

Plymouth-Canton Community Schools hereby establishes a Plan for payment of certain expenses for the benefit of its eligible employees to be known as the Plymouth-Canton Community Schools Employee Benefit Plan.

Plymouth-Canton Community Schools assures its covered employees that during the continuance of the Plan, all benefits hereinafter described shall be paid to or on behalf of them in the event they become eligible for benefits.

The Plan is subject to all the terms, provisions and conditions recited on the following pages hereof.

Plymouth-Canton Community Schools has caused this Plan to take effect as of 12:01 a.m. standard time on January 1, 2004 in Plymouth, Michigan.

Revised and restated effective September 1, 2006.

Sharon Kolassa
Supervisor of Employee Benefits
for Plymouth-Canton Community Schools

Dated: _____

Witnessed By: _____
Plymouth-Canton Community Schools Representative

Dated: _____

ACCEPTANCE FOR VISION BENEFITS

ACKNOWLEDGMENT

I CERTIFY THAT:

- I have received the following Plan Document and Summary Plan Description:

Plymouth-Canton Community Schools Employee Benefit Plan
Vision Benefits
Originally effective: January 1, 2004
Revised and restated effective: September 1, 2006

- I have reviewed and understand my rights to COBRA coverage described in the section of the Plan entitled COBRA CONTINUATION COVERAGE.

NOTE: Under COBRA, it is the responsibility of the employee or a family member to inform the employer of a divorce, judgment of separate maintenance, legal separation, or a child losing dependent status (e.g., student dependent status), within sixty (60) days of the qualifying event.

- I have reviewed and understand the exclusions and limitations of the Plan found in the section of the Plan entitled VISION EXCLUSIONS AND LIMITATIONS.

NAME

DATE

EMPLOYEE I.D. NUMBER

NOTE: Please sign and return this Acknowledgment Form **within ten (10) days** to:

Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170
734-416-4834

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
PLYMOUTH-CANTON COMMUNITY
SCHOOLS EMPLOYEE BENEFIT PLAN**

VISION BENEFITS

WEYCO, INC. PLAN NUMBER 929

IRS PLAN NUMBER 501

BRANCHES

000 – Transportation	200 – Transportation w/rider
001 – Teachers	201 – Teachers w/rider
002 – Custodial/Maintenance	202 – Custodial/Maintenance w/rider
003 – Clerical	203 – Clerical w/rider
004 – Cafeteria	204 – Cafeteria w/rider
005 – Non-affiliated Administrators	205 – Non-affiliated Administrators w/rider
006 – Affiliated Administrators	206 – Affiliated Administrators w/rider
007 – Licensed Technicians	207 – Licensed Technicians w/rider
008 – Security Guards	208 – Security Guards w/rider
009 – Bus Monitors	209 – Bus Monitors w/rider
010 – COBRA	210 – COBRA w/rider
011 – Plant Engineers	211 – Plant Engineers w/rider
012 – Paraprofessionals	212 – Paraprofessionals w/rider
013 – Extended Day and Preschool	213 – Extended Days and Preschool w/rider
014 – Dispatchers	214 – Dispatchers w/rider

**Effective January 1, 2004
Revised and Restated
Effective September 1, 2006**

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INTRODUCTION

This Plan Document and Summary Plan Description has been written to provide a clear understanding of the benefits available under this Plan. The benefits as herein described take precedence over, and replace any previous literature furnished.

Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vice versa, and the definition of any term herein in the singular shall also include the plural and vice versa.

The definition section shall prevail for all purposes within the Plan.

This Plan Document and Summary Plan Description is designed to help you understand your benefit Plan by explaining who is eligible for benefits, when you are eligible for benefits, what your benefits are, and how to file claims for your benefits.

This Plan Document and Summary Plan Description contains all the terms of the Plan and may be amended from time to time by the company or alternatively may be terminated by the company. Any changes so made shall be binding on each covered participant and on any other covered persons referred to in this Plan Document and Summary Plan Description. In the case of a collectively bargained plan, these terms shall be maintained pursuant to the collectively bargained agreement.

**PROTECTED HEALTH INFORMATION (PHI), ELECTRONIC
PROTECTED HEALTH INFORMATION (EPHI), AND
STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE
HEALTH INFORMATION (IIHI) “THE PRIVACY AND SECURITY
STANDARDS”**

DISCLOSURE OF SUMMARY HEALTH INFORMATION (SHI) TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purposes of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographical information to the extent that it is aggregated by a five-digit zip code.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Document/Summary Plan Description or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for 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 PHI infeasible; and
10. Ensure that the adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - a. Only certain named employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed. You may contact the Plan Sponsor for a list of those persons.
 - b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Document/Summary Plan Description relating to use and disclosures of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Document/Summary Plan Description has been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

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

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Benefit Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

ELECTRONIC PROTECTED HEALTH INFORMATION (EPHI) – Effective April 20, 2006

The Plan Sponsor agrees that with respect to any Electronic Protected Health Information disclosed to it by the Plan, or any other covered entity, the Plan Sponsor shall:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect the information; and
3. Report to the Plan any security incident, as defined by the Security Rule, of which it becomes aware; and
4. Ensure that adequate separation required by the Security Rule is established.

The Plan Sponsor shall only allow employees of the Plan Sponsor with specific classifications/designations who have been designated to carry out plan administrative functions (as indicated by the Document Signee on the Confidentiality Agreement provided by the Plan Sponsor to WEYCO, INC.) access to EPHI. These specified employees shall only have access to and use EPHI to the extent necessary to perform those administrative functions for the Plan. In the event any of these specified employees do not comply with the provisions of this amendment, that employee shall be subject to disciplinary action by the Plan Sponsor for noncompliance pursuant to the discipline and termination procedures of the Plan Sponsor.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose health information in a manner that is inconsistent with the Security Rule.

ELIGIBILITY PROVISIONS

EMPLOYEE ELIGIBILITY

Persons eligible for coverage under this Plan shall include only employees employed by the employer on a regular full-time or part-time basis. An employee is considered to be full-time or part-time if he or she normally works the minimum contracted number of hours per week (as defined by the applicable collective bargaining agreement) and is on the regular payroll of the employer for that work.

WHEN THE EMPLOYEE BECOMES ELIGIBLE

1. Each employee in an eligible class whose employment commenced on or before the effective date of this Plan, and who was covered under the prior plan, shall become eligible for employee coverage on the Plan's effective date.

Persons commencing employment after the Plan effective date shall be eligible for vision coverage the first of the month following completion of the employment waiting period as defined by the applicable collective bargaining agreement.

Persons employed before the Plan effective date, but not having satisfied the prior plan's eligibility waiting period, will be given credit for time already earned toward the satisfaction of the waiting period under this Plan.

2. An employee who does not apply for coverage within thirty-one (31) days of the date he becomes eligible for coverage, will be effective the first of the month following application for coverage providing the application is received by the Plan Administrator no later than ninety (90) days following initial eligibility. An employee who applies for coverage later than ninety (90) days may have to wait until the next annual open enrollment period to enroll.
3. The eligibility wait period shall be waived for employees (and their eligible dependents) who are reinstated subject to employer policy and contracted requirements (as defined by the applicable collective bargaining agreement).
4. An employee must elect to decline or to enroll for coverage annually by filling out and signing an enrollment application.

OPEN ENROLLMENT/ELECTION PERIOD

An employee and/or dependent who does not apply for coverage when he is initially eligible but later wishes to apply, may do so only during the open enrollment/election period in June for an effective date of September 1. However, he may apply before the open enrollment/election period if a qualifying event occurs such as marriage, birth, adoption or involuntary loss of coverage from another Plan.

During the annual open enrollment period, eligible employees and their eligible dependents will be able to change their benefit elections based on which benefits and coverages meet their needs.

NOTICE OF SPECIAL ENROLLMENT PERIOD

If you are declining enrollment for yourself or your dependents (including your spouse), you must provide the reason for declining in writing. If written notice is not provided, a special enrollment period may not be provided to you or your dependents.

If coverage is declined because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within thirty-one (31) days after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

Coverage under the special enrollment period must be effective no later than the first (1st) day of the month after an employee requests the enrollment for himself/herself or on behalf of a dependent. In the case of a dependent special enrollment period, HIPAA provides that coverage with respect to a marriage is effective no later than the first (1st) day of the month after the date the request for enrollment is received and coverage with respect to a birth, adoption, or placement for adoption is effective on the date of the birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Employee Benefits Department
Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170
734-416-4834

WHEN EMPLOYEE COVERAGE IS TERMINATED

The coverage of any employee shall automatically cease at the earliest time indicated below, except as provided in the Continuation of Benefits (COBRA) provision:

1. The last day of the calendar month in which employment terminates;
2. **NOTE:** Teachers are carried to the end of their contract if they worked throughout the school year.
3. The last day of the calendar month in which the employee ceases to be in a class of employees eligible for coverage;
4. If due to non-payment of required contributions (if applicable), the last day of the calendar month for which required contributions were paid;
5. Date Plan is terminated;

6. The last day of the calendar month in which the employer terminates employee's coverage;
7. Day after the employee dies.

WHEN THE EMPLOYEE MAY CONTINUE BENEFIT COVERAGE

Benefit coverage may be continued for all benefits:

1. Up to twelve (12) weeks during an approved leave of absence that qualifies under the Family and Medical Leave Act of 1993.
2. Up to end of the month in which the employer ends continuance as defined by the applicable collective bargaining agreement for an employees that becomes totally disabled.
3. Up to end of the month in which the employer ends continuance as defined by the applicable collective bargaining agreement for an employee on an approved leave of absence or a layoff.

NOTE: A leave that qualifies under the Family and Medical Leave Act of 1993 (FMLA) will not be applied toward the continuation period available under COBRA. Any other period of leave that does not qualify under the FMLA may apply toward the continuation period available under COBRA if a qualifying event (as defined by COBRA) occurs at the time of leave, or during the period of leave.

No benefits are payable for charges incurred after an individual's benefit coverage ends.

EMPLOYEES ON MILITARY LEAVE

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights include up to eighteen (18) months of extended coverage (twenty-four (24) months if the election for USERRA coverage is made on or after December 10, 2004) upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no pre-existing condition limitation applied upon return from service. These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

Plan exclusions and waiting periods may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

WHEN THE DEPENDENT BECOMES ELIGIBLE

1. Eligible dependents include a spouse and any unmarried child until the end of the calendar year in which they turn nineteen (19). (To be covered until the end of the calendar year, the child must still meet the eligibility requirements; otherwise, coverage will be terminated the date they are no longer an eligible dependent.) You may cover any unmarried child until the end of the calendar year in which they turn twenty-five (25) if the child is dependent upon you for more than half of their support, resides with you, and is currently a full-time student in an accredited college, university or any other accredited school at least five (5) months of the year *or* had a gross income of less than four (4) times the personal exemption allowance.

A child may be covered to any age “if totally and permanently” disabled by either a physical or mental disability that occurred prior to the limiting age of nineteen (19).

NOTE: The employee shall be required to present, upon request, to the employer certified documentation providing proof of parentage, spousal and/or dependent relationships, proof of the physically or mentally disabled, and proof of dependent eligibility status. This required documentation may be requested at any time to determine eligibility status.

2. Coverage for a dependent will be effective on the date the employee’s coverage becomes effective if he applies for dependent coverage when he enrolls in the Plan. In no event will the employee’s dependents be covered before the date the employee’s coverage begins. An employee without a dependent on the date he becomes eligible for coverage who later acquires a dependent may enroll his dependent in this Plan by written application within thirty-one (31) days after he acquires that dependent.

A newborn child, adopted child, or child placed for adoption will be covered from birth, adoption, or placement for adoption, if enrolled within the thirty-one (31) day period following birth, adoption, or adoption placement.

This Plan is intended to comply with OBRA ’93 with respect to dependent child eligibility and Qualified Medical Child Support Orders.

3. If coverage for a dependent (including newborns, adopted children, or children placed for adoption) is applied for more than thirty-one (31) days following the date that dependent becomes eligible for coverage, coverage will be effective the first of the month following application for coverage providing the application is received by the Plan Administrator no later than ninety (90) days following initial eligibility. If coverage for a dependent is applied for later than ninety (90) days following the date of initial eligibility, you may have to wait until the next annual open enrollment period to enroll the dependent..

WHEN DEPENDENT COVERAGE IS TERMINATED

NOTE: Under COBRA, it is the responsibility of the employee or a family member to inform the employer of a divorce, judgment of separate maintenance, legal separation, or a child losing dependent status (e.g., student dependent status), within sixty (60) days of the qualifying event.

The coverage of any covered dependent shall automatically cease at the earliest time indicated below, except as provided in any Continuation of Benefits (COBRA) provision:

1. The last day of the calendar month in which the employee’s employment terminates;
2. The last day of the calendar month in which the employee ceases to be in a class of employees eligible for coverage;
3. If due to non-payment of required contributions (if applicable), the last day of the calendar month in which the employee fails to make any required contribution for coverage;
4. Date Plan is terminated;

5. The last day of the calendar month in which the employer terminates employee's coverage;
6. The last day of the calendar month in which the employee dies;
7. The last day of the calendar month in which the dependent loses his eligible status as defined herein:

- a. For spouses:

Upon judgment of separate maintenance or legal separation (if applicable within your State); or

Upon divorce.

- b. For children:

Upon reaching the end of the calendar year in which they turn nineteen (19) (if not enrolled as a full-time student); or

(NOTE: Upon reaching age nineteen (19), the dependent must continue to meet eligibility requirements to be covered until the end of the calendar year. Coverage will terminate the date the child is no longer considered an eligible dependent.)

Upon reaching the end of the calendar year in which they turn twenty-five (25) or ceasing to be a full-time student, whichever occurs first; or

Upon marrying; or

Upon becoming a full-time member of the Armed Forces of any country; or

In the case of a disabled dependent, upon the dependent being medically certified as no longer totally and permanently disabled by either a physical or mental disability that substantially limits one or more of such person's major life activities, or not being able to perform the normal activities of a person of like age and sex in good health.

If two (2) employees under this Plan are married, they may be covered under this Plan as both an employee and a dependent. Eligible dependent children of two (2) covered employees may be enrolled as dependents of both employees, whether the employees are married or unmarried.

This Plan will coordinate benefits between the two (2) plans following the guidelines as described in the "Coordination of Benefits" section of this Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Plan Administrator shall adhere to the terms of any medical child support order that satisfies the requirements of this Section. A medical child support order is any judgment, decree, or order (including a court approved property settlement agreement) issued by a court of competent jurisdiction which (a) relates to the provision of child support with respect to the child of a Participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to medical benefits under the Plan, or (b) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a Participant or beneficiary under the Plan. For purposes of this Section, an "alternate recipient" shall mean any child of a Participant who is recognized by a medical child support order as having a right to enrollment under this Plan with respect to the Participant.

A Qualified Medical Child Support Order must clearly specify: (a) the name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order; (b) a reasonable description of the type of coverage to be provided under the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined; (c) the period to which such order applies; and (d) each plan to which such order applies.

Any Qualified Medical Child Support Order shall not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993).

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the "qualified" status of medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether the order is a Qualified Medical Child Support Order and shall notify the Participant and each alternate recipient of this determination. If the Participant or any affected alternate recipient disagrees with the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Alternate recipients of a Qualified Medical Child Support Order shall be treated as beneficiaries under the Plan.

Payments under this Plan pursuant to a Qualified Medical Child Support Order in reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

VISION SCHEDULE OF BENEFITS

All eligible expenses are reimbursed on a year defined as the 12-month period of January 1 through December 31.

PLAN II – ALL EMPLOYEES EXCEPT TEACHERS

BENEFIT	COVERAGE INFORMATION
Eye Examinations	100% R&C to a maximum benefit of \$48.00 per calendar year per covered person
Lenses:	
Single	100% R&C to a maximum benefit of \$63.00 per calendar year per covered person
Bifocal	100% R&C to a maximum benefit of \$72.00 per calendar year per covered person
Trifocal	100% R&C to a maximum benefit of \$90.00 per calendar year per covered person
Progressive	100% R&C to a maximum benefit of \$108.00 per calendar year per covered person
Contact Lenses NOTE: Contact lenses are in lieu of lenses and frames	100% R&C to a maximum benefit of \$150.00 per calendar year per covered person
Frames	100% R&C to a maximum benefit of \$44.00 per calendar year per covered person

PLAN III –TEACHERS (BRANCHES 001 AND 201)

BENEFIT	COVERAGE INFORMATION
Eye Examinations	100% R&C to a maximum benefit of \$75.00 per calendar year per covered person
Lenses:	
Single	100% R&C to a maximum benefit of \$100.00 per calendar year per covered person
Bifocal	100% R&C to a maximum benefit of \$100.00 per calendar year per covered person
Trifocal	100% R&C to a maximum benefit of \$125.00 per calendar year per covered person
Progressive	100% R&C to a maximum benefit of \$125.00 per calendar year per covered person
Contact Lenses	100% R&C to a maximum benefit of \$150.00 per calendar year per covered person
NOTE: Contact lenses are in lieu of lenses and frames	
Frames	100% R&C to a maximum benefit of \$75.00 per calendar year per covered person

NOTE: The provisions of the Medical Plan are incorporated by reference in the Vision Plan except where inconsistent with provisions of the Vision Plan.

VISION EXCLUSIONS AND LIMITATIONS

1. Any services or supplies to the extent that benefits are payable for such expenses under another provision of this Plan or any other health Plan provided by the employer.
2. Charges that are incurred before a person is enrolled under this Plan, or charges that are incurred after the individual ceases to be an enrolled person except as permitted by the Continuation of Benefits (COBRA) provision of this Plan.
3. Charges incurred in excess of any plan maximums.
4. Any covered expense which is in excess of the reasonable and customary charge for similar services, supplies, and treatments.
5. Charges for which a covered person would not legally have to pay if there were no coverage.
6. Charges in connection with the preparation of reports, claim forms or any other necessary documentation, or charges for appointments that are not kept.
7. Charges in connection with an illness or injury sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit, and for which benefits are payable in accordance with the provisions of Worker's Compensation or any similar law.
8. Special procedures, such as orthoptics, vision training, or subnormal vision aids.
9. Plain or prescription sunglasses or any lens with a tint greater than number two (2).
10. Medical or surgical treatment of the eyes.
11. Insurance premium for lenses and/or frame replacement policies.
12. Safety glasses.
13. Charges for coating or laminating of the lens or lenses.
14. Any eye exam or any corrective eyewear required by an employer as a condition of employment.
15. Two (2) pair or glasses in lieu of bifocals.
16. Charges for vision therapy.
17. Taxes on contact lenses and follow-up care to train first time contact lens wearers.

CLAIMS FILING AND REVIEW PROCEDURES

THE SUBMISSION OF CLAIMS:

Time Lines

New time lines are established for responding to and reviewing health care claims, based on whether the claim is determined by the health care plan as it relates to pre-service urgent care, pre-service non-urgent care, post service care, or a concurrent care decision. For applicable time lines see Examples A & B at the end of this section.

The Plan Administrator shall notify the claimant of the benefit determination within ninety (90) days after receipt of a claim by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time up to an additional ninety (90) days for processing the claim.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be afforded forty-five (45) days to provide the specified information.

NOTIFICATION OF THE INITIAL BENEFIT:

Urgent Care Determinations

An urgent care claim is any claim for which the application of the standard time periods for determining claims a prudent layperson would consider, or the patient's physician determines, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or for which delayed treatment would cause the patient severe pain.

In the case of a determination involving urgent care, the Plan Administrator shall notify the claimant of the Plan's benefit determination within seventy-two (72) hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant within twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be permitted forty-eight (48) hours to provide the specified information.

NOTE: Informal DOL guidance has indicated, that urgent care claims are a sub-set of pre-service claims, such as claims that by the terms of the Plan will not be covered unless approved prior to the treatment, service or the procedure is provided.

Pre-Service Determinations

A pre-service non-urgent care claim is one where the receipt of the benefit is conditioned on approval **before** the service is rendered.

In the case of an initial pre-service determination, the Plan Administrator shall notify the claimant of the Plan's benefit determination within fifteen (15) days after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be permitted forty-five (45) days to provide the specified information.

Post-Service Determinations

A post-service care claim is one that may be filed and approved **after** the service is rendered.

In the case of a post-service claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination within thirty (30) days after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be permitted forty-five (45) days to provide the specified information.

Concurrent Care Determinations

A concurrent care decision is one where the Plan has approved an ongoing course of treatment, and then the Plan reduces or terminates coverage for that course of treatment (other than by amendment or plan termination) before the end of the pre-approved course of treatment. This is an adverse benefit determination that can be appealed as a concurrent care claim.

In the case of a reduction or termination of an ongoing course of treatment that the Plan had previously approved, the Plan Administrator shall notify the claimant of the Plan's benefit determination within a reasonable period of time.

In the case of a claimant's request to extend the course of treatment previously approved by the Plan, the Plan Administrator shall notify the claimant of the Plan's benefit determination within a reasonable period of time. In no event shall the period of time exceed twenty-four (24) hours after receipt of the claim.

NOTIFICATION OF INITIAL ADVERSE BENEFIT DETERMINATION:

A notice of benefit determination will be sent to the claimant in written or electronic format in a manner considered to be understood by the claimant as outlined below.

The notification to the claimant shall include:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the determination is based; and
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; and
4. A description of the Plan's review procedures and the time limits applicable to such procedures; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination; a copy of such rule, guideline, protocol, or other criterion will be provided to the claimant at no charge, upon written request; and
6. If the adverse benefit determination is based on medical necessity, experimental treatment or similar exclusion or limitation, then either an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided at no charge, upon written request; and
7. If a medical or vocational expert is consulted by the Plan, the identity of that person or persons must be provided, even if their advice was not relied upon in making the decision.

NOTIFICATION APPLICABLE TO CLAIMS INVOLVING URGENT CARE:

The Plan Administrator shall be entitled to inform the claimant orally within the time frame prescribed within this Plan, provided that a written or electronic notification is furnished to the claimant within three (3) days after the oral notification.

The notification to the claimant shall include:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific Plan provisions on which the determination is based; and
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; and
4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination; a copy of such rule, guideline, protocol, or other criterion will be provided to the claimant at no charge, upon written request; and
6. If the adverse benefit determination is based on medical necessity, experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment

relied upon for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided at no charge, upon written request; and

7. A description of the review process applicable to such claims will be sent to the claimant.

TIMING TO APPEAL AN ADVERSE BENEFIT DETERMINATION:

The claimants who wish to appeal an adverse benefit determination shall:

1. Receive full and fair review of the claim and the appeal of the adverse benefit determination;
2. The request for an appeal of an adverse benefit determination must be in writing, and filed with the third party administrator who shall receive the request on behalf of the Plan Administrator who is the named fiduciary of the Plan. Address your appeal request to:

Plan Administrator – Appeals
c/o WEYCO, INC.
2370 Science Parkway
Okemos, MI 48864

3. Claimants shall have one hundred-eighty (180) days to file an appeal following receipt of an adverse benefit determination.
4. Any and/or all additional information must be submitted to WEYCO, INC. before the final decision has been made by the Plan Administrator. No additional information will be considered after that final decision.

PROCESS FOR APPEAL OF ADVERSE DETERMINATIONS:

An appeal of an adverse determination shall:

1. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject to the appeal, nor the subordinate of such individual;
2. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part 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 appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
3. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
4. Provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse

benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

5. Provide, in the case of a claim involving urgent care, for an expedited review process.

CLAIMANT’S RIGHT TO BRING CIVIL SUIT:

1. The claimant has the right to bring a civil action following an adverse benefit determination on review; and
2. Other voluntary alternative dispute resolutions may be available. The claimant should contact the local office of the DOL or the state insurance regulatory agency as indicated within the Plan Document. Copies of the documents, records and other information relevant to the denied claim shall be made available to the claimant at no charge, upon written request.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION OF A CLAIM REVIEW:

1. Urgent Care Determinations. The Plan Administrator shall notify the claimant of the benefit determination concerning the urgent care claim within seventy-two (72) hours after receipt of claimant’s request.
2. Pre-Service Determinations. The Plan Administrator shall notify the claimant of the benefit determination concerning a pre-service claim within thirty (30) days after receipt of claimant’s request.
3. Post-Service Determinations. The Plan Administrator shall notify the claimant of the benefit determination within sixty (60) days after receipt of claimant’s request.
4. Concurrent Care Determinations. The Plan Administrator shall notify the claimant of the Plan’s benefit determination within a reasonable period of time not to exceed seventy-two (72) hours, thirty (30) days or sixty (60) days as applicable in the case of a reduction or termination of an ongoing course of treatment that the Plan had previously approved.

NOTE: For applicable time lines see Examples A & B at the end of this section.

CONTENT OF THE NOTIFICATION OF A BENEFIT REVIEW:

A notice of benefit determination of the claim will be sent to the claimant in written or electronic format in a manner calculated to be understood by the claimant containing the information as specified below.

The notification to the claimant shall include:

1. The specific reason or reasons for the adverse determination; and
2. Reference to the specific Plan provisions on which the benefit determination is based; and
3. A statement that the claimant is entitled to receive at no charge and upon written request, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; and

4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination; a copy of such rule, guideline, protocol, or other criterion will be provided to the claimant at no charge and upon request; and
5. If the adverse benefit determination is based on medical necessity, experimental treatment or similar exclusion or limitation, then either an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided at no charge and upon written request; and
6. You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency.

EXAMPLE A

TIME PERIODS FOR FILING AND REVIEWING CLAIMS FOR GROUP HEALTH PLANS*

	Notice of Improperly Filed Claim	Notice of Insufficient Information	Initial Determination	Time Allowed Claimant to Provide Additional Information	Extensions on Initial Determination	Time to Seek Review of Denied Claim	Time for Decision on Review	Extensions for Decision on Review
Urgent Care Claims	24 hours	24 hours	72 hours from time claim filed, or earlier of 48 hours after info provided or time to do so ends**	At least 48 hours	N/A	No specific time period provided, but up to 180 days allowed	72 hours	No extension allowed
Pre-service Claims	5 days	Within 15 days	15 days	Up to 45 days	One extension of 15 days, if needed	Up to 180 days	30 days	No extension allowed
Post-service Claims	N/A	Within 30 days	30 days	Up to 45 days	One extension of 15 days, if needed	Up to 180 days	60 days	No extension allowed
Concurrent Care Claims	N/A	N/A	24 hours, if urgent care; otherwise, enough time before cut-off to appeal	N/A	N/A	N/A	72 hours, 30 days or 60 days, as applicable	No extension allowed

***All time is measured in calendar days from date claim is received, even if incomplete. Where additional information is requested, no time is counted until information is received.**

**** Adverse determination may be given orally, if written or electronic notice is provided within 3 days.**

EXAMPLE B

D.O.L. TIME PERIODS FOR FILING AND REVIEWING CLAIMS

Urgent Care Claims

- Notice of Improperly Filed Claim
- Notice of Insufficient Information
- Initial Determination

- Time Allowed Claimant to Provide Additional Info
- Extensions on Initial Determination

Time Frames

24 hours
24 hours
72 hours from time filed, or earlier of 48 hours after info provided or time to do so ends
At least 48 hours
N/A

Pre-Service Claims

- Notice of Improperly Filed Claim
- Notice of Insufficient Information
- Initial Determination
- Time Allowed Claimant to Provide Additional Info
- Extensions on Initial Determination

5 days
Within 15 days
15 days
Up to 45 days
One extension of 15 days, if needed

Post-Service Claims

- Notice of Improperly Filed Claim
- Notice of Insufficient Information
- Initial Determination
- Time Allowed Claimant to Provide Additional Info
- Extensions on Initial Determination

N/A
Within 30 days
30 days
Not less than 45 days
One extension of 15 days, if needed

Concurrent Care Claims

- Notice of Improperly Filed Claim
- Notice of Insufficient Information
- Initial Determination

- Time Allowed Claimant to Provide Additional Info
- Extensions on Initial Determination

N/A
N/A
24 hours if urgent care; otherwise, enough time before cut-off to appeal
N/A
N/A

APPEALS

Urgent Care Claims

- Time to Seek Review of Denied Claim
- Time for Decision on Review
- Extensions for Decisions on Review

Time Frames

No specific time period provided, up to 180 days allowed
72 hours
No extension allowed

Pre-Service Claims

- Time to Seek Review of Denied Claim
- Time for Decision on Review
- Extensions for Decisions on Review

Up to 180 days
30 days
No extension allowed

Post Service Claims

- Time to Seek Review of Denied Claim
- Time for Decision on Review
- Extensions for Decisions on Review

Up to 180 days
60 days
No extension allowed

Concurrent Care Claims

- Time to Seek Review of Denied Claim
- Time for Decision on Review
- Extensions for Decisions on Review

N/A
72 hours, 30 days or 60 days as applicable
No extension allowed

CLAIM FILING PROCEDURE

WEYCO, INC. of Lansing, Michigan will process your claims.

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY. THIS WILL ASSURE PROMPT PAYMENT OF YOUR CLAIMS.

A. VISION EXPENSES

Have the provider of service send the itemized bill to WEYCO, INC. If the bill is sent to your home, submit the itemized bill to WEYCO, INC.:

WEYCO, INC.
P.O. Box 30132
Lansing, Michigan 48909-7632

B. ORIGINAL BILLS

Submit only the original bills. Keep copies for your records or your spouse's insurance. Copies will be accepted only if the Plymouth-Canton Community Schools Employee Benefit Plan is secondary in coordination.

C. ITEMIZED BILLS

Your Plan requires that all bills be itemized. WEYCO, INC. will process only itemized bills.

The bill must include:

1. Patient's name
2. Date of service
3. Services rendered
4. Amount charged for each service performed
5. Provider's name, address and federal tax identification number

D. AUTOMATIC ASSIGNMENT OF BENEFITS

1. Unpaid bills - Payment of all unpaid bills will be made payable to the provider of service and mailed to the provider.
2. Paid bills - Payment of all paid bills will be made payable to the employee and mailed to the employee. If you have paid the bill, be sure "paid" is indicated on the bill.

E. EXPLANATION OF BENEFITS

Each time WEYCO, INC. processes a claim for you or a member of your family, they will respond with an Explanation of Benefits informing the patient what the charges were, how the charges were paid, and to whom the payments were made.

F. DEADLINE FOR FILING CLAIMS

You and your covered dependents must file any vision claim in accordance with the above procedure within 15 months of the date of service in order for such claim to be considered an allowable expense under this Plan.

G. COORDINATION OF BENEFITS

If you are covered by two (2) plans (this Plan and your spouse's plan), both plans may pay. However, the combination of payment from both plans cannot exceed 100%.

This Plan will pay the remaining balance within R&C guidelines, not to exceed Plan maximums. Those employees covered as employees and dependents (or a dependent covered by 2 employees) are eligible for benefits as both employees and dependents up to the Plan maximum.

File your claims in the following manner:

1. Employees of Plymouth-Canton Community Schools

Submit your original bills to WEYCO, INC. Keep copies of the bills. When you receive the explanation of benefits, send a copy of the bill(s) and a copy of the explanation of benefits to your spouse's insurance company.

2. Your spouse if covered by another employer's plan

Your spouse should send his/her bills to his/her insurance company first and WEYCO, INC. second. Send WEYCO, INC. a copy of the explanation of benefits from his/her insurance company and a copy of the bill(s).

3. Children

If children are covered by both parents' plans, the plan of the parent with the birth date earliest in the calendar year will pay first. The plan of the parent with the later birth date will pay second.

4. Divorce

The plan of the parent with custody of the children will pay first and the plan without custody will pay second unless the divorce decree mandates otherwise.

5. Motor Vehicle Accidents

This Plan will pay for eligible expenses in connection with motor vehicle-related accidents/injuries only after any benefits available from automobile insurance have been paid.

6. COBRA

A plan that covers the individual as an active employee or dependent of an active employee will be considered to pay its benefits before a plan that covers the individual as a COBRA participant.

GENERAL PLAN INFORMATION

PLAN NAME

Plymouth-Canton Community Schools Employee Benefit Plan

TYPE OF PLAN

Welfare Plan providing vision benefits.

PLAN BENEFITS PROVIDED BY

Plymouth-Canton Community Schools

PLAN ADMINISTRATOR AND SPONSOR

Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170
734-416-4834

BENEFIT ADMINISTRATOR – VISION

WEYCO, INC.
2370 Science Parkway
Okemos, Michigan 48864

AGENT FOR SERVICE OF LEGAL PROCESS

Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170

PLAN NUMBER

WEYCO, INC.: 929

IRS: 501

EMPLOYER IDENTIFICATION NUMBER

38-6004186

PLAN YEAR ENDS

August 31

BENEFIT YEAR

January 1 through December 31

INSTITUTION HOLDING PLAN FUNDS

Bank One

PLAN COSTS

All contributions for participation in this Plan for a full-time employee shall be made by the employer. All contributions for participation in this Plan for a part-time employee shall be shared by the employer and part-time employee.

FUNDING AND PAYMENT OF CLAIMS

The benefits described herein are self-funded by the employer and are not insured by an insurance company. WEYCO, INC. is a Benefit Administrator who processes claims and does not insure benefits described in this Plan. If for any reason the Plan Administrator does not ultimately pay expenses under this Plan, the individuals covered by the Plan will be liable for those expenses.

PLAN ASSET DISTRIBUTION AFTER TERMINATION OF THE PLAN

Information concerning asset distribution after termination of the Plan shall be made available by the Plan Administrator at no cost upon written request.

GOVERNING LAW

This Agreement shall be governed by and construed under the laws of the State of Michigan to the extent not preempted by Federal law.

RIGHTS RESERVED

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan and any or all benefits provided under the Plan, covering any active employee or current or future retiree or dependent in whole or in part at any time. Any such change or termination in benefits will be based solely on the decision of the Plan Sponsor and may apply to all eligible active and nonactive employees and dependents as either separate groups or as one group, regardless of status. For the Union employees, this Plan is maintained pursuant to a collective bargaining agreement.

When changes are made to Plymouth-Canton Community Schools benefit plan(s), they are made in the form of amendments and/or summaries of material modification. The procedure for amending a plan is as follows:

- a. The proposed amendment request by the Plan Sponsor is sent to the Benefit Administrator of the plan.
- b. The Benefit Administrator develops an amendment and/or summary of material modification in accordance with the amendment request from the Plan Sponsor. The Supervisor of Employee Benefits of Plymouth-Canton Community Schools will then approve and sign the amendment and/or summary of material modification.

- c. The approved amendment and/or summary of material modification becomes part of the plan document and summary plan description and is available to the Department of Labor upon request. Adoption of an amendment and/or summary of material modification shall be effective immediately upon approval by the Plan Sponsor. Alternatively, the amendment and/or summary of material modification shall be retroactively effective (to the extent permitted by law) if the amendment and/or summary of material modification so states. The Plan Sponsor will notify plan participants of the amendment and/or summary of material modification, in writing.

NAMED FIDUCIARY

Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170
734-416-4834

The Plan has granted the Plan Fiduciary final discretionary authority in determining eligibility for benefits or to interpret the terms of the Plan for claims purposes.

EMPLOYEE BENEFITS SECURITY ADMINISTRATION

For additional information on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), please contact the following:

Michigan residents

Employee Benefits Security Administration
211 W. Fort Street, Suite 1310
Detroit, Michigan 48226-3211
(313) 226-7450

Non-Michigan residents

Employee Benefits Security Administration
200 Constitution Avenue, NW
Room N56226
Washington, D.C. 20210
(202) 219-8776

COORDINATION OF BENEFITS

NOTE: This Plan is intended to comply with the National Association of Insurance Commissioners (NAIC) Model Coordination of Benefits Rules.

The Coordination of Benefits provision applies when the employee or any person in his family is covered by this Plan and is covered by any other group plan(s). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses.

If two (2) employees are married and either or both are covered under the other's plan, this Plan will coordinate benefit payments within this contract. This shall also apply to any eligible dependent children covered under both parents' plan. This provision shall apply to any eligible dependent children of two (2) unmarried employees who are both covered under this Plan. This Plan will pay the remaining balance within the fee schedule not to exceed Plan maximums. Those employees covered as employees and dependents (or a dependent covered by two (2) employees) are eligible for benefits as both employees and dependents up to the Plan maximum.

In no event will this Plan coordinate benefits for expenses that are not considered "allowable expenses" under the terms and conditions of this Plan. "Allowable expense" shall be deemed to mean any necessary, reasonable and customary item of expense for services, supplies, or treatment which is covered under this Plan. "Plan" shall be deemed to mean any plan providing benefits or services by group insurance coverage or any other arrangement of coverage for individuals in a group, whether on an insured or an uninsured basis, including any governmental program (except Medicaid) or coverage required or provided by statute.

ORDER OF PAYMENT

According to the following section outlining the order of payment, one (1) plan will be designated as the "primary plan" and succeeding plans will be designated as "secondary plans."

The "primary plan" will pay expenses based on the payment obligations it has established under its Schedule of Benefits, and all "secondary plans" will then adjust their expense payments so that the total benefits available to the covered person will not exceed the benefit allowable under the Coordination of Benefits Provisions of the Plan. This Plan will never pay more than it would without this coordination provision.

When a person is covered under two (2) or more plans, the rules below will apply to decide which plan's benefits are payable first:

1. A plan with no provision for coordination of benefits will be considered to pay its benefits before a plan that contains such a provision.
2. A plan that covers an individual as other than a dependent (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.
3. The Plan that covers a person as an employee who is neither laid off or retired (or as that employee's dependent) is primary. 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 is ignored. Coverage provided to an

individual as a retired worker, and as a dependent of an actively at work spouse will be determined under Rule #2.

4. If two (2) plans cover a dependent child, the Plan of the person whose birthday anniversary occurs earlier in the calendar year shall be primary if:
 - a. The parents are married; or
 - b. The parents are not separated (whether or not they have ever been married); or
 - c. A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

If both parents have the same birthday, the Plan that has covered either of the parents longer is primary.

5. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.

If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which the benefits are paid or provided before the entity has actual knowledge. (If it is determined that another plan is primary due to the terms of the divorce decree after the secondary plan has paid as primary, the secondary plan will not retroactively seek refunds of the overpayments it previously issued as the primary plan.)

6. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parent's spouse (if any) is:
 - a. The plan of the custodial parent
 - b. The plan of the spouse of the custodial parent
 - c. The plan of the non-custodial parent
 - d. The plan of the spouse of the non-custodial parent
7. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. 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 is ignored.

8. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.
 - a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.
 - b. The start of a new plan does not include:
 - A change in the amount or scope of a plan's benefits; or
 - A change in the entity that pays, provides, or administers the plan's benefits; or
 - A change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan).
 - c. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
9. If another plan contains a provision whereby such plan considers their plan to be excess of other available benefits or considers their plan to be secondary only in normal coordination of benefits situations, this plan will coordinate to consider benefits payable on a 50%/50% basis, between this plan and the other plan.
10. If none of these preceding rules determines the primary plan, the allowable expenses shall be determined equally between the plans.

The total maximum benefit limits under this Plan will only be reduced by the charges actually paid by this Plan. Any benefits coordinated and paid by other coverage providers will not be charged against the benefit limits of this Plan.

AUTOMOBILE INSURANCE, INCLUDING NO-FAULT INSURANCE

This Plan will pay for eligible expenses in connection with motor vehicle-related accidents/injuries only after any benefits available from automobile insurance have been paid.

MEDICARE

This Plan is intended to comply with Federal Regulations as they apply to plans with respect to Medicare coverage and coordination of benefits.

In determining Medicare benefits, it will be assumed that the covered person has full medical coverage (that is, both Part A and Part B) whether or not the covered person has enrolled for the full coverage.

In the case of services and supplies for which Medicare makes direct reimbursement to the health care provider, this Plan will coordinate its benefits based on the amount approved by Medicare and not the amount of the charge.

COORDINATION WITH MEDICAID

Notwithstanding any other provisions of this Plan to the contrary, this Plan shall not take into account that a covered person or covered person's beneficiary qualifies for medical assistance under a State Medicaid plan when determining eligibility for Plan enrollment or the payment of Plan benefits.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, AS AMENDED (COBRA) :

YOUR CONTINUATION COVERAGE RIGHTS

NOTE: COBRA administration, in accordance with federal law, remains the sole responsibility of the Plan Administrator as fiduciary of the Plan, even when COBRA administration functions are contracted to a third party (“agent”). WEYCO, INC. is the ministerial agent and the benefits administrator for the Plan Administrator and the Plan.

If you, your spouse, or your dependent children are covered under the Plan and coverage under the Plan terminates due to certain events described below (commonly referred to as "qualifying events"), you may elect to continue such coverage under the federal law enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, known as "COBRA." Qualified beneficiaries entitled to COBRA coverage may include you, your spouse, or your dependent children depending on the type of qualifying event. Qualified beneficiaries also may include children born to or placed for adoption with the “covered employee” during a period of COBRA continuation coverage.

QUALIFYING EVENTS

IF YOU ARE AN EMPLOYEE

You have a right to COBRA coverage if you *lose your Plan coverage** because of any of the following qualifying events:

- ◆ A reduction in your hours of employment with the employer; or
- ◆ The termination of your employment with the employer for reasons other than gross misconduct on your part.

*The 1999 Final COBRA Regulations state “to lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the event. The Final Regulation clarifies that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above.

IF YOU ARE THE SPOUSE OF AN EMPLOYEE

You have the right to COBRA coverage if you *lose your Plan coverage** because of any of the following qualifying events:

- ◆ The death of your employee-spouse;
- ◆ A termination of your employee-spouse's employment with the employer (for reasons other than gross misconduct) or reduction in your employee-spouse's hours of employment with the employer;
- ◆ Your employee-spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(continued on next page)

IF YOU ARE THE SPOUSE OF AN EMPLOYEE

- ◆ Divorce or legal separation from your employee-spouse.

NOTE: If your spouse (the employee) reduces or eliminates your coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the actual event. There is no obligation to offer coverage during the period between your termination from the Plan and the divorce.

*The 1999 Final COBRA Regulations state “to lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the event. The Final Regulation clarifies that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above.

IF YOU ARE A DEPENDENT CHILD OF AN EMPLOYEE

You have the right to COBRA coverage if you *lose your Plan coverage** because of any of the following qualifying events:

- ◆ The death of your parent-employee;
- ◆ A termination of your parent-employee's employment with the employer (for reasons other than gross misconduct) or reduction in your parent-employee's hours of employment with the employer;
- ◆ Your parent-employee's divorce or legal separation;
- ◆ You no longer qualify as an eligible dependent child under the Plan; or
- ◆ Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).

*The 1999 Final COBRA Regulations state “to lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the event. The Final Regulation clarifies that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above.

ELECTING COBRA AFTER FMLA

If you take FMLA leave and do not return to work at the end of the leave, you (and your covered spouse and dependent children) will be entitled to elect COBRA if:

1. they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
2. they will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled, “Duration of COBRA Coverage.”)

SPECIAL SECOND ELECTION PERIOD

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the 6 months immediately after the individual’s group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Plan Administrator using the Plan contact information provided below. *Contact the Plan Administrator promptly after qualifying for TAA or ATAA or you will lose the right to elect COBRA during a special second election period.*

COBRA COVERAGE

COBRA coverage is coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or dependents. In most cases, this means you will have the same coverage under COBRA as you did before the qualifying event. Contact the Plan Administrator for more details.

You do not have to show evidence of good health to elect COBRA coverage. However, COBRA coverage is provided subject to your eligibility for that coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible. This cancellation right applies even if the Plan Administrator previously accepted one or more of your COBRA premium payments.

Alternative coverage is coverage provided to a qualified beneficiary after a qualifying event that is not COBRA coverage. Regardless of whether alternative coverage is available, COBRA coverage must also be made available.

ENROLLMENT OF NEWBORN OR ADOPTED CHILDREN

A newborn child, adopted child, or child placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary. The child’s COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other qualified beneficiaries. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (e.g., limiting ages).

ELECTING COBRA COVERAGE

In order to obtain COBRA coverage you, your qualified beneficiaries and the employer must satisfy certain notification requirements.

NOTICE REQUIRED TO BE GIVEN BY QUALIFIED BENEFICIARY

You and your qualified beneficiaries have the responsibility to inform the Plan Administrator of a qualifying event that is:

- ◆ A divorce;
- ◆ A legal separation; or
- ◆ A child losing dependent status under the Plan.

A COBRA election will be available to you only if you *notify the Plan Administrator in writing* within 60 days after the later of:

- ◆ the date of the qualifying event; or
- ◆ the date on which your Plan coverage ends (or would end) because of the event.

Additionally, to extend COBRA coverage, you must notify the Plan Administrator of any secondary qualifying events or of a determination of disability. In the case of a disability, you also must notify the Plan Administrator when you are no longer disabled. (See the sections below entitled, "Disability," "Secondary Qualifying Event," and "Early Termination of COBRA Coverage").

Any notice that you provide to your plan administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must contain the following information:

- ◆ the name of the Plan;
- ◆ the name and address of the employee covered under the Plan;
- ◆ the name(s) and address(es) of the qualified beneficiaries; and
- ◆ the qualifying event and the date it occurred.

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. If the qualifying event is a child losing dependent status under the Plan, then your notice must state the date the child is no longer eligible and the child's address.

Individuals who can provide this notice include the covered employee or qualified beneficiary with respect to the qualified event, or any representative acting on behalf of the covered employee or qualified beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

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NOTICE REQUIRED TO BE GIVEN BY QUALIFIED BENEFICIARY

Mail or hand-deliver the written notice of qualifying event to:

Employee Benefits Department
Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170

If you or your dependents do not notify the Plan Administrator in writing of the qualifying event within the required time period, the right to elect COBRA coverage will end.

NOTICE REQUIRED TO BE GIVEN BY THE EMPLOYER

The employer has the responsibility to notify the Plan Administrator of a qualifying event that is:

- ◆ The employee's death;
- ◆ The employee's termination (other than by reason of gross misconduct);
- ◆ The employee's reduction in hours of employment;
- ◆ The employee's Medicare entitlement (Part A, Part B, or both); or
- ◆ The Employer's bankruptcy under Chapter 11 of the Federal Bankruptcy Code, with reference to retirees and their dependents.

This notice must be provided within 30 days after:

- ◆ the date of the qualifying event; or
- ◆ the date of the loss of coverage in cases where continuation coverage shall commence on the date of loss of coverage.

NOTICE REQUIRED TO BE GIVEN BY PLAN ADMINISTRATOR

When the Plan Administrator is notified that a qualifying event has happened, the Plan Administrator, or its agent, will in turn notify you and your dependents of the right to elect COBRA coverage. This notice must be provided within 14 days.

HOW TO ELECT COBRA

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA Notice and submit it to the Plan Administrator. A COBRA Notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the COBRA Notice from the Plan Administrator.

Under federal law, you have 60 days to elect COBRA from the later of:

- the date you would lose coverage because of one of the qualifying events described above; or
- the date the Plan Administrator informs you of your COBRA election rights.

If you do not submit the completed Election Form by this date, you will lose your right to elect COBRA coverage.

Mail or hand-deliver the completed Election Form to:

Employee Benefits Department
Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170

Deadline for COBRA Election

If mailed, your Election Form must be postmarked (and if hand-delivered, your Election Form must be received by the individual at the address specified above) no later than 60 days after the date of the COBRA Notice provided to you at the time of your qualifying event. *If you do not submit a completed Election Form by this due date, you will lose your right to elect COBRA coverage.*

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Independent Election Rights

Each qualified beneficiary will have an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents or legal guardians may elect COBRA on behalf of a minor child. *Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his/her right to elect COBRA coverage.*

Notification of Medicare Entitlement

When you complete the election form, you must notify the Plan Administrator, or its agent, if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the election form, immediately notify the Plan Administrator, or its agent, of the date of your Medicare entitlement at the address specified above for delivery of the election form.

COBRA Coverage and Other Coverage or Medicare

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled, "Termination of COBRA Before the Maximum Coverage Period."

DURATION OF COBRA COVERAGE

COBRA coverage is measured from the date of your loss of coverage. The duration of your COBRA coverage depends on the reason coverage was lost:

QUALIFYING EVENT (RESULTING IN LOSS OF COVERAGE)	MONTHS OF COBRA COVERAGE
Termination of employment	18
Reduction in Hours	18
Divorce or legal separation	36
Death	36
Loss of Dependent Child Status	36
Medicare Entitlement	36

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described above are maximum coverage periods and the actual duration could vary depending on your actual facts and circumstances. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Before the Maximum Coverage Period."

Special Rules Regarding the Duration of COBRA

If you are an employee and become entitled to Medicare within the 18-month period *preceding your termination of employment or reduction in hours*, the COBRA continuation period will be extended for all other qualified beneficiaries (e.g., your covered spouse and dependents) to a maximum period of 36 months from the date of your Medicare entitlement. For example, if you become entitled to Medicare and then terminate employment with the employer 6 months later, your qualified beneficiaries would be entitled to elect COBRA coverage for a period of 30 months from the date of your termination.

Additionally, the duration of COBRA coverage resulting from termination of employment or reduction in hours may be extended in the case of a Social Security disability determination and in the case of multiple qualifying events. *However, in no event will COBRA coverage last beyond 36 months from the date of the original qualifying event that made the qualified beneficiary eligible to elect COBRA coverage.*

DISABILITY

If a qualified beneficiary (e.g., the employee or the employee's covered spouse or dependent child) is determined by the Social Security Administration to be disabled and you notify the Plan Administrator, or its agent, in writing in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the Plan Administrator, or its agent, in writing of the Social Security Administration's determination of disability before the end of the first 18 months of continuation coverage and within 60 days after the later of:

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

Mail or hand-deliver the notice of determination of disability ("SSA Award Letter") to:

Employee Benefits Department
Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170

If this notice is not provided, the right to extend coverage from 18 months to 29 months will be lost.

Any notice that you provide to your plan administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the last day of the required notice period. Additionally, any notice you provide must contain the following information:

- the name of the Plan;
- the name and address of the employee or former employee covered under the Plan;
- the name and address of the disabled qualified beneficiary;
- the date the Social Security Administration made its determination of disability;
- the date the qualified beneficiary becomes disabled;
- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA at the time of this notice; and
- the initial qualifying event and the date it occurred.

Individuals who can provide this notice include the covered employee or qualified beneficiary with respect to the qualified event, or any representative acting on behalf of the covered employee or qualified beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries.

SECOND QUALIFYING EVENTS

If you are a qualified beneficiary who is a spouse or dependent child, the 18-month period (or, in the case of a disability extension, the 29-month period) may be extended to 36 months from the date of the employee's termination of employment or reduction in hours if a second qualifying event occurs. A second qualifying event is one of the following that occurs during the original 18-month period:

- ◆ Death of the employee;
- ◆ The employee's divorce or legal separation;
- ◆ A child's loss of dependent status under the Plan; or
- ◆ The employee's entitlement to Medicare (Part A, Part B or both).

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

You or your qualified beneficiary must provide written notification to the Plan Administrator (or its agent) of the second qualifying event within 60 days after the later of:

- ◆ the date of the second qualifying event; or
- ◆ the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

Mail or hand-deliver the written notice of second qualifying event to:

Employee Benefits Department
Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170

If this notice is not provided, the right to extend coverage from 18 months to 36 months will be lost.

Any notice that you provide to your plan administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must contain the following information:

- ◆ the name of the Plan;
- ◆ the name and address of the employee or former employee covered under the Plan;
- ◆ the name(s) and address(es) of the qualified beneficiaries who are receiving COBRA at the time of this notice; and
- ◆ the initial and secondary qualifying events and the dates they occurred.

If the second qualifying event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement. If the second qualifying event is a child losing dependent status under the Plan, then your notice must state the date the child is no longer eligible and the child's address.

Individuals who can provide this notice include the covered employee or qualified beneficiary with respect to the qualified event, or any representative acting on behalf of the covered employee or qualified beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

COST OF CONTINUATION COVERAGE

Under COBRA, you may have to pay all or part of the premium for your continuation coverage. In addition, the employer may charge you a 2% administration fee during the 18 or 36 month COBRA continuation period. If you and your dependents are entitled to 29 months of continuation coverage on account of disability, the employer may charge a 50% administration fee during the additional 11-month coverage period. The amount of your COBRA premium may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

COBRA Premium Due Date

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

Employee Benefits Department
Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170
734-416-4834

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

Generally your premiums are due on the first of the month. COBRA premiums must be paid by personal check, cash, or certified check. However, there is a 30-day grace period for payment of the regularly scheduled premium. To qualify for the grace period, your premium must be postmarked or received by the Plan Administrator no later than 30 days after the original premium due date. Also, your first COBRA premium is not due until 45 days after you elect COBRA coverage. This means that your premium must be postmarked or received by the Plan Administrator no later than 45 days after the date your election of COBRA coverage is postmarked or received by the Plan Administrator. In addition, your initial premium must cover the entire period from the date of the loss of coverage. For example, if you elect COBRA coverage on the last day of the 60-day COBRA election period, your initial premium payment would be for the first 2 months of your COBRA coverage.

You have 30 days after a notice of an insignificant underpayment to make up that payment.

When a health care provider inquires as to a qualified beneficiary's coverage status, the Plan is responsible to convey all details regarding the qualified beneficiary's right to coverage during the election period and applicable grace periods.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election or you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

TERMINATION OF COBRA BEFORE THE MAXIMUM COVERAGE PERIOD

EARLY TERMINATION OF COBRA COVERAGE

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

- ◆ The premium for your COBRA coverage is not paid in full on time;
- ◆ The employer no longer provides group health coverage to any of its employees;
- ◆ You become covered, after electing COBRA, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have or any such pre-existing condition clause does not apply to you under the rules concerning creditable coverage;
- ◆ You become entitled to Medicare (under Part A, Part B or both) after electing COBRA; or
- ◆ During a disability extension period, you are determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled “Special Rules Regarding the Duration of COBRA.”

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

Medicare Entitlement and Coverage Under Another Group Health Plan

You must notify the Plan Administrator, or its agent, *in writing within 30 days* if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under another group health plan (but only after any pre-existing condition exclusion period of the other plan is exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of an applicable pre-existing condition exclusion period). Plymouth-Canton Community Schools will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

Cessation of Disability

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator, or its agent, *in writing within 30 days* after the Social Security Administration’s determination that the qualified beneficiary is no longer disabled.

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EARLY TERMINATION OF COBRA COVERAGE

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the later of:

- ◆ the first day of the month that is more than 30 days after the Social Security Administration's determination; or
- ◆ the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

Plymouth-Canton Community Schools will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled. For more information about the disability extension period, see the section above entitled "Special Rules Regarding the Duration of COBRA."

Notice Procedures

Mail the written notice of Medicare entitlement, coverage under another group health plan or determination that the qualified beneficiary is no longer disabled to:

Employee Benefits Department
Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170

Any notice that you provide to your plan administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must contain the following information:

- ◆ the name of the Plan;
- ◆ the name and address of the employee or former employee covered under the Plan;
- ◆ the name(s) and address(es) of the qualified beneficiaries; and
- ◆ the initial qualifying event and the subsequent event terminating coverage and the dates they occurred.

Individuals who can provide this notice include the covered employee or qualified beneficiary, or any representative acting on behalf of the covered employee or qualified beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries.

QUESTIONS AND ADDITIONAL INFORMATION

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 or correspondence you send to the Plan Administrator, or its agent.

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below.

For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

You may obtain information about the Plan and COBRA coverage on request from:

COBRA Representative
Plymouth-Canton Community Schools
454 S. Harvey
Plymouth, Michigan 48170
734-416-4834

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Plan Document and Summary Plan Description (if you are not sure whether this is the Plan's most recent Plan Document and Summary Plan Description, you may request the most recent copy from the Plan Administrator).

GENERAL PROVISIONS

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For purposes of determining the applicability of and implementing the terms of this provision or any similar provision of any other Plan, the Benefit Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person, any information with respect to any person whom the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan must furnish the Benefit Administrator such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan in accordance with its provisions have been made under any other plans, the employer shall have the right, exercisable alone and in its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this provision, and any amount so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments, the employer shall be fully discharged from liability under this Plan.

RIGHT OF RECOVERY

Whenever payments have been made by the Benefit Administrator with respect to allowable expenses in an amount that is, at any time, in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Benefit Administrator will have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments were made, any other insurance companies, including but not limited to Worker's Compensation carriers, and any other organizations.

If an overpayment is made in the opinion of the Plan Administrator, this Plan has the right to recover the overpayment. If a covered person is paid more than allowed by this Plan, the covered person must refund that overpayment. A request for refund will be made in writing by this Plan. If an overpayment is made by the Plan on behalf of the covered person to a hospital, physician, or other covered provider, this Plan may request a refund of the overpayment from either the covered person or the covered provider. If the refund is not received from either the covered person or the covered provider, the overpayment will be deducted from any future Plan benefits available to the covered person or collected through legal process.

STATE RECOVERY OF MEDICAID PAYMENTS

Notwithstanding any other provisions of the Plan to the contrary, if this Plan provides benefit payments on behalf of a covered person who is also covered by a State's Medicaid program, the Plan shall be subject to the State's right to reimbursement for benefits the State has paid on behalf of the covered person, provided that the State has an assignment of rights made by or on behalf of the covered person, or the covered person's beneficiary, as may be required by the State Medical Assistance Plan.

SUBROGATION, REIMBURSEMENT AND THIRD PARTY RECOVERY PROVISION

If you, your spouse, one of your dependents, or anyone who receives benefits under this Plan becomes ill or is injured and entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, the employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. If the employee or covered person retains an attorney, then the employee or covered person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of State law and/or whether the minor's representative has access or control of any recovery funds.

The employee or covered person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the employee or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the employee or covered person and their attorney if applicable. If any provision is made for future medical expenses in the settlement or recovery, accident related claims made after satisfaction of this obligation shall be paid by the employee or covered person and not the plan.

The employee or covered person agrees to take no action that in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

HONOR OF STATE SUBROGATION RIGHTS

Notwithstanding any other provision of this Plan to the contrary, the Plan will honor any subrogation rights that a State may have gained from a Medicare eligible beneficiary covered by the

Plan by virtue of the State's having paid Medicare benefits, provided that the Plan has a legal liability for coverage.

PRIVACY

In administering your Plan benefits, the Benefit Administrator will comply with all applicable privacy and access statutes, rules and regulations.

DEFINITIONS FOR THE PURPOSE OF THIS PLAN

ADVERSE BENEFIT DETERMINATION: The appeals procedures are triggered by an adverse benefit determination. According to the new regulations the term “adverse benefit determination” means a denial, reduction or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit. Requests for determinations of eligibility under the Plan are not required to be treated as claims for benefits for purposes of the claim procedure. However, where a claim for benefits is made and the claim is denied because the claimant is not eligible for benefits under the terms of the Plan, the claimant shall be afforded the right to appeal that determination in accordance with the claims procedures outlined in the Plan.

AGENT FOR SERVICE OF LEGAL PROCESS: Legal process may be served on the Plan Administrator at the address indicated on the General Plan Information page.

AMENDMENT: A formal document that changes the provision of this Plan that is adopted through a formal resolution by the employer through its governing body or authorized executive.

The employer may amend this Plan at any time and will provide written notice to participants. Summary of Material Modifications (SMM) must be distributed within sixty (60) days after a material reduction in benefits has been adopted. Plan Amendments can be made retroactive to the extent permitted by law.

ASSIGNMENT OF BENEFITS: Assignment of Benefits occurs when you file a claim and authorize the Plan to pay your doctor or hospital directly.

AUTHORIZED REPRESENTATIVE: A claimant may act through an authorized representative. The Department of Labor (DOL) has clarified, that it is reasonable to require written authorization signed by the Plan participant or beneficiary, on a form specified by the Plan for an authorized representative to act on behalf of the Plan participant or beneficiary in connection with non-urgent and post-service claims. However, if an urgent care claim is involved, a health care professional evidencing knowledge of a claimant’s medical condition will have to be accepted as sufficient to establish authorized representative status. According to the DOL, a medical service provider does not become an authorized representative within the meaning of the regulations as a result of an assignment of benefits by a plan participant or beneficiary.

The claimant has the right to revoke the assignment of an authorized representative at any time.

BENEFIT ADMINISTRATOR: The firm providing administrative services to the employer in connection with the operation of the Plan and performing certain functions, including underwriting, enrollment applications, maintaining current Plan data, billing, processing and payment of claims and providing the employer with any other information deemed necessary by the Third Party Administrator.

BUSINESS ASSOCIATE (BA): A person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity’s workforce. A business associate can also be a covered entity in its own right.

CALENDAR YEAR: For purposes of this Plan, a length of time beginning January 1 and ending December 31.

CHILD: Your unmarried:

- natural child
- adopted child
- child placed for adoption
- stepchild
- child for whom you are the legal guardian and who resides with you
- or a child under age nineteen (19) that resides with you and for whom you provide the principal support

An “adopted child” or a “child placed for adoption” is any person under the age of eighteen (18) as of the date of adoption or placement for adoption. “Placed for adoption” means, in connection with adoption proceedings, the assumption and retention by a health plan participant or beneficiary of the legal duty for the total or partial support of a child to be adopted. The child’s placement with such person terminates upon the termination of such legal obligation.

This Plan is intended to comply with the Omnibus Budget Reconciliation Act of 1993 with respect to dependent child eligibility and Qualified Medical Child Support Orders.

CLAIM: A claim is any request for a plan benefit or benefits, made by a claimant or by a representative of a claimant that complies with a Plan’s reasonable procedure for making benefit claims. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

Requests for determinations of eligibility under the Plan are not required to be treated as claims for benefits for purposes of the claim procedure. However, where a claim for benefits is made and the claim is denied because the claimant is not eligible for benefits under the terms of the Plan, the claimant shall be afforded the right to appeal that determination in accordance with the claims procedures outlined in the Plan.

Under the terms of this Plan, a claim is not deemed to be a claim when there is a casual inquiry about benefits. For this Plan to consider a request for benefits as a claim, it is required that a claim for pre-service care, post-service care and concurrent care benefits must be filed in writing or submitted electronically and must include applicable codes. Less stringent guidelines may apply in the case of an urgent care claim.

CONCURRENT CARE CLAIM: A concurrent care decision is one where the Plan has approved an ongoing course of treatment, and then the Plan reduces or terminates coverage for that course of treatment (other than by amendment or plan termination) before the end of the pre-approved course

of treatment. This is an adverse benefit determination that can be appealed as a concurrent care claim.

Reduction or termination of benefits: In the case of a reduction or termination of an ongoing course of treatment which the Plan had previously approved, the Plan Administrator shall notify the claimant of the Plan's benefit determination within a reasonable period of time.

Request to extend benefits: In the case of a request of a claimant to extend the course of treatment which the Plan had previously approved, the Plan Administrator shall notify the claimant of the Plan's benefit determination within a reasonable period of time but in no event greater than twenty-four (24) hours after receipt of the claim by the Plan.

CONSENT: Permitted disclosures allow a covered entity to disclose Protected Health Information (PHI) to the individual whose PHI is being disclosed and with consent of the individual for the purposes of treatment, payment or health care operations. Covered entities may use or disclose PHI with written authorization from plan participants. The claimant has the authority to revoke an authorized consent at any time.

COORDINATION OF BENEFITS: If an individual is covered by another benefit plan, this Plan will coordinate its payment of benefits with the other plan to allow as complete claim reimbursement as possible, within the coverage limits, without providing duplicate payments.

COVERED ENTITY (CE): Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any individually identifiable health information in any form or medium in connection with a HIPAA transaction.

COVERED PERSON: The term "covered person" shall mean any eligible employee or eligible dependent(s) as defined in the section entitled "ELIGIBILITY PROVISIONS."

DAY: The term used in the regulations means calendar days, not business days. 65 Fed. Reg. 70248,n.9 (Nov. 21, 2000).

DISCLOSURE, ACCOUNTING OF: Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) (to include minimum necessary scope): Release or divulgence of information by an entity to persons or organizations outside of that entity.

ELECTRONIC DATA INTERCHANGE (EDI): This usually means X12 and similar variable-length formats for the electronic exchange of structured data. It is sometimes used more broadly to mean any electronic exchange of formatted data.

ELECTRONIC PROTECTED HEALTH INFORMATION (EPHI): Protected health information, as defined by the Security Rule, that is (i) transmitted by electronic media; or (ii) maintained in electronic media.

EMPLOYEE: The word "employee" as used herein, shall mean any person employed and compensated for services by the employer as defined in the section entitled "ELIGIBILITY PROVISIONS."

ENROLLMENT DATE: The first day of coverage or, if there is a waiting period, the first day of the waiting period.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES:

1. Care, procedure, treatment or technology which: (a) is not widely accepted as safe, effective and appropriate for the injury or illness throughout the recognized medical profession or established medical societies in the United States; (b) is experimental, in the research or investigational stage, or conducted for research or similar purposes.
2. Drugs and tests which: (a) the Federal Food and Drug Administration has not approved for general use; (b) are considered experimental; or (c) are for investigational use. Drugs and tests approved for a specific medical condition but which are used for another condition will be considered experimental.

In determining any of the above, reliance will be placed on recognized medical sources such as, but not limited to, the American Medical Association, the National Institutes of Health, the U.S. Food and Drug Administration and other broadly accepted medical authorities and sources.

FULL AND FAIR REVIEW: A full and fair review of the appeal of an adverse benefit determination must be made by the fiduciary of the Plan, the Plan Administrator, who is neither the party who made the initial adverse determination, nor the subordinate of such person. The review may not defer to the initial adverse benefit determination. The review must take into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was previously submitted or relied upon in the initial determination.

FUNDING: Funds for payment of claims are paid into an Employee Benefit Account or Trust from which claims are paid. All funds received by the account or trust shall be applied toward payment of claims and reasonable expenses of administration of the Plan.

HEALTH AND HUMAN SERVICES (HHS): The federal government department that has primary responsibility for implementing HIPAA.

HEALTH CARE CLEARINGHOUSE: Under HIPAA, this is an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

IMMEDIATE FAMILY MEMBER: A person who is related to the claimant as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI): Is information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - a. That identifies the individual; or
 - b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

INJURY AND ILLNESS: The term “injury” shall mean accidental or self-inflicted bodily injury. All injuries sustained by a covered person in connection with any one incident shall be considered one injury.

The term “illness” shall include illness, mental, emotional, or nervous disorders, and pregnancy and complications thereof.

No benefits will be payable for expenses arising out of occupational injuries and illnesses which are compensable under a Worker’s Compensation insurance program.

LATE ENROLLEE: An individual whose enrollment in a plan is a late enrollment.

LATE ENROLLMENT: Enrollment under a group health plan other than on the earliest date on which coverage can become effective under the terms of the plan, or a special enrollment date for the individual.

LIFETIME: For purposes of this Plan, lifetime shall mean while covered under this self-funded Plan.

MEDICALLY NECESSARY: Health care services, supplies or treatment which, in the judgment of the attending physician, are appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient’s condition or the quality of medical care rendered.

MEDICARE: The programs established by Title 1 of Public Law 89-97 (79 Statutes 291) as amended, and entitled Health Insurance for the Aged Act and which includes Part A and Part B.

MINIMUM NECESSARY REQUIREMENT: Whenever using or disclosing PHI reasonable efforts to limit the PHI used or disclosed to the minimum necessary to accomplish the intended purpose of the use or disclosure must be maintained.

MOTOR VEHICLE: A vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular which has more than two (2) wheels. Motor vehicle does not include a motorcycle or a moped, as defined by the State of Michigan. Motor vehicle does not include a farm tractor or other implement of husbandry that is not subject to the registration requirements of the Michigan Vehicle Code.

NAMED FIDUCIARY: The employer is the named fiduciary of the Plan. The employer shall exercise all discretionary authority and control with respect to management of the Plan that is not specifically granted to the Benefit Administrator or any fiduciary.

The employer may delegate certain of its fiduciary responsibilities under the Plan to persons who are not named fiduciaries of the Plan. If the employer delegates its fiduciary responsibilities to another person, the delegation shall be made in writing by the employer, and a copy of the delegation will be kept with the records of the Plan.

Each fiduciary is solely responsible for its own acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. No fiduciary shall have any liability for a breach of fiduciary responsibility by another fiduciary with respect to the Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary is liable for a breach of fiduciary duty committed before it became a fiduciary and nothing in the Plan shall relieve any person from liability for his or her own misconduct or fraud.

NO-FAULT MOTOR VEHICLE PLAN: A compulsory motor vehicle plan that may provide payments for medical, dental care, or wage loss which are payable, in whole or in part, without regard to fault.

OPTICIAN: A person licensed to translate, fill, and adapt ophthalmic prescriptions, products, and accessories.

OPTOMETRIST: A person licensed to measure the powers of vision and adapt lenses or prisms for the aid thereof, utilizing any means other than drugs.

PHYSICIAN OR OTHER LICENSED OR CERTIFIED PROVIDERS: Means a duly licensed doctor of medicine (M.D.), osteopath (D.O.), podiatrist (D.P.M.), chiropractor (D.C.), fully licensed psychologist (Ph.D.) or psychiatrist, or any other provider rendering a covered service, acting within the scope of his license who is required to be recognized as such by an applicable State code.

PLAN: Your Health and Welfare benefits. This document is your Plan Document and Summary Plan Description.

PLAN ADMINISTRATOR, AND PLAN ADMINISTRATION: The employer is the Plan Administrator of the Plan. As Plan Administrator, the company must supply you with this document and other information and file various reports and documents with government agencies. In its role of administering the Plan, the Plan Administrator also may make rulings, interpret the Plan, prescribe procedures, gather needed information, receive and review financial information regarding the Plan, employ or appoint individuals to assist in any administrative function, and generally do all other things needed to administer the Plan.

The Plan Administrator has all powers and authority needed to enable it to carry out its duties under the Plan, including by way of illustration and not limitation (a) the power and authority contemplated with respect to the Plan, and (b) the power and authority to make regulations with respect to the Plan and to determine, consistent with those regulations all the status and rights of participants, beneficiaries and other persons.

Failure by the Plan or Plan Administrator to insist upon compliance with any provisions of the plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

The Plan Administrator shall interpret the Plan under Federal law.

PLAN DOCUMENT: The legal document according to which the Plan is administered.

PLAN MODIFICATION: The Plan may be modified or amended by the employer from time to time. Modifications that affect covered participants will be communicated to the Plan participants.

PLAN SPONSOR: (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two (2) or more employers or jointly by one (1) or more employers and one (1) or more employee organizations, the association, committee, joint board of trustee, or other similar group of representatives of the parties who establish or maintain the plan. The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan and any or all benefits provided under the Plan, covering any active employee or current or future retiree or dependent in whole or in part at any time. Any such change or termination in benefits will be based solely on the decision of the Plan Sponsor and may apply to all eligible active and nonactive employees and dependents as either separate groups or as one group, regardless of status.

PLAN YEAR: A period commencing with the effective date of this Plan or a Plan anniversary and terminating the day before the next succeeding Plan anniversary date.

POST-SERVICE CLAIM: A post-service care claim is one that may be filed and approved **after** the service is rendered.

In the case of post-service claims, the Plan Administrator shall notify the claimant of the Plan's benefit determination within thirty (30) days after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if the Plan administrator determines that such an extension is necessary due to matters beyond the control of the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be afforded forty-five (45) days to provide the specified information.

PRE-SERVICE NON-URGENT CARE CLAIM: A pre-service non-urgent care claim is one where the receipt of the benefit is conditioned on approval **before** the service is rendered.

In the case of pre-service determinations, the Plan Administrator shall notify the claimant of the Plan's benefit determination within fifteen (15) days after receipt of the claim by the Plan, unless

the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be afforded forty-five (45) days to provide the specified information.

PROTECTED HEALTH INFORMATION (PHI): Individually Identifiable Health Information

1. Except as provided in paragraph (2) of this definition, that is:
 - a. Transmitted by electronic media;
 - b. Maintained in any medium described in the definition of electronic media; or
 - c. Transmitted or maintained in an other form or medium.
2. Protected Health Information excludes Individually Identifiable Health Information in:
 - a. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and
 - b. Records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (“QMCSO”): The Plan Administrator shall adhere to the terms of any medical child support order that satisfies the requirements of this Section. A medical child support order is any judgment, decree, or order (including a court approved property settlement agreement) issued by a court of competent jurisdiction which (a) Relates to the provision of child support with respect to the child of a participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and related to medical benefits under the Plan, or (b) Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan, and which creates or recognizes the existence of an alternate recipient’s right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a participant or beneficiary under the Plan. For purposes of this Section, an “alternate recipient” shall mean any child of a participant who is recognized by a medical child support order as having a right to enrollment under this Plan with respect to the Participant.

A Qualified Medical Child Support Order must clearly specify: (a) The name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order; (b) A reasonable description of the type of coverage to be provided under the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined; (c) The period to which such order applies; and (d) Each plan to which such order applies.

Any Qualified Medical Child Support Order shall not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Reconciliation Act of 1993).

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the "qualified" status of medical child support orders, the Plan Administrator shall determine whether the order is a Qualified Medical Child Support Order and shall notify the Participant and each alternate recipient of this determination. If the Participant or any affected alternate recipient disagrees with the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Alternate recipients of a Qualified Medical Child Support Order shall be treated as beneficiaries under the Plan.

Payments under this plan pursuant to a Qualified Medical Child Support Order in reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

REASONABLE AND CUSTOMARY CHARGE: A reasonable and customary ("R&C") charge shall be the usual charge made by a physician or supplier of services, medicines, or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies within the area in which the charge is incurred for the illness or injury being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater areas as is necessary to obtain a representative cross section of the level of charges.

SECURITY RULE: The HIPAA regulations that are codified at 45 C.F.R. § 160 and 45 C.F.R. § 164, as amended from time to time.

SOUND, NATURAL TOOTH: A tooth that is whole or properly restored and is without impairment, periodontal or other conditions and which is not in need of treatment for any reason other than an accidental injury.

SPOUSE: The person who is legally married to you while you are covered under this Plan. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your State.

SUMMARY HEALTH INFORMATION: Information, that may be Individually Identifiable Health Information, and:

1. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

2. From which the information described at §164.514(b)(2)(i) has been deleted except that the geographic information described in §164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

TOTAL DISABILITY: An employee is considered totally disabled if they are unable to perform each and every duty of their regular job for the period of disability as defined by this Plan. An employee is no longer considered totally disabled if they are or become qualified for any gainful occupation by education, training or experience.

A dependent child is considered totally disabled if they are not able to perform the normal activities of a person of like age and sex in good health. A dependent child is no longer considered totally disabled if the child is able to perform the normal activities of a person of like age and sex in good health.

TPO (TREATMENT – PAYMENT – HEALTH CARE OPERATIONS):

TREATMENT - Means the provision, coordination or management of health care and related services by one or more health care providers, including the coordination and management of health care by a provider and a third party, consultation between health care providers relating to a patient or the referral of a patient for health care from one provider to another.

PAYMENT - Means activities undertaken by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provisions of benefits including but not limited to: determination of eligibility or coverage; adjudication or subrogation of health benefit claims; billing; claims management; collection activities; related health care data processing; review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, justification of charges; utilization review activities, including pre-certification, pre-authorization, concurrent and retrospective review.

Health Care **OPERATIONS** cover a wide range of activities including:

1. Quality assessments and improvement activities, case management, protocol development, and contacting providers about alternative treatments and related functions that do not include treatment.
2. Reviewing competence or qualification of health care professionals, evaluating provider or health plans performance, certification, licensing, or credentialing activities.
3. Underwriting, premium rating and other activities relating to the creation, renewal or placement of health insurance or health benefits – ceding, securing or placing a contract of reinsurance or stop-loss insurance; providing that if a health plan receives PHI for such purposes and the insurance is not placed, the health plan may not use or disclose the PHI received for any other purpose, except as may be required by law.
4. Conducting or arranging for medical review, legal services or auditing function including fraud and abuse.
5. Business planning or development such as cost management, development or improvement in payment methods or policy coverages.

6. Business management and general administrative activities of the covered entity including customer service, resolution of internal grievances, due diligence in connection with a business transaction if the potential successor is or will become a covered entity.

TRICARE: The Civilian Health and Medical Program of the Uniformed Services formerly known as CHAMPUS.

URGENT CARE CLAIM: An urgent care claim is any claim for which the application of the standard time periods for determining claims a prudent layperson would consider, or the patient's physician determines, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or for which delayed treatment would cause the patient severe pain.

In the case of a determination involving urgent care, the Plan Administrator shall notify the claimant of the Plan's benefit determination within seventy-two (72) hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant within twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded forty-eight (48) hours to provide the specified information.

WORKER'S COMPENSATION: A fund to which an employer contributes, which provides coverage regarding job-related injuries and illnesses.

YOU: The eligible covered employee.