

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**PLYMOUTH-CANTON COMMUNITY SCHOOLS
EMPLOYEE BENEFIT PLAN**

**AMENDED AND RESTATED AS OF:
July 1, 2009**

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INTRODUCTION

In the event of any conflict between this document and any other document or oral communication, this document will control.

This is the Plymouth-Canton Community Schools Employee Benefit Plan (“the Plan”) for vision benefits, amended and restated as of July 1, 2009.

The Plan Sponsor reserves the right to terminate or amend the Plan at any time and for any reason.

The Plan will pay benefits only for the eligible expenses incurred while this coverage is in force. Benefits are not payable for eligible expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

As used in this document, the word year refers to a calendar year. All annual benefit maximums and deductibles accumulate during the calendar year.

Defined terms are capitalized and defined in the Defined Terms section. This document is divided into the following sections:

Schedule of Vision Benefits. Provides a description of the Plan's benefits.

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

Eligibility and Commencement of Coverage Provisions. Explains eligibility and when coverage begins under the Plan.

Annual Enrollment Period. Explains when a Plan Participant can change plan and enrollment options.

Termination of Coverage and Extension of Coverage Provisions. Explains when a Plan Participant's coverage would end and when a Plan Participant may extend coverage under the Plan.

Vision Benefits. Provides a description of vision benefits provided under the Plan.

Filing a Claim. Explains how to submit a claim for consideration of benefits under the Plan.

Claims Procedure. Explains the procedures for filing a claim.

Other Important Plan Provisions. Explains other important Plan provisions.

COBRA Continuation Options. Explains continuation options available under the Plan.

Responsibilities for Plan Administration. Explains the responsibilities of the Plan Administrator.

Health Information Privacy and Security. Summary of the Plan's HIPAA Privacy Policy and Security.

General Plan Information. Provides general Plan information.

SCHEDULE OF BENEFITS

VISION BENEFITS

All benefits described in the Schedule of Vision Benefits are subject to the exclusions and limitations described in the Vision Benefits Section.

SCHEDULE OF VISION CARE BENEFITS

Plan 2

BENEFIT DESCRIPTION	BENEFIT
Vision Benefits are limited to the following:	
Eye exam, per Covered Person, limited to one per calendar year	\$48
Frame-type lenses, per Covered Person, per pair, limited to one per calendar year:	
Single vision	\$63
Bi-focal	\$72
Tri-focal	\$90
Progressive	\$108
Frames, per Covered Person, limited to one per calendar year	\$44
Contact Lenses, per Covered Person, per calendar year (In lieu of lenses and frames)	\$150

SCHEDULE OF VISION CARE BENEFITS

Plan 3

BENEFIT DESCRIPTION	BENEFIT
Vision Benefits are limited to the following:	
Eye exam, per Covered Person, limited to one per calendar year	\$75
Frame-type lenses, per Covered Person, per pair, limited to one per calendar year: Single vision Bi-focal Tri-focal Progressive	 \$100 \$100 \$125 \$125
Frames, per Covered Person, limited to one per calendar year	\$75
Contact Lenses, per Covered Person, per calendar year (In lieu of lenses and frames)	\$150

DEFINED TERMS

The following terms, when capitalized in the Plan, have the special meanings indicated.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer, as determined by the Employer.

Covered Person is an Employee or Dependent who is covered under the Plan.

Employer is the Plan Sponsor and any other entity, with the consent of the Plan Sponsor that adopts the Plan.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Physician (Health care Provider) means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Acupuncturist, Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Nutritionist/Dietician and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

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.

Spouse means the person of the opposite sex recognized as the covered Employee's legal husband or wife under the laws of the state where the covered Employee lives. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in the state where the Employee resides.

ELIGIBILITY AND COMMENCEMENT OF COVERAGE PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. An Employee of the Employer who is a United States citizen and non-citizen with a valid work visa and is:

- (1) a full-time or part-time Employee. 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.

Waiting period for Employee coverage.

An Employee must:

- (1) complete the waiting period (as defined by the applicable collective bargaining agreement) as an Active Employee. Please see section titled Effective Date of Coverage to determine when coverage begins after the waiting period. For the purpose of this provision, an Employee shall not be treated as absent from work if the absence is because of a health condition.
- (2) The eligibility waiting 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).

Notwithstanding the foregoing, the term Employee shall not include:

- (1) any leased employee of the Employer, or
- (2) any person who is not classified by the Employer as a common law employee of the Employer, regardless of whether or not such person is later reclassified by a court or any regulatory agency as a common law employee of the Employer, or
- (3) any person classified by the Employer as a temporary employee of the Employer (as determined by the Employer).

Effective Date of Employee Coverage. When the enrollment requirements are met, an eligible Employee's coverage is effective on the first day of the month following the waiting period.

An Employee must be an Active Employee (as defined by the Plan) for coverage to begin.

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

- (1) A covered Employee's Spouse, unless legally separated.
- (2) A covered Employee's unmarried children until the end of the calendar year in which such child turns age 19; and
- (3) A covered Employee's unmarried children until the end of the calendar year in which such child turns age 25, provided he or she:
 - (A) (i) resides with the Employee; and
 - (ii) is receiving more than one-half of his or her support from the Employee.

-and-

- (B) is a full-time student at an accredited college, university, or any other accredited school, at least 5 months of the year;

-or-

(C) had a gross income of less than four times the personal exemption allowance.

For purposes of this section, the term "child" or "children" means an Employee's (i) natural child, (ii) adopted child, (iii) child placed for adoption, (iv) stepchild (as long as a natural parent remains married to the Employee), (v) child that resides with the Employee and for which such Employee is the legal guardian and (vi) child that is under the age of nineteen (19) that resides with the Employee and for which the Employee provides more than one-half of such child's support.

The term "Full-Time Student," as used herein, shall be defined as an unmarried dependent child who is enrolled in and regularly attending an educational institution such as high school, an accredited post-secondary school, an accredited college or university for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

Other examples of post-secondary education institutions include an accredited business school, trade school, nursing school, business school, mortuary school, cosmetology school, community or junior college, or other similar accredited educational institution that offers a full-time curriculum. The institution must be accredited in order to qualify the dependent for Full-Time Student status.

Coverage for a Full-Time Student will be effective as follows:

(A) A dependent child covered by this Plan who graduates from high school will remain covered provided the child enrolls and begins attending classes full-time in an accredited post-secondary school, college, or university in the next quarter/semester following the child's high school graduation date; or

(B) A dependent child who is not covered by this Plan and who subsequently enrolls and begins attending classes as a Full-Time Student will also be eligible for coverage. In this instance, the date the child begins attending full-time classes will be considered the date the employee acquires an Eligible Dependent for plan enrollment purposes. The Plan may require a completed application for the dependent's coverage within a specified time frame.

A Full-Time Student will remain covered during any regular scheduled break in the educational institution's full-time curriculum (such as spring or summer break), as long as the dependent was a Full-Time Student the quarter/semester before the break and is a Full-Time Student again the quarter/semester following the break. If the student is not enrolled as a full-time student in the next regular term, coverage will be terminated retroactively to the last day of the attended school term. The Employer has the right to recover benefit payments made during a semester break if the Dependent fails to return to school as a full-time student the following term.

If the Plan Administrator determines that a child was placed under the care of a covered Employee pursuant to a court order or other legal proceeding, and if the child is primarily dependent upon the covered Employee for support, the child will be treated as a child of the covered Employee for all purposes of this Plan and will continue to be treated as a child of the covered Employee for as long as they are primarily dependent upon the covered Employee for support; regardless, that the child has attained age 18 (or other applicable age of emancipation of minors) and therefore, under the terms of the original court order, is no longer under the legal custody of the covered Employee. However, the child will be subject to meeting all other age limitations and full-time student requirements of the Plan.

(4) A covered Dependent child who reaches the limiting age and is Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support, unmarried and does not qualify for any other health coverage. The Plan Administrator may require subsequent proof of the child's Disability and dependency, including a Physician's statement certifying the child's physical or mental incapacity.

The following are excluded as Dependents: any person who is on active duty in any military service of any country.

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

If two 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 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 plans following the guidelines as described in the "Coordination of Benefits" section of this Plan.

Effective Date of Dependent Coverage. Dependent coverage is effective on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all enrollment requirements are met. In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within 31 days of the event.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing, signing and timely submitting an enrollment application along with the appropriate payroll deduction authorization. If the Employee wishes to enroll eligible Dependents, the enrollment application and payroll deduction authorization must include Dependent information.

Enrollment Requirements for Newborn Children

A newborn child must be enrolled as a Dependent under the Plan within 31 days of the child's birth in order for coverage to take effect from the date of birth.

TIMELY INITIAL ENROLLMENT

Initial enrollment is considered "timely" if the completed enrollment form is received by the Plan Administrator no later than 31 days after the person becomes eligible for coverage under the Plan.

An Employee or eligible Dependent who does not apply for coverage within thirty-one (31) days of the date he or she 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 or eligible Dependent who applies for coverage later than ninety (90) days may have to wait until the next annual open enrollment period to enroll.

When two Employees (husband and wife) are covered under the Plan and the Employee covering the Dependent children is no longer eligible for coverage under the Plan, Dependent coverage may continue under the other Covered Employee with no waiting period. However, coverage must be continuous from one Employee to the other.

SPECIAL ENROLLMENT SITUATION/STATUS CHANGE

An Employee or Dependent may be eligible to enroll for coverage under the Plan during a Special Enrollment Period. There are two types of Special Enrollment Periods, as described below. For either type of Special Enrollment, an Employee who has a Special Enrollment Right (for the Employee or one or more Dependents) may elect coverage under any Plan option that is available to an Employee during an initial enrollment opportunity, as long as the Employee (or Dependent) is otherwise eligible for that Plan option:

- (1) **Special Enrollment Rights because of loss of other coverage.** An Employee or Dependent is eligible for coverage under the Plan, but chose not to enroll in the Plan, because he or she was covered at the time coverage under the Plan was previously offered may enroll later if one of the following conditions is met:
 - (a) The other coverage was not COBRA coverage and that coverage terminates because of a Loss of Eligibility (as described below);
 - (b) The other coverage was not COBRA coverage and an employer's contributions towards the coverage cease; or
 - (c) The coverage of the Employee or Dependent was under COBRA and the COBRA coverage is exhausted.

A "Loss of Eligibility" includes a loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment or a reduction in the number of hours of employment. A Loss of Eligibility also occurs if the other coverage is provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, if the Employee or Dependent no longer lives or works in the applicable services area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "Loss of Eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. "Exhaustion of COBRA coverage" occurs when COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or for cause. Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available). In addition, exhaustion of COBRA coverage occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.

The Plan Administrator may require the Employee to state in writing at the time coverage is offered that other health coverage was the reason for declining enrollment in the Plan (for the Employee or a Dependent). If the Plan Administrator imposes such a requirement and informs the Employee of the requirement, the Employee or Dependent will not be eligible for Special Enrollment based on the loss of coverage unless the Employee provided the required statement at the time coverage was declined.

The Employee or Dependent must request enrollment in the Plan during the Special Enrollment Period, which ends 31 days after (1) the other coverage terminates, (2) employer contribution's cease, or (3) COBRA coverage is exhausted, whichever applies. However, if the loss of coverage results from an individual reaching a lifetime limit on all benefits, the Special Enrollment Period ends 31 days after a claim is denied because of the lifetime limit, except that, if the loss of coverage is exhaustion of COBRA coverage, the Special Enrollment Period ends 31 days after the individual incurs a claim that would exceed the lifetime limit on all benefits. Coverage will be effective no later than the first day of the first month that begins after the Plan Administrator receives a completed request for enrollment.

An individual does not have a Special Enrollment Right if the Employee or Dependent loses other coverage because of a failure to pay premiums or required contributions or if the other coverage is terminated for cause (such as for making a fraudulent claim).

(2) Special Enrollment Rights because of marriage, birth or adoption.

- (a)** An otherwise eligible Employee (i.e., an Employee who is not a current participant but who has completed any waiting period and any other eligibility requirements under the Plan) may enroll himself or herself in the Plan during the Special Enrollment Period described below if an individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.
- (b)** An active Participant may enroll an individual who becomes or is his or her spouse (determined under federal law) during the Special Enrollment Period described below if either (1) the individual becomes the Participant's spouse or (2) the individual is the Participant's spouse and a child becomes a Dependent of the Participant through birth, adoption or placement for adoption.
- (c)** An otherwise eligible Employee may elect to enroll in the Plan the Employee and an individual who becomes or is his or her spouse (determined under federal law) during the Special Enrollment Period described below if (1) the Employee and the individual become married or (2) the Employee and the individual already are married and a child becomes a Dependent of the Employee through birth, adoption or placement for adoption.
- (d)** An active Participant may enroll an individual in the Plan during the Special Enrollment Period described below if the individual becomes a Dependent of the Participant through marriage, birth, adoption or placement for adoption.
- (e)** An otherwise eligible Employee may elect to enroll the Employee and an individual who becomes a Dependent of the Employee (including the Employee's spouse) in the Plan, if the individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

For purposes of paragraphs (a) through (e) above, "marriage" is limited to marriages that are recognized for purposes of federal law.

The Special Enrollment Period is a period of 31 days that begins on the date of the marriage, birth, adoption or placement for adoption.

Coverage for an Employee or Dependent who enrolls in the Plan because of a marriage, birth or adoption Special Enrollment Right will be effective:

- (a)** in the case of marriage, no later than the first day of the first month beginning after the date the Plan Administrator receives a completed request for enrollment electing coverage for the Employee or Dependent, if the completed request for enrollment is submitted within 31 days after the marriage;
- (b)** in the case of a Dependent's birth, on the date of birth if the completed request for enrollment is submitted within 31 days of the birth; or
- (c)** in the case of a Dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption if the completed request for enrollment is submitted within 31 days of the date of the adoption or placement for adoption.

- (3) **Special Enrollment due to coverage under Medicaid or under a State Children’s Health Insurance Program (CHIP).** If an Employee or eligible Dependent did not enroll in the Plan when initially eligible, but were otherwise eligible to enroll, he or she will be permitted to later enroll in the Plan under one of the following circumstances:
- (a) The Employee or eligible Dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or
 - (b) The Employee or eligible Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The Employee or eligible Dependent must request enrollment in the Plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after his or her eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

ANNUAL ENROLLMENT PERIOD

Plan Participants will receive information regarding the annual re-enrollment period from the Employer.

OPEN ENROLLMENT

During the open enrollment period, established by the Plan Sponsor, eligible Employees and their eligible Dependents who are not currently enrolled in the Plan will be allowed to enroll in the Plan. However, all enrollment applications must be received prior to the open enrollment effective date.

Benefit choices made during the open enrollment period will become effective September 1 and remain in effect until the next September 1 unless the Employee experiences a Special Enrollment Situation or Status Change (refer to Special Enrollment Situation/Status Change subsection).

TERMINATION OF COVERAGE AND EXTENSION OF COVERAGE PROVISIONS

When Employee Coverage Terminates. Employee coverage terminates on the earliest of the following dates:

- (1) The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.
- (2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes termination of Active Employment of the covered Employee.

NOTE: Teachers are carried to the end of their contract if they worked throughout the school year.

- (3) The day after the Employee dies.
- (4) The date the Employee reports to active military service.
- (5) The beginning of the period for which a required contribution has not been paid.

Continuation During Periods of Disability, Personal Leave of Absence or Layoff. A covered Employee may remain eligible if Active, full-time work ceases due to a Disability which is certified by a Physician, personal leave of absence or layoff. Continuance of coverage will end as follows:

For Disability leave: The end of the month that follows the date on which the covered Employee last worked as an Active Employee as defined by the applicable collective bargaining agreement. Disability leave is concurrent with the Family and Medical Leave (as defined by the Family Medical Leave Act of 1993 (FMLA)).

For an approved leave of absence: The end of the month that follows the date in which the covered Employee last worked as an Active Employee as defined by the applicable collective bargaining agreement.

Layoff: The end of the month that follows the date on which the covered Employee last worked as an Active Employee as defined by the applicable collective bargaining agreement.

Continuation of coverage will be coverage which was in force on the last day the covered Employee worked as an Active Employee. However, if benefits reduce for Active Employees in the same Eligible Class, benefits will also reduce for the continued person.

Continuation During Family and Medical Leave (FMLA)

If the Employee fails to return to work after the Family and Medical Leave Act, the Employer has the right to recover its contributions toward the cost of coverage during the Family and Medical Leave Act.

If coverage under the Plan terminates during the Family and Medical Leave Act, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work at the end of the Family and Medical Leave Act.

Rehiring a Terminated Employee. Except as otherwise specifically specified in the Plan, a terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all Eligibility and enrollment requirements of the Plan.

The re-hire provision of the Plan applies only to Employees that terminate employment and are later re-hired by the Employer. This provision does not apply when benefits under the Plan terminate due to reasons not related to termination of employment.

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

- (1) The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.
- (2) The last day of the calendar month that the Employee's coverage under the Plan terminates for any reason including death.
- (3) The date the Dependent reports to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the Employees on Military Leave provision of the Plan.
- (4) The last day of the calendar month a covered Spouse ceases to be a Dependent.
- (5) The last day of the calendar year a dependent child ceases to be a Dependent as defined by the Plan.

NOTE: Upon reaching age 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.

If the Dependent child loses eligibility under the Plan because he or she reached the limiting age of 19 years and was not a full-time student, and subsequently satisfied the Plan's eligibility requirements of a full-time student, he or she may be reinstated as an eligible Dependent. Coverage will be effective on the first day the student enrolls for the following semester, provided the student enrolls within 31 days of the date he or she registers as a full-time student.

The Employer has the right to recover contributions toward the cost of coverage made on behalf of the Employee by the Employer if the Dependent fails to return to school as a full-time student the following semester. If a dependent child ceases to maintain Full-Time Student status, the dependent child's coverage will cease at the end of the month following the dependent's last day in attendance as a Full-Time Student. For purposes of offering Continuation of Benefits (COBRA) to such dependent child, the sixty (60) day period during which the Plan must be notified of the dependent's ineligibility will begin the earlier of:

- (a) The state of classes in the next quarter/semester designated by the last school attended; or
 - (b) In the case of withdrawal, the day after withdrawal; or
 - (c) In the case of graduation, the day after the last day of the semester in which the child graduates.
- (6) The first day of the period for which the required contribution has not been paid.

VISION BENEFITS

Vision care benefits apply when a Covered Person incurs services for vision care that is recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Vision Care Benefits.

VISION CARE CHARGES

Vision care charges are the Usual and Customary Charges for the vision care services and supplies shown in the Schedule of Vision Care Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Vision Care Benefits for each vision care service or supply. As listed below:

- (1) **Vision examinations** by a Physician or Optometrist which include care history, visual acuity (clearness of vision), external examination and measurement; interior examination with ophthalmoscope; pupillary reflexes and eye movements; retinoscopy (shadow test); subjective refraction; coordination measure (far and near); medicating agents for diagnostic purposes; and, analysis of findings with recommendations and prescription if required.
- (2) **Glass or plastic lenses** prescribed by a Physician or Optometrist.
- (3) **Frames** to hold prescribed lenses.
- (4) **Contact lenses** as an alternative to conventional lenses.

PLAN LIMITATIONS

The Plan will not provide benefits for any of the items listed below. This list is intended to give a general description of expenses for services and supplies not covered by the Plan. There may be expenses in addition to those listed below which are not covered by the Plan.

- (1) **Prior to effective date.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan.
- (2) **Coating or Laminating.** Charges for coating or laminating of the lens or lenses.
- (3) **Cost** of frames or contact lenses which exceed the maximum benefit.
- (4) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.
- (5) **Excess.** Charges incurred in excess of any plan maximums.
- (6) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than the Plan.
- (7) **Insurance premium** for lenses and/or frame replacement policies.
- (8) **Medical** or surgical treatment of the eye.
- (9) **No prescription.** Charges for lenses ordered without a prescription.
- (10) **Occupational.** 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.
- (11) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

- (12) **Non-Prescription Sunglasses.** Charges for non-prescription sunglasses, or tints, including Tints #1 or #2, including prescription type and extra charges for photosensitive or anti-reflective lenses.
- (13) **Prescription Sunglasses.**
- (14) **Safety goggles.**
- (15) **Training.** Charges for vision training or subnormal vision aids.
- (16) **Replacement.** Charges for lost, stolen or broken lenses and/or frames if benefits applicable to the replacement were previously provided during the calendar year.
- (17) **Taxes** on contact lens and follow-up care to train first time contact lens wearers.
- (18) Two (2) pair of glasses in lieu of bifocals.

FILING A CLAIM

HOW TO SUBMIT A CLAIM

The following general steps should be followed in order to submit a claim for Vision:

- (1) Obtain a claim form from the Human Resource Department, the Plan Administrator or on-line at Mymeritain.com.
- (2) Complete the Employee section of the form. Answer all questions, even if the answer is "none" or "N/A" (not applicable), including the section referring to other insurance ("COB"). A separate claim form must be completed for each Covered Person for whom benefits are being requested.
- (3) The Physician or other provider must complete the provider's portion of the form.
- (4) Attach bills for services rendered. Documentation must include:
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number and federal tax identification number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of service
 - Charges
 - If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to the Plan.
- (5) Mail the completed claim form and attached documentation to the Claims Processing Office or at the address listed below:

Meritain Health
P.O. Box 30132
Lansing, Michigan 48909-7632

Questions regarding the claim can be addressed by calling the toll-free number on the member's ID card.

WHEN CLAIMS MUST BE SUBMITTED

Claims must be filed with the Claims Processor within 15 months of the date the service was incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed after 15 months of the date the service was incurred will be declined.

The Claims Processor will determine if sufficient information has been submitted for appropriate consideration of the claim. If not, additional information may be requested.

CLAIMS PROCEDURE

The Plan's claims procedures are intended to reflect the Department of Labor's claims procedures regulations, and should be interpreted accordingly. In the event of any conflict between the summary and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this summary automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to the claimant.

Initial claims for Plan benefits are made to the Plan Administrator or, if applicable, the Insurer providing that benefit. The Plan Administrator, (or Insurer, if applicable) will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

- (a) **Urgent Care Claims.** If the claimant's claim is for urgent care health benefits, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 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. In the case of such a failure, the reviewer will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

- (b) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the reviewer will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

- (c) **Other Health Benefit Claims.** In the case of a health benefit claim not described above:

- (i) In the case of a pre-service health benefit claim, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to matters beyond the control of the Plan, the reviewer needs

additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination for up to 15 days, provided that the reviewer notifies the claimant.

- (ii) Within 15 days after the Plan receives the claim, of those special circumstances and of when the reviewer expects to make its decision. However, if such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

- (iii) In the case of a post-service health benefit claim, the reviewer will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination on a one-time basis for up to 15 days, provided that the reviewer notifies the claimant within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the claimant has already received.

- (d) Calculation of Time Periods. For purposes of these time periods relating to the Plan's initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to the claimant until the date the claimant responds to the request for additional information.
- (e) Manner and Content of Denial of Initial Claims. If the reviewer denies a claim, it must provide to the claimant, in writing or by electronic communication:
 - (i) The specific reasons for the denial;
 - (ii) A reference to the Plan provision or insurance contract provision upon which the denial is based;
 - (iii) A description of any additional information or material that the claimant must provide in order to perfect the claim;
 - (iv) An explanation of why the additional material or information is necessary;
 - (v) Notice that the claimant has a right to request a review of the claim denial and information on the steps to be taken if the claimant wishes to request a review of the claim denial along with the time limits applicable to a request for review;
 - (vi) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the claimant and without charge); and

- (vii) If the adverse benefit determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to the claimant's medical circumstances, or (b) a statement that the same will be provided upon request by the claimant and without charge.

NOTE: In the case of an adverse benefit determination concerning a health claim involving urgent care, the information described in this Section may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished to the claimant no later than 3 days after the oral notification.

Reviews of Initially Denied Claims

If a claimant submits a claim for Plan benefits and it is initially denied under the procedures described above, the claimant may request a review of that denial under the following procedures.

- (a) **Health Benefit Claims.** A claimant for health benefits has one hundred eighty (180) days following receipt of a notification of an adverse initial benefit determination within which to request a review of the adverse initial benefit determination. In such cases, the review will meet the following requirements:
 - (i) The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.
 - (ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial benefit determination 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 professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.
 - (iii) The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.
 - (iv) In the case of a requested review of a denied adverse initial benefit determination involving urgent health care, the review process shall meet the expedited deadlines described below. The claimant's request for such an expedited review may be submitted orally or in writing by the claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.
 - (v) The reviewer will afford the claimant an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan Administrator (or Insurer, if applicable). The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.
- (b) **Deadline for Review Decisions.**
 - (i) **Urgent Health Benefit Claims.** In the case of urgent care health benefit claims, the reviewer will notify the claimant of the Plan's determination on review as soon as possible, taking into

account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of the adverse initial benefit determination by the Plan.

- (ii) Other Health Benefit Claims.
 - a. In the case of a pre-service health claim, the reviewer will notify the claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the claimant's request for review of the adverse initial benefit determination.
 - b. In the case of a post-service health claim, the reviewer will notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after receipt by the Plan of the claimant's request for review of the adverse initial benefit determination.
- (iii) Calculation of Time Periods. For purposes of the time periods specified in this Section, the period of time during which a benefit determination on review is required to be made begins at the time relating to the Plan's review of adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination or review accompanies the request for review. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination shall be "frozen" from the date the notification requesting the additional information is sent to the claimant until the date the claimant responds to the request for additional information.
- (c) Manner and Content of Notice of Decision on Review. Upon completion of its review of an adverse initial benefit determination, the reviewer will give the claimant, in writing or by electronic notification, a notice containing:
 - (i) its decision;
 - (ii) the specific reasons for the decision;
 - (iii) the relevant Plan provisions or insurance contract provisions on which its decision is based;
 - (iv) a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;
 - (v) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the claimant upon request;
 - (vi) if the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such an explanation will be provided without charge upon request; and
 - (vii) the following statement: "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, if your benefit is an insured benefit, your State insurance regulatory agency."

Appeal

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

provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

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

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

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

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

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits is the order of payment when charges are eligible under two or more benefit plans. Coordination of benefits also occurs when the Covered Person is covered by the Plan and Medicare.

The plan that pays first according to the rules will pay as if there was no other coverage. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

If two 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 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 employees) are eligible for benefits as both Employees and Dependents up to the Plan maximum.

Benefit plan. The Plan will coordinate the vision benefits with the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs, including Medicare.
- (5) Other plans required or provided by law. This provision does not include any benefit plan or Medicaid that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance.

Allowable charge. The Plan will consider only covered charges under the Plan as Allowable Charges.

In the case of "service type plans" where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

No-Fault limitations. When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan will always be considered secondary and coordinate with benefits provided or required by any no-fault insurance statute whether or not a no-fault policy is in effect.

Benefit plan payment order. When two or more benefit plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

- (1) Benefit plans that do not have a coordination of benefits provision will pay first.
- (2) Benefit plans with a coordination of benefits provision will pay benefits up to the Allowable Charge as follows:
 - (a) The benefit plan which covers the person directly (that is, as an employee, member or subscriber) will determine benefits thereunder before benefits are considered under a benefit plan which covers the person as a dependent.
 - (b) The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before a benefit plan which covers that person as a laid-off or retired employee. The benefit plan which covers a person as a dependent of an employee who is neither laid-off nor retired will determine benefits thereunder before benefits are considered under a benefit plan which covers a person as a dependent of a laid-off or retired employee.

- (c) The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers that person as a laid-off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (d) The benefit plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers the person as a COBRA beneficiary.
 - (e) When a child is covered as a dependent and the parents are not separated or divorced, the following rules will apply:
 - (i) The benefit plan of the parent whose birthday falls earlier in a year will determine benefits before benefits are considered under a benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefit plan which has covered the patient for the longer period of time will determine benefits before benefits are considered under the benefit plan which covers the other parent.
 - (f) When a child's parents are divorced or legally separated, the following rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will determine benefits before benefits are considered under the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. First, the benefit plan of the parent with custody determine benefits. Next, the benefit plan of the stepparent that covers the child as a dependent will determine benefits. Finally, the benefit plan of the parent without custody will determine benefits.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and vision benefits of the child. In this case, the benefit plan of that parent will determine benefits before benefits are considered under other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the benefit plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (g) When a child's parents were never married to each other, the rules as set out above in letter (e), will apply as long as paternity has been established.
 - (h) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer period of time will determine benefits thereunder first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last, as specified in applicable law.
 - (4) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and the Plan will pay second.

OTHER IMPORTANT PLAN PROVISIONS

Assignment Of Benefits. No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an Alternate Recipient.

Inability to Locate Recipient. If the Plan Administrator is unable to make payment to any Covered Person or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Covered Person or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited eighteen (18) months after the date such payment first became due.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. As a condition to receiving benefits under the Plan, Covered Person(s), including all Dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the Injury or Illness giving rise to the benefits occurs through the act or omission of another person.

Alternatively, if a Covered Person receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person or business entity, the Covered Person agrees to reimburse the Plan, in first priority, for any benefits paid by the Plan (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by the Plan, from any monies received, with the balance, if any, retained by the Covered Person).

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including Plan expenses. Furthermore, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery together with all other previous or anticipated recoveries fully compensates the Covered Person for any damages the Covered Person may have experienced.

This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the Covered Person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the Covered Person.

The Plan may enforce its reimbursement or subrogation rights by requiring the Covered Person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the Covered Person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rules.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan offer covered Employees and their covered spouses and dependent children the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the Plan Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at specific rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The continuation coverage is identical to the coverage under the Plan that the Qualified Beneficiary had immediately before the Qualifying Event, or, if the coverage has been changed, the coverage is identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event.

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under the Plan as either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee, and who loses coverage under the Plan because of the Qualifying Event.
- (ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage.

In addition, if the Qualifying Event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to an Employer, a covered retired Employee (who retired from employment with that Employer) and any individual who is covered under the Plan as the Spouse, surviving Spouse or Dependent child of such a retired Employee may also be Qualified Beneficiaries. Those individuals are qualified beneficiaries only if (1) for the Employee, he or she retired on or before the date of substantial elimination of coverage and (2) for any other individuals, they were beneficiaries under the Plan on the day before the bankruptcy proceeding commenced.

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

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

What is a Qualifying Event? A Qualifying Event is any of the following if an Employee, a Spouse or a Dependent child would lose coverage (i.e., would cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

For a covered Employee, the following may be a Qualifying Event:

- (i) The termination (other than because of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

For a covered Spouse, in addition to (i), the following may be Qualifying Events:

- (ii) The death of a covered Employee.
- (iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (iv) A covered Employee's entitlement to Medicare.

For a covered Dependent child, in addition to events (i)-(iv) above, the following may be a Qualifying Event:

- (v) A Dependent child's ceasing to satisfy the Plan's requirements for coverage as a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

Finally, for a covered retired Employee (or a Spouse, surviving Spouse, or Dependent who has coverage as the Spouse, surviving Spouse or Dependent of a retired Employee), the following may also be a Qualifying Event:

- (vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered retired Employee retired at any time.

If the Qualifying Event causes the Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (the persons losing such coverage become Qualified Beneficiaries under COBRA. In addition, if a bankruptcy Qualifying Event causes a former Employee (who retired on or before the date of a substantial elimination of coverage), or such a former Employee's Spouse, surviving Spouse or Dependent child to experience a substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), that former Employee, Spouse, surviving Spouse or Dependent child becomes a Qualified Beneficiary under COBRA. Any increase in contribution that must be paid by a covered Employee, former Employee or the Spouse, surviving Spouse or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a covered Employee does not return to employment at the end of the FMLA leave. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date. Note that the covered Employee and covered Family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. Availability of COBRA continuation coverage is conditioned upon the timely election of such coverage. The election period begins on the date of the Qualifying Event and ends 60 days after the later of (1) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or (2) the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? Yes, in some cases. Each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (i) A Dependent child's ceasing to be a Dependent child under the Plan.
- (ii) The divorce or legal separation of the covered Employee.

A Qualified Beneficiary (or the covered Employee or Spouse) must notify the Plan Administrator within 60 days after the later of the date one of these Qualifying Events occurs.

This notice must be provided, along with any required documentation to:

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

The notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- (i) The covered Employee's name, address, phone number and health plan ID number.
- (ii) The name, address, phone number and health plan ID number for any Dependent child or Spouse whose eligibility is affected by the qualifying event.
- (iii) A description of the Qualifying Event (or a notice of a disability determination or termination of disability status, as described below) and the date on which it occurred.
- (iv) The following statement: "By signing this letter, I certify that the Qualifying Event described in this letter occurred on the date described in this letter." If the notice concerns a disability determination or a change in disability status, as described below, this statement is not required.
- (v) The signature of the person sending the letter.

The Qualified Beneficiary (or the covered Employee or Spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a Qualified Beneficiary or anyone else has a question about what type of documentation is required, he or she should contact the Plan Administrator.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or Dependent child may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of (1) the date of the Qualifying Event or (2) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

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

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? COBRA continuation coverage ends on the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other group health plan that does not include an exclusion or limitation with respect to any pre-existing condition that would affect the Qualified Beneficiary.
- (v) The date, after the date of the election, that the Qualified Beneficiary is first entitled to Medicare. This date does not apply for anyone who became a Qualified Beneficiary because of a bankruptcy proceeding.
- (vi) For a Qualified Beneficiary who is entitled to a disability extension, the later of:
 - (a) the first day of the first month that is later than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the last day of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA participants, (for example, for fraud.)

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

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

- (i) If the Qualifying Event is a termination of employment or reduction of hours of employment, except as provided in paragraphs (ii) and (iii) below, the maximum coverage period ends 18 months after the Qualifying Event.
- (ii) If the Qualifying Event is a termination of employment or reduction of hours of employment and the Qualified Beneficiary is entitled to a disability extension, the maximum coverage period ends 29 months after the Qualifying Event if there is a disability extension (unless the disability ends before the end of that 29- month period).
- (iii) If a covered Employee becomes entitled to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes entitled to Medicare; or
 - (b) 18 months (or up to 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (iv) For a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is a retired covered Employee (or a surviving Spouse who was participating in the Plan as a surviving Spouse on the day before the bankruptcy Qualifying Event) ends on the date of the covered retired Employee's (or surviving Spouse's) death. The maximum coverage period for a Qualified Beneficiary who is the Spouse or Dependent child of the covered retired Employee ends 36 months after the death of the covered retired Employee.
- (v) For a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum

coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

- (vi) For any Qualifying Event other than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the maximum coverage period may be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to last longer than 36 months after the date of the first Qualifying Event.

However, no event is a second Qualifying Event unless that event would have been an initial Qualifying Event if it had occurred for an active covered Employee. For example, an Employee's entitlement to Medicare cannot be a second Qualifying Event for a Spouse or a Dependent child unless an active Employee's entitlement to Medicare would have been an initial Qualifying Event, i.e., unless an Employee's entitlement to Medicare would have resulted in a loss of coverage for the Spouse or Dependent child.

A Qualified Beneficiary (or a covered Employee or Spouse) must notify the Plan Administrator of a second Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage because of the Qualifying Event. To submit this notice, the Qualified Beneficiary must follow the procedures described above under "**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?**"

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

If a Qualified Beneficiary becomes entitled to a disability extension and then there is a final determination by the Social Security Administration, under title II or XVI of the Social Security Act, that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary (or the covered Employee or someone else) must notify the Plan Administrator of that determination within 30 days after the date of the final determination. The notice should take the form of a letter as described above under "**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?**"

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, the Plan will require the payment of an amount equal to 102% of the actual cost of coverage except the Plan will require the payment of an amount equal to 150% of the actual cost of coverage for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension.

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

What is Timely Payment for payment for COBRA continuation coverage? For regular monthly payments, Timely Payment means a payment made by the first day of the month in question (the "due date") or within a 30 day grace period beginning on that due date.

Notwithstanding the above paragraph, the Plan will not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA

continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

Special Additional Continuation Coverage Election Period for "TAA-Eligible Individuals". In addition to the other COBRA rules described in the Plan, there are some special rules that apply if an individual is classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if the individual qualifies for assistance under the Trade Adjustment Assistance Reform Act 2002 because he or she became unemployed as a result of increased imports or the shifting of production to other countries.)

If an individual who is classified by the Department of Labor as a TAA-eligible individual does not elect continuation coverage when he or she first loses coverage, he or she may qualify for an election period that begins on the first day of the month in which the individual becomes a TAA-eligible individual and lasts up to 60 days. However, in no event does this election period last later than 6 months after the date of the individual's TAA-related loss of coverage. If a TAA eligible individual elects continuation coverage during this special election period, continuation coverage would begin at the beginning of that election period, but, for purposes of determining the maximum required COBRA coverage period, the coverage period will be measured from the date of the original Qualifying Event, i.e., the TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some expenses for continuation coverage. An affected individual should consult with a financial advisor if he or she has questions about the tax credit.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Plan Sponsor shall be the Plan Administrator. The Plan Administrator shall be the named fiduciary. Except as to those functions reserved to the Plan Sponsor or an Insurer, the Plan administrator shall control and manage the operation and administration of the Plan.

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

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

SELF-FUNDED NATURE OF PLAN

For Full-Time Employee Coverage: Funding is derived solely from the funds of the Plan Sponsor.

For Part-Time Employee Coverage: Funding is derived from the funds of the Plan Sponsor and contributions made by the covered Employees.

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

All Plan benefits are paid from the Employer's general assets. No trust or other separate fund is maintained in connection with the Plan.

The level of any Employee contributions will be set by the Plan Sponsor.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract of employment. Nothing contained in the Plan shall be deemed:

- (1) to give any Employee the right to be retained in the employ of the Employer; or
- (2) to affect the right of the Employer to discipline or discharge any Employee at any time.

ADMINISTRATIVE ERROR

If, due to an administrative error, an overpayment occurs in a reimbursement amount from the Plan, the Plan retains a contractual right to recover the overpayment. The person or institution receiving the overpayment will be required to return the overpayment. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING, MODIFYING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination. If the Plan is amended or modified, expenses incurred prior to the modification or amendment of the Plan will be considered as provided under the terms of the Plan prior to its amendment or modification.

The Employer by action evidenced in writing reserves the right, at any time, without prior notice, to amend, suspend or terminate the Plan in whole or in part. In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan automatically will terminate unless it is continued by a successor to the Plan Sponsor.

HEALTH INFORMATION PRIVACY AND SECURITY

SCOPE OF SECTION

This Section is intended to provide for the Plan's compliance with all applicable requirements of the final Regulations issued by the Department of Health and Human Services pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the Regulations entitled Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulations") and the Regulations entitled Health Insurance Reform: Security Standards (the "Security Standards").

The Plan will comply with all applicable requirements of the Privacy Regulations, as provided in this Section and in the Privacy Regulations and as interpreted pursuant to any subsequent authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Privacy Regulations and any provision of this Plan, the Privacy Regulations will control. Also, any amendment or revision or authoritative interpretation of the Privacy Regulations is incorporated into the Plan as of the effective date of that guidance.

Notwithstanding the preceding, this Section applies only to those plans that provide health benefits and that are subject to the Privacy Regulations, as determined by the Plan Administrator.

PROTECTED HEALTH INFORMATION

For purposes of this Section, "Protected Health Information" (PHI) has the same meaning as provided for that term in the Privacy Regulations and is limited to information that is Protected Health Information with respect to the Plan.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

The Plan will disclose Protected Health Information to the Plan Sponsor only as follows:

- (a) Summary Health Information. The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information that is summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:
 - (i) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan; or
 - (ii) Modifying, amending or terminating the Plan.

For purposes of this subsection, "summary health information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan, from which certain identifying details have been removed, as provided in section 164.504(a) of the Privacy Regulations.

- (b) Enrollment Information. The Plan, or a health insurance issuer or HMO with respect to 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 option or HMO offered by the Plan.
- (c) Other Disclosures to Plan Sponsor. Except as provided in subsections (a) or (b) above, or under the terms of an applicable individual authorization, the Plan may disclose Protected Health Information to the Plan Sponsor and may permit the disclosure of Protected Health Information by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the Protected Health Information to administer the Plan.

The Plan Sponsor, by signing this document, certifies that it:

- (i) will not use or further disclose Protected Health Information other than as permitted or required by the Plan or as required by law;
 - (ii) will ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
 - (iii) will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
 - (iv) will report to the Plan any use or disclosure, of which it becomes aware, of the information that is inconsistent with the uses or disclosures permitted under the Plan;
 - (v) will make Protected Health Information available to the individual who is the subject of that information in accordance with Section 164.524 of the Privacy Regulations;
 - (vi) will consider requested amendments to an individual's Protected Health Information in accordance with Section 164.526 of the Privacy Regulations;
 - (vii) will make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with Section 164.528 of the Privacy Regulations;
 - (viii) will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;
 - (ix) if feasible, will return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
 - (x) will ensure that the adequate separation of the Plan and the Plan Sponsor as required in this Section is established.
- (d) Prohibited Disclosures. The Plan will not disclose Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

SEPARATION OF HEALTH PLANS AND PLAN SPONSOR

The Plan is a legal entity separate from the Plan Sponsor. The Plan Sponsor has designated and trained certain employees of the Plan Sponsor as the only employees of the Plan Sponsor who will have access to Protected Health Information. Those employees are identified on the attached Schedule A. If there are any changes to the group of employees who are authorized to have access to Protected Health Information on behalf of the Plan, Schedule A will be updated to reflect those changes. Any revised Schedule A is incorporated into the Plan as of the effective date of the revision without the need for further amendment to the Plan. Employees listed on Schedule A will use or disclose Protected Health Information only to the extent appropriate for performing administrative services that the Plan Sponsor provides for Plan.

The Plan Sponsor will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that employees of the Plan Sponsor who have access to Protected Health Information use that Protected Health Information only for the purposes specified in this Section.

PRIVACY NOTICE

The Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Regulations and the Plan's Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan.

HIPAA SECURITY REGULATIONS

This Subsection is effective as of the date the Plan is required to comply with the Security Standards. Beginning on that date, the Plan will comply with all applicable requirements of the Security Standards, as provided in this document and in the Security Standards and as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Security Standards and any provision of this Plan, the Security Standards will control. Also, any amendment or revision or authoritative interpretation of the Security Standards is incorporated into the Plan as of the effective date of that guidance.

In addition, the Plan Sponsor, by adopting this document, certifies that, beginning on the date this Subsection becomes effective, the Plan Sponsor will:

Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan;

Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

Ensure that the adequate separation required by Section 164.504(f)(2)(iii) of the Privacy Regulations is supported by reasonable and appropriate security measures;

Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect that information; and

Report to the Plan any security incident (occurring on or after the date this Subsection becomes effective) of which it becomes aware.

OTHER ADMINISTRATIVE SIMPLIFICATION REGULATIONS

Notwithstanding any other provision of the Plan, the Plan will comply with all applicable requirements of the Administrative Simplification regulations issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as they become applicable to the Plan and the Plan shall be construed to be consistent with such requirements.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan administered by the Employer.

PLAN NAME

Plymouth-Canton Community Schools Employee Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 38-6004186

PLAN EFFECTIVE DATE AS AMENDED AND RESTATED: July 1, 2009

PLAN YEAR: The 12-month period for the Plan Sponsor preceding August 31, unless otherwise stated.

EMPLOYER INFORMATION

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

CLAIMS PROCESSOR

Meritain Health
P.O. Box 30132
Lansing, Michigan 48909-7632
(800) 748-0003

SIGNATURE PAGE

BY THIS AGREEMENT, Plymouth-Canton Community Schools Employee Benefit Plan, amended and restated as of July 1, 2009 is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Plymouth-Canton Community Schools on or as of the day and year first below written.

By _____
Plymouth-Canton Community Schools

Date _____

Witness _____

Date _____