of COB is to avoid a duplication of benefits when an individual has coverage under more than one plan, such as often occurs when both a husband and wife are employed. In such an instance, the two (or more) plans will determine, between them, who will provide benefits on a "primary" basis and who will provide "secondary" benefits.

For COB purposes an "Other Plan" will include:

- Group or group blanket plan on an insured basis;
- Any other plan that covers people as a group;
- Self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
- Pre-payment plan which provides medical, vision, dental or health service;
- Government plans, except Medicaid;
- Group auto insurance, but only to the extent medical benefits are payable there under;
- No-fault auto insurance on an individual basis;
- Single or family subscribed plans issued under a group or blanket-type plan.

To assure prompt claims handling, Claimants with more than one plan of coverage should be certain to provide other coverage details (name of carrier, claims-paying address, policy no., etc.) when filing claims.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees
To participate as an "Employee", an individual must be in active employment for the Employer and performing all customary duties of his occupation at his usual place of full-time employment. "Full-time" is as defined by the Employer ("District").

Subject to a Participating Employer's (i.e., a District's) written policies, members of the Board of Education and retirees may also be eligible to participate.

Effective Date - Employees
An eligible Employee's coverage is effective, subject to timely enrollment, upon completion of a waiting period to the first of the month following commencement of active employment in an eligible status.

If an Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights" provisions below.

Eligibility Requirements - Dependents
An eligible Dependent of an Employee is:

- A spouse. The marriage must meet all requirements of a valid marriage contract in the Employee's state of residence but will not include a common law spouse;

- A domestic partner when both the partner and Employee: (1) are of the same sex, (2) are at least eighteen years of age and mentally competent to consent to a contract, (2) are each other's sole domestic partner and intend to remain so indefinitely, (3) are not married to or legally separated from anyone else, (4) are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside, (6) are living together in the same residence and intend to do so indefinitely, (7) are engaged in a committed relationship of long standing, mutual care and support and are jointly responsible for each other's common welfare and living expenses. Domestic partnership certification will be subject to Plan Sponsor approval and the Plan Sponsor's decision will be final. If the domestic partnership ends or ceases to meet the above criteria, it is the Employee's responsibility to obtain and submit a notice of termination of coverage for a

domestic partner within thirty (30) days. Any false, incorrect and/or misleading information in the application for domestic partnership can result in the loss of benefits and the cost of any benefits improperly paid based on false, incorrect or misleading information will be subject to the Plan's overpayment provisions. Employee must comply with the Internal Revenue Code and applicable regulations pertaining to the value of the benefits provided for a domestic partner;

- An unmarried child under age 26. For these purposes a "child" will include:

  - Natural child;

  - Stepchild who is dependent on the Employee for support and maintenance;

  - Child of an Employee's eligible same-sex domestic partner;

  - Foster child who is dependent on the Employee for support and maintenance. To establish the child's eligibility, the Employee must submit evidence of a bonafide foster child relationship, identifying the foster child by name and setting forth all the relevant aspects of the relationship. A child placed in a home by a welfare agency which obtains control of and provides for maintenance of the child is not an eligible dependent;

  - Child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun;

  - Notwithstanding any main support and care requirements, a child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (which are incorporated herein by reference and which can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements.
  - an unmarried child age 19 or over but less than 25, if such

- An unmarried Dependent child, regardless of age, with a physical or mental disability and who is unable to be self-sufficient as the result of a such disability. The disability must have occurred before the child turned age 26. A "physical or mental disability" includes, but is not limited to: physical handicap or disability due to injury, sickness or congenital defect, mental retardation, cerebral palsy, epilepsy or any other neurological disorder or condition which is diagnosed by a Physician as a permanent and continuing condition. Proof of the disability must be provided to the Plan or the Employer within thirty-one (31) days of any request. Proof will not be required more than once a year after the child reaches age 27.

NOTE: An eligible Dependent does not include:

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

- Any person who is on active duty in a military service.

If an Employee and spouse are both regular employees of Participating Employers, both may be covered as Employees and as Dependents of each other and eligible children may be covered as Dependents of both spouses. Any such individual with dual coverage will be eligible to receive up to the maximum benefits under each spouse's plan of benefits (i.e., two (2) Calendar Year maximums). See the **Coordination of Benefits** section for additional information.

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

NOTE: A Dependent's coverage will never be effective prior to the Employee's effective date. An Employee may cover his spouse without covering eligible child(ren) and vice versa.

Special Enrollment Rights

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

- They were covered under another group health plan or other health insurance coverage at the time coverage was initially offered. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

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

- Individual lost the other coverage as a result of a certain event, such as loss of eligibility for coverage, exhaustion of the maximum COBRA continuation coverage period, termination of employment or reduction in the number of hours of employment or employer contributions towards such coverage were terminated. Loss of other coverage for failure to pay premiums on a timely basis or for cause (i.e., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes;

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

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

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

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

- Employee's marriage is the "triggering event" - the spouse's coverage and the coverage of any eligible Dependent children the Employee acquires in the marriage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application;

- Birth, adoption or placement for adoption is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends. The "triggering event" date for a newborn adoptive child is the date of birth if the child is placed with the Employee within thirty-one (31) days of birth and is enrolled within that 31-day period.

NOTE: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with the late enrollment provisions of the Plan.

Court-Ordered Coverage - If an Employee or spouse is required to provide coverage for a child under a Medical Child Support Order and such order is determined to be a Qualified Medical Child Support Order (QMCSO), the child shall become covered subject to the terms of the order or as quickly as is administratively feasible. A request to enroll the child may be made by the Employee or spouse, by the child's other parent or by a State Agency on the child's behalf.

When the Plan is presented with a QMCSO and the Employee is not enrolled, the Employer may enroll the Employee and the Dependent child with or without the Employee’s completed and signed enrollment form and may withhold any applicable payroll contributions from such Employee’s pay.

Open Enrollment
If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period that will be held annually. Plan coverage will be effective on the first of the month following the end of the Open Enrollment period.

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

Reinstatement / Rehire
If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA) and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). The Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with Federal law, certain Employees who return to employment following active duty service as a member of the United States Reserves or National Guard will be reinstated to coverage under the Plan (for themselves and any Dependents who were covered prior to the military assignment). Neither the waiting period requirement nor any Plan limitations with reference to pre-existing conditions will apply. However, this provision is intended to comply with the minimum requirements of the Veteran's Re-employment Rights Law and, if it is in conflict or incomplete in any way, such law will prevail.

TERMINATION OF COVERAGE

Employee Coverage Termination
An Employee's coverage under the Plan will terminate upon the earliest of the following:

- Termination of the Plan;
- Termination of Employee's eligibility or termination of participation in the Plan by the Employee;
- End of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e., Employee shares in the cost);
- At midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision.

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

Dependent Coverage Termination
A Dependent's coverage under the Plan will terminate upon the earliest of the following:

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

Extension of Coverage During Military Service
Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for a person entering military service. This includes the right to extend Plan coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

*- (See **COBRA Continuation Coverage**) -*

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must name the Plan and the Claimant, must include a list of services or supplies (or procedures or procedure codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services were received and the provider name, address, phone number and tax identification number.

A claim must be submitted to the following claims office within 1-year following the date of service:

Navia Benefit Solutions
PO Box 5809
Fresno, CA 93755

ASSIGNMENTS TO PROVIDERS

Plan benefits will be paid to the covered Employee except that: (1) assignments of benefits to providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan or enforce rights due under the Plan or any other causes of action he may have against the Plan or its fiduciaries.

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

*- (See **COBRA Continuation Coverage**) -*

EXTENSION OF COVERAGE PROVISIONS

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

Extensions of Coverage During Absence From Work
If an Employee fails to continue in active employment but is not terminated from employment (i.e., he is absence due to an approved leave, a temporary layoff, etc.), he may be permitted to continue coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis and are as outlined in the Employer's personnel policies or other Employee communications. Such documents are incorporated by reference.

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

- Date specified in the Employer's written personnel policies or Employee communications;
- End of the period for which the last contribution was paid, if such contribution is required;
- Date of termination of this Plan.

NOTE: The Plan Sponsor intends to comply with the Family and Medical Leave Act of 1993 (FMLA). To the extent that the FMLA applies to the Employer, Plan benefits may be maintained during certain leaves of absence at the levels and under the conditions that would have been present if employment was continuous. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave and notification and reporting requirements are specified in the FMLA. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

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

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time will be allowed for Claimants to respond, etc.).

Important: These claims procedures address the periods within which claims determinations will be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.

CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives Completing Information	Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.

CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.	

Authorized Representative May Act for Claimant
Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization.

Written or Electronic Notices
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial.

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial. The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

- Specific reason(s) for the decision to reduce or deny benefits;
- Specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules and protocols that were relied upon in making the decision;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice or a statement that the identity of the expert(s) will be provided upon request;

- A description of any additional information needed to change the decision and an explanation of why it is needed;

- A description of the Plan's procedures and time limits for appealed claims.

APPEAL PROCEDURES

Filing an Appeal
Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (comments, documents, records, etc.) in support of his appeal.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

NOTE: The Plan will not require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both will be completed within the time frame applicable to one (1) level.

Decision on Appeal
A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

- Specific reason(s) for the decision;

- Reference to the pertinent Plan provisions on which the decision is based;

- 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;

- Identification of any medical or vocational experts whose advice was obtained in connection with the claim denial;

- Identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

- A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

DEFINITIONS

When capitalized within the text of this booklet, the following terms will have the meanings shown below. Other capitalized terms may be defined in the Plan Document.

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

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Dentist - An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. A physician (M.D.) will be considered to be a Dentist when he performs any dental services within the operating scope of his license.

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

GENERAL PLAN INFORMATION

Name of Plan:	**El Centro Elementary School District Dental & Vision Benefit Plan**
Plan Sponsor / Plan Administrator:	**El Centro Elementary School District**
Address:	c/o Navia Benefit Solutions 5260 N Palm Ave Ste 300 Fresno, CA 93704
Business Phone Number:	(559) 259-1320
Plan Number:	**501**
Plan Year:	**October 1 through September 30**
Plan Benefits:	**Dental & Vision Benefits**
Named Fiduciary (Superintendent):	**Jon LeDoux / El Centro Elementary School District**

_____ _____

Chair Signature Date

Contract Administrator:	**Navia Benefit Solutions**
Address:	5260 N Palm Ave Ste 300 Fresno, CA 93704
Phone:	(559) 256-1320
Website:	www.asischools.com

FUNDING - SOURCES AND USES

Contribution Determinations
The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the Employer(s). Employee contributions are determined by the Plan Sponsor and in some instances may be subject to collective bargaining at the district level.

Employer contributions and those paid by Employee, if any, will be placed in a special account administered by the Contract Administrator to provide the non-insured benefits under the Plan.

Plan Funded Benefits
The contributions will be applied to provide the benefits under the Plan.

Administration Expenses
Contributions will also be used to pay administrative expenses of the Plan in accordance with the terms and conditions of an administration agreement between the Plan Sponsor and the Contract Administrator(s).

ADMINISTRATIVE PROVISIONS

Administration
Certain benefits of the Plan are administered by Contract Administrator(s) under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator(s).

Creditable Coverage Certificates - Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

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

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document. No action may be brought for benefits provided by the Plan or an amendment or modification thereof or to enforce any right thereunder, until after the claim has been submitted to and determined by the Plan and then action may only be brought within one year after the date of such decision.

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

- An employee's cessation of active service for the employer;
- Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- Dependent ceases to meet the Plan's eligibility requirements (i.e., a child reaches a maximum age limit or a spouse divorces);
- Claim for benefits is not filed within the time limits of the Plan.

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

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

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

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

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

- A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- Claims experience
- Receipt of healthcare
- Medical history
- Evidence of insurability
- Disability
- Genetic information

Privacy Rules & Security Standards & Intent to Comply
The Plan Sponsor certifies that the Plan is amended (by separate addendum) to comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rules”) of the Health Insurance Portability and Accountability Act (HIPAA). The Plan Sponsor also certifies that the Plan is amended to comply with HIPAA Security Standards with respect to electronic Protected Health Information.

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

Purpose of the Plan
The purpose of the Plan is to provide certain dental and vision benefits for eligible Employees of the Districts Employee and their eligible Dependents. The Plan is not a plan of insurance.

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

Right of Recovery
Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of the Plan Document, the Plan will have the right to recover all such excess amounts from any persons, insurance companies or other payees and the Employee or Dependent will make a good faith attempt to assist the Contract Administrator in such recovery.

The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder. The Covered Person (parent, if a minor) will execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Sponsor or Contract Administrator for the purpose of enforcing the Plan's rights under this provision.

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

Type of Plan
This Plan is an employer self-funded nonfederal dental benefit plan.

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

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Open enrollment rights which allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary.

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

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

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

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

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

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

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

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

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

The cost of COBRA continuation coverage can only increase if:

- Cost previously charged was less than the maximum permitted by law;
- Increase is due to a rate increase at Plan renewal;
- Increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage;
- Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments which are not significantly less than the required amount are deemed to satisfy the Plan's payment requirement, unless the Plan notifies the Qualified Beneficiary of the deficiency and grants a reasonable period of time (at least 30 days) to make full payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

- The date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary; the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

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

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

  - The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

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

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