SUMMARY PLAN DESCRIPTION OF
GAYLORD COMMUNITY SCHOOL DISTRICT
EMPLOYEE VISION BENEFIT PLAN
EFFECTIVE JANUARY 1, 2016

CORESOURCE
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INTRODUCTION

Your Gaylord Community School District vision plan is intended to help you or any covered family member, maintain an active and continuous program of vision care.

This booklet or **Summary Plan Description** includes information describing your plan benefits, first in general, and then specifically, including how each type of service is covered by this plan. Specific services that are not covered are listed in the section of this booklet titled "What Is Not Covered?"

You will notice that certain words in this **Summary Plan Description** have been highlighted. These words have a special meaning in this plan and are defined in the section titled "Glossary" in this booklet.

Your benefit plan is governed by a legal document referred to as the **Plan Document**. This booklet, referred to as a **Summary Plan Description**, is written in a manner meant to be easily understood as an explanation of the benefits provided for you in the **Plan Document**.

The Gaylord Community School District may modify, amend or terminate the plan at any time at its discretion. Coverage under this benefit program, or receipt of any benefit from the plan, does not in any way affect your employment relationship with your **employer**, or in any way limit your **employer's** right to terminate your employment.

You will find information on the following pages that describes your benefits. If you have any questions, please contact your Human Resources Department.

This plan is intended to comply with all provisions of any federal acts and/or applicable court decisions which set forth a precedent. This plan shall be deemed to be amended to minimum standards required by these acts and/or applicable court decisions, as interpreted by the **Plan Administrator**.

OVERVIEW OF BENEFITS: BENEFIT CRITERIA

You need to know that this plan provides coverage for treatment, services and supplies that meet certain criteria. FOR CHARGES TO BE CONSIDERED FOR PAYMENT UNDER THIS PLAN, THE TREATMENT, SERVICE OR SUPPLY:

1. MUST BE **MEDICALLY NECESSARY** (OR BE PREVENTIVE),
2. MUST BE RENDERED BY A COVERED PROVIDER/FACILITY,
3. MUST NOT EXCEED **REASONABLE AND CUSTOMARY** AMOUNTS,
4. MUST NOT BE CONSIDERED **EXPERIMENTAL/INVESTIGATIONAL**, AND
5. MUST NOT BE LIMITED, RESTRICTED OR EXCLUDED ELSEWHERE IN THIS **SUMMARY PLAN DESCRIPTION (SPD)**.

These criteria, which are explained below, are admittedly very technical. It is not our intention to confuse you. Instead, we would like to assist you with understanding how these provisions relate to your proposed course of treatment. You and/or your **physician** should feel free to contact CoreSource, Inc. for additional clarification on any of the provisions listed below.

1. When Is A Procedure, Service Or Supply Considered Medically Necessary?

A procedure, service or supply is deemed to be **medically necessary** when it is for the treatment of an **illness** or **injury**; it is prescribed by a **physician** and is professionally accepted as the usual, customary and effective means of treating a condition. Diagnostic x-rays and laboratory tests that are performed due to definite symptoms of **illness** or **injury** or reveal the need for treatment will be considered **medically necessary**. In the evaluation of medical necessity, the plan may request records that, if legally required to be maintained, must be made available to the plan in order to consider the expenses. The plan may also seek outside medical opinions from appropriate board certified specialists. The plan reserves the right to have the patient examined by an independent specialist in the appropriate field of medicine.

2. Who Is A Covered Provider?

A provider shall be considered a covered provider if he or she is a provider listed in the definition of "**physician**," (Please see the "Glossary") acting within the scope of his or her license. Additionally, the plan will cover other providers who are not **physicians** but who are specifically mentioned as covered providers in this **SPD**, provided they are acting within the scope of their license.

3. What Is Meant By "Reasonable And Customary"?

"**Reasonable and Customary**" (R&C) refers to certain plan limitations on provider charges, in regard to what will be accepted as allowable under the plan. As the actual purchaser of health care services, you should not hesitate to seek information from medical providers on the cost of proposed treatments for you and your family members, just as you would if you were making any other type of purchase.

By playing an active role in seeking cost information, you can minimize your own out-of-pocket costs and conserve the dollars applied to any maximums under the plan as well. In general, R&C means that the charge is comparable to fees charged for the same or similar services in the geographic area where the service is rendered. **Reasonable and customary** calculations also use standard methods to adjust for unusual circumstances or complications which may require additional time, skill or experience.

4. What Is Meant By "Experimental" Or "Investigational"?

The plan shall use the following guidelines to determine that a drug, device, medical treatment or procedure is **experimental** or **investigational**:

1. The procedure, drug or device cannot be lawfully marketed without approval of the U.S. FDA and approval for marketing has not been given at the time the drug or device is furnished or the drug or device has been granted FDA approval solely as a humanitarian exemption. Certain off label uses of a drug that is otherwise FDA approved may be considered non-experimental, as set forth under "Off Label Use" below. IN ANY EVENT, ANY DRUG, MEDICAL DEVICE OR BIOLOGICAL PRODUCT WHICH THE FDA HAS DETERMINED TO BE CONTRAINDICATED FOR THE SPECIFIC TREATMENT FOR WHICH THE DRUG HAS BEEN PRESCRIBED WILL BE CONSIDERED **EXPERIMENTAL/ INVESTIGATIONAL**; OR
2. The drug or drug therapy, device, or procedure was reviewed and approved for **experimental/investigational** use by the treating facility's institutional review board (IRB), if federal law requires such a review or approval; or the patient is participating in a Phase I, II or III clinical trial; or
3. Reliable Scientific Evidence (RSE) *indicates* that the prevailing opinion among experts regarding the drug or drug therapy, device or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treating the diagnosis.

Off-Label Use

Once FDA approval has been granted for a drug or biological product for use in the treatment of a particular diagnosis or condition, use of the drug or biological product for another diagnosis or condition will require that use of that drug or biological product be recognized as medically appropriate and generally accepted by one or more of the following:

- The American Hospital Formulary Service Drug Information or other major drug compendia.
- Reliable Scientific Evidence as defined below.

Reliable Scientific Evidence

Reliable scientific evidence means:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
- Peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in index Medicus, Excerpta Medicus (EMBASE), Medline, NCCN, or Medlars database Health Services Technology Assessment Research (STAR).

5. What Is Excluded Under The Plan?

The plan excludes payment for certain treatment, services or supplies in the form of limitations or maximums, subject to the criteria listed above, the general exclusions listed in the exclusions section at the back of the document, and specific benefit exclusions described under the benefit details section of this plan. When determining if a particular treatment, service or supply is payable, it is important to first consider the criteria listed above, then review the benefit details and general exclusions to determine if any limitations, maximums or exclusions apply.

GLOSSARY

Whenever one of the following words or phrases appears highlighted, they shall have the meaning explained below, unless the context otherwise requires. Please note, "**reasonable and customary**," "**experimental**," "**investigational**" and "**medically necessary**" have been defined under the section titled "Overview of Benefits: Benefit Criteria" in this **SPD**.

Adverse benefit determination: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a participant's or beneficiary's eligibility to participate in the plan. This includes a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review (if applicable), as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be **experimental** or **investigational** or not **medically necessary** or appropriate.

Alternate Recipient: any child of a participant in a group health plan who is recognized under a Medical Child Support Order as having a right to enrollment under the plan with respect to such participant.

Annual open enrollment period: an annual period of time during which you may enroll in this plan. The enrollment period will be determined and announced each year by the **employer**. Please contact the Benefits Department (or HR) for further information.

Authorized representative: a **physician** rendering the service for which a bill is submitted (but not a designee of the **physician**), or a person who a covered **employee** or covered **dependent** has authorized in writing to act on his/her behalf. If the claim is an urgent care **pre-service claim**, the plan will consider a **health care professional** with knowledge of a **claimant's** medical/dental or vision condition as an **authorized representative**.

If a covered **employee** or covered **dependent** wishes to authorize another person (e.g., family member) to act on his/her behalf on matters that relate to filing of benefit claims, notification of benefit determinations, and/or appeal of benefit denials, he/she must first notify the **Plan Administrator** of such authorization by providing a completed Notice of Authorized Representative form. The Notice of Authorized Representative form can be obtained from your Human Resources Department.

Claimant: an eligible **employee**, a covered **dependent** or an **authorized representative**.

Claims Administrator: your plan has different **Claims Administrators** based on the type of claim. The **Claims Administrator** for each type of claim is responsible for claim processing within the time periods listed for initial claims determination as well as for the final decision for any appeal filed in response to an **adverse benefit determination**. Each is independently, responsible for notifying you of the **adverse benefit determination**, based on the type of claim, as well as reviewing any appeal you may make. Your **Claims Administrator** is as follows:

Post-Service Claims

Vision: CoreSource, Inc. P.O. Box 2310, Mt. Clemens, MI 48046, (800) 999-0114.

Concurrent claims decision: a decision by the plan relating to an ongoing course of treatment.

Covered individual: an eligible **employee**, covered spouse, **domestic partner** or **dependent** that is enrolled in the Gaylord Community School District Employee Vision Benefit Plan. (This includes only those people who qualify for enrollment as indicated in the section titled "Participating in the Plan".)

Dependent(s): people who have a relationship to an **employee**. This includes only those people who qualify for enrollment as indicated in the section titled "Participating in the Plan".

Domestic partner: an individual who:

- has a committed relationship with the **employee** which has existed for at least 12 months prior to enrollment for coverage and is expected to last indefinitely; and
- shares the responsibility for each other's welfare and financial obligations; and
- is 18 years of age or older; and
- is not married; and
- has two or more of the following as evidence of joint responsibility for basic financial obligations:
  - joint mortgage or lease;
  - designation of the **domestic partner** as durable power of attorney or health proxy;
  - joint wills or designation of the **domestic partner** as executor and/or primary beneficiary;

- joint bank account, joint credit cards or evidence of other joint financial responsibility;
- designation of the **domestic partner** as beneficiary for life insurance or retirement benefits.

Employee: an individual who is regularly scheduled to work at least 30 hours per week as a full-time **employee** of the **company** or a half-time teacher.

Employer: Gaylord Community School District, 615 S. Elm Street, Gaylord, MI 49735, (989)705-3002.

Enrollment date: the earlier of the date your coverage begins or the date your waiting period for coverage begins. For a late enrollee, the **enrollment date** is the first day of coverage.

Enrollment form: the form provided by the **employer** for your completion and signature to enroll you and your **dependents** in this benefit plan.

Health care professional: a **physician** or other **health care professional** licensed, accredited, or certified to perform specified health services consistent with state law.

Illness: the condition of being sick or unhealthy as classified in the International Classification of Diseases (ICD-9).

Injury: a sudden, unexpected and unforeseen bodily harm that occurs solely through external bodily contact.

Medicare: a Federal program through the Social Security System that provides benefits for hospital and **physician** care. This includes a Health Maintenance Organization (HMO) which participates with **Medicare** and receives payment from **Medicare**. (It is available on an enrollment basis to individuals receiving hemodialysis treatment beyond 30 months, individuals eligible for Social Security benefits if they are age 65 or older or those individuals who have qualified for Social Security disability benefits and have received such disability benefits for 24 months.)

Physician(s): a qualified Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Optometrist (OD) within the scope of their licenses, are permitted to perform services for which coverage is provided in this plan; as well as other providers who are not **physicians**, but who are specifically mentioned as covered providers in the section titled “Vision Benefits”.

Plan Administrator: Gaylord Community School District, 615 S. Elm Street, Gaylord, MI 49735.

Plan Document: the legal description of and the governing document for the Gaylord Community School District Employee Vision Plan that may be amended from time to time, and the documents incorporated by reference.

Plan Supervisor: CoreSource, Inc. P.O. Box 2310, Mt. Clemens, MI 48046, (800) 999-0114

Plan year: begins on January 1 and ends on December 31.

Post-service claim: a claim that is a request for payment under the plan for covered vision services that a **claimant** has already received.

Pre-service claim: any claim for a benefit under this plan where the plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

- This plan does not condition benefit payment whether an urgent care claim or a non-urgent care claim, on any advance notification. Plan inquiries regarding benefits will be responded to as a courtesy and are not a guarantee of payment. Inquiries may be made in writing to the **Plan Supervisor**, CoreSource, Inc. P.O. Box 2310, Mt. Clemens, MI 48046, (800) 999-0114

Qualified Medical Child Support Order (QMCSO): an order of a court or authorized administrative agency requiring medical child support which meets the federal law requirements to be a **Qualified Medical Child Support Order**.

Summary Plan Description (SPD): this summary of your benefits.

PARTICIPATING IN THE PLAN

1. Who Can Participate In The Plan?

You are eligible for coverage in this plan if you are a full time **employee** who is regularly working **at least** 30 hours per week, or you are a half-time teacher.

2. When Can I Participate In The Plan?

As an eligible **employee**, you may participate in the plan described in this booklet on the first day of active employment. Your Human Resources Department will provide you with an **enrollment form**.

3. How Do I Enroll For Coverage?

You must complete, sign and return your **enrollment form** to your Human Resources Department within 30 days of eligibility for you to be covered in this plan.

4. Can I Enroll My Spouse And Dependent Children?

Yes. If you enroll for coverage, you may also enroll your eligible spouse and **dependent** children.

Verification of **dependent** eligibility may be required at any time. Please be prepared to provide a federal income tax return, marriage certificate, birth certificate, or any other document required by the **Plan Administrator**.

5. How Do I Know If My Spouse Is Eligible?

Your spouse is eligible if you are legally married and neither legally separated nor divorced.

6. What If Both My Spouse And I Work For The Company?

If both you and your spouse are covered as **employees** under this plan, both of you may enroll children as dependents. If you are covered as an **employee** for benefits, you also may be covered as a dependent of your spouse if he/she is covered as an **employee** under a plan maintained by the **employer**.

If both you and your spouse are covered separately as **employees** and coverage for one of you is terminated, the one who remains an **employee** may within 30 days cover their spouse as a **dependent** and may cover any children who were covered under the spouse's coverage.

7. How Do I Know If My Dependent Children Are Eligible?

If you enroll for coverage, you may also enroll your eligible **dependent** children. Please refer to the chart below for eligibility requirements:

Eligible dependents	Requirement
Your **dependent** children	Your children up to the end of the year of their 26th birthday. Children are your: • natural born children, • step-children, • legally adopted children, • Foster Children • children for whom you have court appointed guardianship, • children under age 18 who have been placed for adoption, whether or not the adoption is final. Proof of adoption or placement for adoption is required for enrollment in the plan.
Totally disabled children	Your unmarried children who are totally disabled either mentally or physically may continue their participation in the plan after they reach age 26 provided they were enrolled in the plan prior to their 26th birthday. Proof of their incapacity must/may be provided. Coverage will end when the child is no longer totally disabled.
QMCSO	This plan will also provide coverage as described by a **Qualified Medical Child Support Order (QMCSO)** that assigns the rights of a participant or beneficiary to receive benefits under this health plan.

8. What If A Court Order Requires That I Provide Coverage For My Dependent Child?

A **Qualified Medical Child Support Order (QMCSO)** is a court decree under which a court mandates coverage for a child (called an **Alternate Recipient**). Upon receipt of a Medical Child Support Order or a National Medical Support Notice issued under applicable state or federal law, the Plan Sponsor shall take the following steps, within 20 business days:

1. Determine if the notice or order conforms to the requirements of a **QMCSO**,
2. Reply to the issuing agency if you are no longer employed, fall into a class of **employees** who are ineligible for coverage or if **dependent** coverage is not provided,
3. Notify the issuing agency if the notice or order is determined to not meet the requirements of a **QMCSO**,
4. Notify the issuing agency of the coverage options available under the plan and any waiting periods which exist for coverage under the plan (if applicable),
5. Determine if federal withholding limits or prioritization rules permit the withholding from your income of the amount required to obtain coverage for the children specified,
6. If appropriate, withhold from your income any contributions required,
7. Notify you of any contributions to be withheld from future pay,
8. Notify **Plan Supervisors**/vendors about enrollment, and
9. Notify the issuing agency of the date of enrollment and date coverage under the plan will begin.

The participant and each **Alternate Recipient** shall have the right to request in writing that the Plan Sponsor again review the status of the notice or order. The request must be submitted within 60 days after being notified of the Plan Sponsor's decision. The participant and each **Alternate Recipient** may present additional materials to the Plan Sponsor for review. The Plan Sponsor may request additional information or material from the participant or **Alternate Recipient**. The Plan Sponsor must provide sufficient information to understand available options and to assist in appropriately completing the notice or order.

9. Who Would Not Be Considered Eligible For Enrollment In This Plan?

- You and your **dependents**, on the date your employment terminates or the date you no longer meet eligibility requirements as defined in this plan.
- Your spouse beginning on the date you are legally divorced or legally separated.
- Any individual who begins active service in the armed forces of any country, unless coverage is continued as provided under Federal law.
- Any individual who does not meet the definition of an **employee** or **dependent**.

NOTE: If your coverage terminates or if a **dependent** ceases to be covered for any of the above reasons, you and/or your **dependent** may be eligible to continue coverage under the plan.

10. What Is My Cost To Participate In The Plan?

If you are a full time **employee** who is working **at least** 30 hours per week, the **employer** pays for the cost of providing benefits for you and your eligible dependents.

If you are a half-time teacher, the **employer** shares in the cost of coverage for you and your eligible **dependents**. Information regarding the specific cost for coverage can be obtained from your Human Resources Department.

11. Can I Enroll Myself And/Or My Dependents If I Previously Declined Participation In The Plan?

If you are an eligible **employee**, you may have the opportunity to enroll yourself and **dependents** at open enrollment. During this time, you will have an opportunity to select the coverage that is best for your family. The **annual open enrollment period** is held once each year from December 1 through December 31. You may enroll or transfer into any plan maintained by the company for benefits and change the eligible **dependents** you cover. Elections made during the **annual open enrollment period** will be effective on the first of January of the following year.

If you declined enrollment for yourself or your **dependents** and you or your **dependents** become eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP), you may enroll yourself and **dependents** in this plan within 60 days of when eligibility for the subsidy was determined.

If you declined enrollment for yourself or your **dependents** and coverage under Medicaid or Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, you may enroll yourself and **dependents** in this plan within 60 days of the loss of coverage.

If you declined enrollment for yourself or your **dependents** because you or your **dependents** have other group coverage or another health insurance arrangement, you may, in the future, be able to enroll yourself or your **dependents** in this plan, provided you request enrollment within 30 calendar days after your other coverage ends.

If the other coverage was not provided under a continuation provision, that coverage must have terminated either as a result of loss of eligibility or because **employer** contribution to that coverage has ended. If the other coverage was provided under a continuation provision, the maximum continuation period must be exhausted. Proof of loss of coverage must be provided.

If you have a new **dependent** as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself, your spouse and your **dependent** child, provided you enroll within 30 days after the marriage, birth, adoption, or placement for adoption.

12. What Information Do I Need To Enroll During The Year?

If you have a new **dependent** as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your **dependent** child, provided you request enrollment within 30 calendar days after the marriage, birth, adoption or placement for adoption. You must provide your Human Resources Department with the following information in writing and provide written documentation of the event (i.e., birth certificate, marriage license, etc.) within that 30 calendar day period:

1. The reason for the addition (e.g., newborn baby, adoption, marriage, full-time student, etc.)
2. The name of each **dependent**
3. Their relationship to you
4. Their dates of birth
5. The date they became your **dependents** (e.g., newborn baby – date of birth; adoption – date of adoption; marriage – date of marriage)
6. Their social security number

If you add your **dependents** within the 30-day period specified above, their coverage will be effective, as of the dates they became your **dependents**. If they are not added at that time, they may only be added as described above.

13. Are There Other Changes I Need To Provide To My Human Resources Department?

To keep your coverage up-to-date, you should notify your Human Resources Department immediately whenever your personal status or that of your **dependents** changes in such a way as to affect your coverage. Typically changes of this sort occur when:

- you move,
- you marry,
- you have a child,
- you are divorced,
- a covered **dependent** becomes ineligible, and
- there is a change in your spouse's, **domestic partner** or **dependent's** health coverage.

14. Can I Change My Coverage During The Year?

IRS regulations require that your benefit elections remain in effect throughout the full **plan year** (January 1 – December 31). The only exception that permits you to change your election during the year is when you experience a qualified change in family status.

When you do experience a qualified change in family status based on the chart below, the mid-year election changes must be consistent with the following requirements:

- The event must cause you or your **dependent** to gain or lose eligibility for:
  - benefits under one of the benefit plans;
  - benefits available through the cafeteria plan; or
  - benefits available under another employer's benefit plan or plan option.
- The mid-year election change must be "on account of" the change in status; and
- The mid-year election change must "correspond with" the change in status that caused a gain or loss of plan eligibility.

The following chart explains which events are considered qualified changes in family status and what changes you may make as a result.

Event	Enrollment Procedure
Change in marital status	You may add your spouse and children, drop coverage or change coverage as a result of marriage. You may delete spouse/add **dependents** due to a divorce, legal separation or annulment. You may delete spouse/add **dependents** or change coverage due to the death of a spouse.
Change number of **dependents**	You may add your children/spouse or change coverage as a result of a birth, adoption or placement for adoption. You may delete **dependent**/change coverage due to a death of a **dependent** child.
Change in employment status or work schedule of the **employee**, spouse or **dependent**	You may drop coverage/add coverage, delete spouse or **dependent** or change coverage as the result of commencement or termination of employment, change in worksite, commencement or return from leave of absence, change from part-time to full-time employment or vice-versa, or change from salaried to hourly pay.
Change in residence of the **employee**, spouse or **dependent**	You may drop coverage or change coverage if you move, provided the move causes you or your **dependent** to gain or lose eligibility.
Dependents gain or lose eligible status	You may add/drop coverage of a **dependent** that is meeting or ceasing to meet the plan's definition of **dependent**, such as attainment of a specified age or ceasing to be a student.
Mid-year eligibility for or loss of **Medicare** or Medicaid	You may add/drop coverage or delete **dependent** as a result of gain or loss of **Medicare** or Medicaid coverage.
A judgment, decree or order requiring **dependent** coverage (e.g., **QMCSO**)	You may add coverage and **dependent** child due to a judgment, decree or order requiring **dependent** coverage.

15. What Should I Do If I Experience A Family Status Change?

If you have a qualified change in family status, please contact your Human Resources Department immediately so that they can provide you with the information you will need to make any changes allowed under this plan. You must make these changes within 30 days of the event.

16. When Will My Coverage And/Or My Dependents Coverage End?

Your coverage

Your coverage will end when any of the following occur:

- you are no longer an eligible **employee**,
- you stop making required contributions,
- you decline coverage,
- you leave employment at the **company**,
- you go on a non-work related unpaid medical leave,
- you go on a personal leave of absence,
- you retire,
- you die,
- the plan is terminated, or is amended such that you do not meet the requirement for coverage under the plan,
- you commit an act of fraud or intentional misrepresentation of a material fact.

Your dependent's coverage

Coverage for your **dependents** will end when any of the following occur:

- your coverage ends,
- your **dependent** no longer meets the plan's requirement of an eligible **dependent**,
- you stop making required contributions,
- you decline coverage for your eligible **dependents**,
- you go on a non-work related unpaid medical leave,
- you go on a personal leave of absence,
- you retire,
- you die,
- the plan is terminated, or is amended such that you or your **dependent** do not meet the requirement for coverage under the plan,
- you or your covered **dependent** commit an act of fraud or intentional misrepresentation of a material fact.

When coverage ends for you and your covered **dependents** as provided above, you and/or your covered **dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to the section titled "Continuation Coverage."

In certain circumstances your coverage may be extended. These situations are described in the following few questions.

17. What Happens To My Dependents' Coverage If I Pass Away?

Coverage for your covered **dependents** will continue until the end of the month in which your death occurred. Your **dependents** must pay the regular contribution for coverage.

Your **dependents** may then be eligible for continuation of coverage as explained in the section titled "Continuation Coverage."

18. What Happens To My Coverage If I Am Laid Off?

Coverage for you and your covered **dependents** will end at midnight of your last day worked, or until the end of the period for which a contribution has been paid (whichever is later).

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "Continuation Coverage".

19. What Happens To My Coverage If I Retire?

Your coverage and that of your covered **dependents** will end on your last day worked.

When you and your covered **dependents** no longer qualify for coverage as provided above, you and/or your covered **dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to the section titled "Continuation Coverage".

20. What Happens To My Coverage If I Take A Personal Leave Of Absence?

Your coverage and that of your covered **dependents** will continue for up to one year from the date your personal leave of absence began. During this time, you must pay the entire cost of coverage. This portion of your leave is also included in the maximum period of continued coverage allowed under "Continuation Coverage".

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "Continuation Coverage."

21. What Happens To My Coverage If I Go On Medical Leave?

Coverage for you and your covered **dependents** will continue for up to three months (up to six months under certain narrow criteria) from the date your approved work related or non-work related medical leave of absence began. During this time, you must continue to pay your share of any contribution required. If you should have any Family and Medical Leave Act (FMLA) leave entitlement remaining, this approved leave time will count towards your FMLA leave entitlement.

When you and your covered **dependents** no longer qualify for coverage as provided above, you and/or your covered **dependents** may be eligible for continuation of coverage (available at your own expense) as explained in the section titled "Continuation Coverage."

22. What If I Return To Work From My Medical Leave, Personal Leave Of Absence Or Layoff?

If you elect "Continuation Coverage", and you return from a layoff, medical/personal leave of absence, coverage for you and your eligible **dependents** will begin on the day you return to active employment. Amounts previously credited toward a plan deductible (same calendar year) will be carried forward.

If you elect "Continuation Coverage", and you are rehired, coverage for you and your eligible **dependents** will begin as stated in the section titled "Participating in the Plan", question 2. Amounts previously credited toward a plan deductible will not be carried forward.

If you do not elect "Continuation Coverage", and you return from a layoff, a medical or personal leave of absence or are rehired, coverage for you and your eligible **dependents** will begin as stated in the section titled "Participating in the Plan", question 2. Amounts previously credited toward a plan deductible will not be carried forward.

23. Do I Have Continuation Rights Under USERRA If I Am On Military Leave?

You may elect to continue coverage under the plan (including coverage for **dependents**) for up to 24 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with the **company** under the Uniformed Services Employment and Reemployment Rights Act of 1994). If your period of military service is less than 31 days, you will be required to pay your normal contributions for coverage. If your period of military service is 31 days or more, your contributions for the continued coverage shall be the same as for a **COBRA** beneficiary.

Whether or not you continue coverage during military service, you may reinstate coverage under this plan upon your return to employment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994. The reinstatement will be without any waiting period otherwise required under the plan, except to the extent that the waiting period would have been imposed if coverage had not terminated due to military service. This waiver of the waiting period shall not apply to any **illness** or **injury** that is incurred in, or aggravated during, the performance of military service.

24. Do I Have Continuation Rights Under FMLA If A Member Of My Family Is Called To Active Military Leave Or Is Injured While On Active Military Duty?

The Family Medical Leave Act of 1993 (FMLA), as amended effective January 28, 2008 provides rights to certain family members of **employees** who are individuals in the service of the United States Armed Forces. These benefits include the extension of health benefits and the resumption of benefits upon return from the leave. You are a qualified **employee** if:

- You have worked for the company for at least 12 months, and
- You have worked for at least 1,250 hours during the year preceding the start of the leave, and
- Your spouse, son, daughter or parent has been called to active duty in the Armed Forces of the United States (including the National Guard). This is called "qualifying exigency leave", or

- You are the spouse, parent, son, daughter or next of kin of a service member who is undergoing medical treatment, recuperation or therapy for an **injury** or **illness** incurred in the line of active duty in the Armed Forces (including the National Guard) that renders the service member medically unfit to perform his or her duties. This is called "service member care leave."

A qualified **employee** is entitled to up to 12 weeks of "qualifying exigency leave" in a 12 month period. This 12 week period will be measured looking back 12 months from the date leave is used.

A qualified **employee** is entitled to up to 26 weeks of "service member care leave" in a 12 month period. This 26 week period will be measured looking back 12 months from the date leave is used.

Please see the question titled "What Happens to My Coverage If I Take a Leave under the Family and Medical Leave Act (FMLA) (For a Reason Other Than Military Leave)?" for a description of contributions that will be required during FMLA leave and other FMLA provisions.

25. What Happens To My Coverage If I Take A Leave Under The Family And Medical Leave Act (FMLA) (For A Reason Other Than Military Leave)?

The Family and Medical Leave Act of 1993 (FMLA) provides certain rights to qualified **employees**. Included in these rights are certain provisions regarding the extension of health benefits and the resumption of benefits for **employees** who are granted leave. You are a qualified **employee** if:

- You have worked for the company for at least 12 months, and
- You have worked for at least 1,250 hours during the year preceding the start of the leave, (and)

A qualified **employee** is entitled to leave under the FMLA for:

- Birth of a child and to care for such child (up to 12 months after the birth of the child).
- Placement of a child for adoption or foster care (up to 12 months after the placement of the child).
- Care of your seriously ill spouse, child or parent.
- A serious health condition that makes you unable to perform your essential job functions.

A qualified **employee** is entitled to up to 12 weeks of leave in a 12 month period under the FMLA. The 12 month period will be measured looking back 12 months from the date leave is used. During the time an **employee** is granted leave under the FMLA you must pay your regular contribution for coverage for you and your covered **dependents**. Your contribution must be paid monthly according to the **employer's** direction.

If you do not return to work at the end of your leave, the company will have the right to collect the cost of you and your covered **dependent's** coverage during the leave. The cost is limited to the then effective continuation rates (less the 2% allowable administrative cost in the continuation rate). This provision does not apply if you do not return to work for:

1. A serious health reason (either affecting you or an immediate family member) that would entitle you to leave under FMLA; or
2. Other circumstances beyond your control.

You will be allowed a 30 day grace period from the due date to make the premium payment. If payment is not made during that time, your coverage will be suspended when the grace period ends. If you fail to pay a contribution during your leave, coverage will be suspended. Coverage will resume, when you return to work, as though it had not been lost and no waiting period will be imposed.

If your coverage ends due to failure to pay a required premium or if you do not return to work, you and/or your covered **dependents** may continue coverage as provided under **COBRA**. The maximum **COBRA** coverage period begins on the last day of your FMLA leave, the qualifying event date.

CONTINUATION OF COVERAGE

What Is Continuation Of Coverage?

The plan is a government plan, so it is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). However, the City has elected to provide Continuation of Coverage, which may become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage.

Under certain circumstances you and/or your covered **dependents** have the right to continue coverage in the plan, at your/their expense, beyond the time coverage would normally end. Your **dependents** include children born or placed for adoption with the covered **employee** during the period of continuation of coverage.

When Is Continuation Of Coverage Available?

Continuation of coverage is available if coverage would otherwise end due to:

- termination of your employment for reasons other than gross misconduct;
- reduction in your work hours;
- for your **dependent** spouse – divorce or legal separation from you;
- for your **dependent** spouse or child(ren) – your death;
- for your **dependent** child(ren), loss of eligibility as a covered **dependent** (e.g., because he or she reaches the maximum age provided by the plan); or
- for a **retiree**, if the former employer files for bankruptcy under Chapter 11.

What Must I Do To Notify My Employer Of An Event That Would Trigger Continuation Of Coverage?

If coverage would end because of divorce or legal separation, or because a child is no longer eligible to be a **dependent**, the **employee** or covered **dependent** MUST notify Human Resources in writing. If Human Resources is not notified within 60 days after the coverage would otherwise end, and the person is no longer eligible as a **dependent**, continuation coverage cannot be offered.

How Can I Elect Continuation Of Coverage?

If coverage would end because of divorce or legal separation, or because your child is no longer eligible to be a **dependent**, you or your covered **dependent** must notify Human Resources immediately. If Human Resources is not notified within 60 days after coverage would otherwise end, coverage cannot be continued.

When Human Resources receives notification of one of the above events, or when any other qualifying event occurs, you or your covered **dependent** will be notified of the right to continue coverage. If continuation is desired, the participant must elect to do so within 60 days of the date the notice was sent (or 60 days after the participant last coverage, if later). You and each of your covered **dependents** can individually decide whether or not to continue coverage, but the election of coverage by you or your spouse will be considered to be an election by all **covered individuals**, unless another **covered individual** rejects coverage.

What Is The Cost For Continuation Of Coverage?

Continuation of coverage is at the participant's expense. The monthly cost of this continued coverage will be included in the notice. Premiums are the same for all individuals who are in the same type of classification – adult single individuals have the same cost and family groups have the same cost.

When Must I Make Premium Payments?

For coverage to continue, the first premium must be received by the date stated in the notice. Normally this date will be 45 days after the continuation coverage is elected. Premiums for every following month of continuation coverage must be paid monthly on or before the premium due date stated in the notice. There is a 30 day grace period for these monthly premiums. During the grace period, claims will be suspended until the premium is paid. If the premium is not paid within 30 days after the due date, continuation coverage will end on the first day of that period of coverage. Coverage cannot be reinstated.

How Long Can I Continue Coverage?

If coverage would otherwise end because employment ends or hours are reduced so you are no longer eligible for group benefits, continuation coverage may continue until the earliest of the following:

- 18 months from the date that the employment ended or the hours were reduced.
- The date on which a premium payment was due but not paid.
- The date the person continuing the coverage becomes covered by another employer's group health plan.
- The date, after continuation coverage has been elected, the person becomes eligible for **Medicare**.
- The date the **employer** terminates all of its group health plans.

If coverage would otherwise end for a covered **dependent** (spouse or child) because of divorce, legal separation, death or a child's loss of dependence status, continuation coverage may continue until the earliest of the following:

- 36 months from the date the covered **dependent's** coverage would have otherwise ended.
- The date on which the premium payment was due but not paid.

- The date the person continuing coverage becomes covered by another employer's group health plan.
- The date, after continuation coverage has been elected, the person continuing coverage becomes eligible for **Medicare**.
- The date the **employer** terminates all of its group health plans.

Can The Length Of My Continuation Of Coverage Be Extended?

Second Qualifying Event

If continuation coverage was elected by a covered **dependent** because your employment ended or your hours were reduced and, if during the period of continued coverage, another event occurs which is itself an event which would permit continuation coverage to be offered, the maximum period of continued coverage for the covered **dependent** is extended for 18 months to a maximum of 36 months from the date of the initial event. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Spouse and Dependents of Medicare-Eligible Employees

If continuation coverage was elected by your spouse or **dependent** child and you became entitled to **Medicare** while an **employee**, the maximum period of continuation coverage for spouse or child is the greater of 36 months from the date you became entitled to **Medicare** or 18 months from the date you lost coverage. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Disabled Individuals

If a **covered individual** is disabled, according to the Social Security Act, at the time he or she first becomes eligible for continuation coverage or within 60 days of that date, the maximum period of continuation coverage is extended to 29 months. (Coverage will still end for any other reason listed above, such as failure to pay premiums when due, etc.) The **covered individual** must notify the employer within 60 days of the date he or she is determined to be disabled under the Social Security Act and within 30 days of the date he or she is finally determined not to be disabled. (Coverage will end on the first day of the month beginning 30 days after the **covered individual** is determined not to be disabled.) The cost of continuation coverage may increase after the 18th month of continuation coverage, and may be adjusted from time to time when group rates are adjusted.

Special Provisions For Retirees

If your plan provides coverage for retirees, sometimes, filing a proceeding in bankruptcy under Title 1 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the **company** and that bankruptcy results in the loss of coverage of any retired **employee** covered under the plan, the retired **employee** is a qualified beneficiary with respect to the bankruptcy. The retired **employee's** spouse, surviving spouse, and **dependent** children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

What Else Should I Know Regarding My Continuation Of Coverage?

In order to protect your family's rights, you should keep your employer informed of any changes in the addresses of family members who are or may become eligible for continuation coverage. You should also keep a copy of any notices you send the **Plan Administrator** for your records.

Who Should I Contact For Further Information And To Whom Should I Provide Notice Of An Event?

If you need more information regarding continuation of coverage, please feel free to contact CoreSource, Inc. or contact the **Plan Administrator**.

The **company** is responsible for administering continuation coverage. These functions may include mailing of continuation coverage notices, collection of premium payments and reporting of paid participants to applicable vendors.

VISION BENEFITS

What Is Covered Under The Vision Plan?

The plan provides benefits for services related to vision care and correction. Services for vision care may be provided by a Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Optometry (OD).

Benefit Type	Copay	Plan Maximum	Frequency
Eye Exam	$20	$40	Calendar year
Benefit Type	**Copay**	**Plan Maximum**	**Frequency**
Lenses (in lieu of contact lenses)	$10	Varies by type (see below)	Calendar year
• Single Vision	$10	$35	Calendar year
• Bifocal	$10	$55	Calendar year
• Trifocal	$10	$90	Calendar year
• Progressive* (Basic)	$10	$110	Calendar year
• Progressive* (Standard)	$10	$166	Calendar year
• Progressive* (Premium)	$10	$190	Calendar year
• Progressive* (Digital)	$10	$218	Calendar year
*All progressive lenses include scratch and UV protection. Other lens styles may require an added charge. (see "Extras and add-ons" below)			
Benefit Type	**Copay**	**Plan Maximum**	**Frequency**
Frames (in lieu of contact lenses)	$10	$120	Calendar year
Benefit Type	**Copay**	**Plan Maximum**	**Frequency**
Contact Lenses (in lieu of frames and lenses)	$20	$230	Calendar year
Benefit Type	**Copay**	**Plan Maximum**	**Frequency**
Extras and Add-ons	n/a	Varies by type (see below)	Calendar year
• Glare-free Standard	n/a	$45	Calendar year
• Glare –free premium	n/a	$76	Calendar year
• Photochromic	n/a	$72	Calendar year
• Polarized	n/a	$105	Calendar year
• Solid Tints	n/a	$16	Calendar year

Note: This is only a brief overview of benefits. Please refer to the Summary Plan Description for complete information on the eligibility provisions, limitations and for all other terms of the plan.

What Is Not Covered Under The Vision Plan?

This vision plan allows for payment of only **reasonable and customary** charges for necessary services which are incurred after the coverage effective date of the **covered individual** and before his or her coverage termination date. There are many situations where benefits may be limited or not provided by this plan.

The following charges are not covered by any portion of this plan:

Charges for covered procedures that exceed plan maximums

Services and supplies not provided by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or a Doctor of Optometry (O.D.)

Charges for sunglasses

Duplication or replacement of broken, lost or stolen lenses and/or frames

Treatment or services provided outside the United States, unless:

- traveling, provided you are not securing vision care diagnosis or treatment and you will return within six months,
- on a business assignment and you will return within six months,
- a full-time student, meaning you are either attending an accredited school in a foreign country or participating in an academic program in a foreign country for a credit from your school in the U.S.

Lenses obtainable without a prescription

Ortho training and subnormal vision aids

Vision testing examination more frequently than once every calendar year

More than two lenses (one pair) in any calendar year or one set of frames in any calendar year

Charges for vision testing examinations, lenses or frames that do not meet accepted standards of optometric practice

Photosensitive or anti-reflective lenses to the extent the charge for such lenses exceeds the benefit amount for regular lenses as provided by the plan

Safety glasses and goggles

Repair of frames or regrinding of lenses

Duplicate or spare lenses or frames

Vision testing examinations, lenses or frames furnished for any condition, disease, ailment or **injury** arising out of and in the course of employment

Vision testing examinations and lenses and frames ordered before the **covered individual** became eligible for coverage or after the coverage termination date

Charges for vision testing examinations, lenses or frames for which no charge is made that the **covered individual** is legally obligated to pay or for which no charge would be made in the absence of this vision benefit plan

Charges for vision testing examinations, lenses or frames received as a result of eye disease, defect or **injury** due to an act of war, declared or undeclared

Radial keratotomy

Lasik Surgery

Drugs or other medication not administered for the purpose of a vision testing examination

Charges for the completion of any claim form

Charges for services or supplies not rendered, including charges for cancelled appointments

Covered charges when there has been an incomplete claims submission

Charges for treatments, consultations or visits that consist of a telephone conversation

Claims filed later than one year from the date the charge was incurred

COORDINATION OF BENEFITS (COB)

Today many people have more than one source of benefit coverage. Because of this, the plan has a coordination of benefits (COB) feature that helps to avoid duplication of payments for the same services. Not only does it prevent duplication of payments, it also makes sure that you are receiving the maximum benefit for which you are entitled.

This plan will coordinate benefits with any plan, policy, or coverage providing benefits or services for, or by reason of medical, dental, or vision care. (This plan shall mean any portion of the **company's** plan which provides benefits that are subject to the applicable COB provisions that may be reduced because of the benefits of other plans.) These other plan(s) may include, without limitation:

- Group insurance or any other arrangement for coverage for **covered individuals** in a group, whether on an insured or uninsured basis, including, but not limited to **hospital** reimbursement-type plans;
- **Hospital** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
- A licensed Health Maintenance Organization (HMO);
- Any coverage under a government program and any coverage required or provided by any statute;
- Group/individual automobile insurance coverage, including coverage based upon the principles of "No-fault" coverage;
- Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
- Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

This **plan** will not coordinate benefits with hospital indemnity or other fixed indemnity plans; accident only, specified disease, limited benefit health coverage; school accident type coverage; medical supplemental plans; and Medicaid plans. Also, this **plan** will not coordinate benefits with flexible spending accounts (FSA), health reimbursement accounts (HRA), or health savings accounts (HSA).

How Does Coordination Work?

When there are other sources that provide benefits, the plan that pays benefits first is called the primary plan. The plan that pays benefits next is the secondary plan.

When this plan is primary, it will pay the normal benefit. When this plan is secondary, it will use the maintenance of benefits method of coordination. With the maintenance of benefits method, this plan will first calculate benefits to see what it would have paid in absence of other coverage and then subtract that amount from the amount paid by the primary plan. In other words, the benefits of this plan will be maintained, even on a secondary basis. When this plan's payment would be greater than the primary plan's payment, this plan will pay the difference. This plan will never pay more than it would have paid if it were the primary plan. If the primary plan and this plan would have paid the same amount, this plan will not make any additional payment.

Right To Receive And Release Necessary Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits under this plan and other plans covering the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply those rules and determine benefits payable.

How Does The Plan Coordinate Benefits When Multiple Preferred Provider Arrangements Are Utilized?

When both this plan, paying as secondary, and the primary plan have a preferred provider arrangement in place, payment will be made up to the preferred provider allowance available to the primary plan.

Determining The Order Of Benefit Payments

The following applies when determining whether this plan will be primary or will pay benefits secondary to another plan:

- If the other source of coverage does not contain a coordination of benefits provision, that source always pays benefits first.
- If the **claimant** is covered by this plan as an **employee** and has coverage through another source as a dependent (e.g., your spouse's plan), this plan is the primary plan and will pay benefits first. The other coverage, that provides benefits for the **claimant** as a dependent, will pay benefits second.
- If the **claimant** is covered by this plan as a **dependent** spouse and has coverage through another source as an employee, this plan is the secondary plan and will pay benefits second. The other coverage, which provides benefits for the **claimant** as an employee will pay benefits first.

- If the **claimant** is a child and is covered as a **dependent** under both this plan and the other parent's source of coverage, this plan will use the "birthday rule." The birthday rule means that the coverage of the parent whose birthday falls earlier in the year (regardless of the year of birth) is the primary plan and pays benefits first. The source providing coverage for the parent whose birthday falls later in the year pays benefits second. For example, if the mother's birthday is in June and the father's birthday is in August, the mother's source of coverage will pay benefits first. The age of the parent has no effect on whose coverage pays benefits first.
- If the **claimant** is a child of divorced or separated parents, the following order applies as to which source of coverage pays benefits first:
  - The parent who has financial responsibility for medical, **dental**, or other health care expenses due to a court order.
  - If the court order does not establish financial liability, the parent with physical custody pays first, then the spouse of the parent with physical custody, then the parent without physical custody and spouse of the parent without physical custody.
  - If neither of the above provisions establish which coverage is primary, the plan will use the birthday rule.
- If none of the above guidelines or the following charts apply, then the source providing coverage for the **claimant** longer pays benefits first.

Other Instances Where The Plan Coordinates Benefits With Other Coverages

This plan also coordinates benefits with other types of coverage, as shown in the following charts. If none of the below rules determine the order of benefits, the allowable expenses will be shared equally between the plans. This plan will not pay more than it would have paid had it been the primary plan.

If You Have...	Here Is How This Plan Pays Benefits...
Coverage through your former employer, but not as a **COBRA** continuant or retiree	This plan pays benefits second.
COBRA continuation coverage through a former employer	This plan pays benefits first.
Coverage through **Medicare** as the result of age (65 or older)	This plan pays benefits first, **Medicare** pays benefits second (or third after your spouse's employer's plan - if applicable).
Retiree coverage through a former employer and you are not yet eligible for **Medicare**	This plan pays benefits first. Your former employer's retiree plan pays benefits second. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Retiree coverage through a former employer and you are eligible for **Medicare** (age 65 or older)	This plan pays benefits first. **Medicare** pays benefits second, and your former employer's retiree plan pays benefits third.
Coverage through **Medicare** as the result of end-stage renal disease	This plan pays benefits first and **Medicare** pays benefits second during the first 30 months of **Medicare** coverage. After 30 months, **Medicare** pays benefits first and this plan may or may not pay secondary benefits (depending on the amount **Medicare** pays).
Coverage through **Medicare** as the result of a disability	If your employer has less than 100 **employees**: If you are on a leave of absence and coverage continues during your leave, **Medicare** pays benefits first and this plan pays benefits second (or third after **Medicare** and your spouse's employer's plan - if applicable). If your employer has 100 or more **employees**: This plan pays benefits first as long as you are actively employed. If you are on a leave of absence and coverage continues during your leave, this plan pays benefits first, **Medicare** pays benefits second (or third after your spouse's employer's plan - if applicable).
Coverage through Medicaid	This plan pays benefits first, any other plan through which you have coverage pays benefits second, and Medicaid pays benefits last. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through another government-sponsored program (e.g., TRICARE)	This plan pays benefits first, any other plan through which you may have coverage pays benefits second, and the government-sponsored program pays benefits last. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage under this plan as a former **employee** through **COBRA**	This plan pays benefits second to any coverage provided through a plan covering you as an employee or dependent. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through an employer, but not as a **COBRA** continuant or retiree	The other plan pays benefits first. If the other plan's payment is equal to or greater than the amount this plan would pay, this plan does not pay benefits. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.

IMPORTANT NOTE REGARDING MEDICARE: If you or your covered **dependent** is eligible for Medicare Parts A and/or B, this plan will assume you have enrolled in **Medicare** coverage and will coordinate benefits accordingly, regardless of whether you actually enrolled in **Medicare**.

If Your Spouse Has…	Here Is How This Plan Pays Benefits...
Coverage through their employer	Your spouse's current employer's plan pays benefits first, this plan pays benefits second.
COBRA continuation coverage through another employer	Your spouse's current employer's plan pays benefits first, this plan pays benefits second (depending on the amount the other employer's plan pays), and **COBRA** continuation pays third.
Retiree coverage through a former employer and is not yet eligible for **Medicare** (younger than age 65)	The other plan pays benefits first, and this plan pays benefits second (depending on the amount the other plan pays). If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Retiree coverage through a former employer, is eligible for **Medicare** (age 65 or older), and the retiree coverage supplements **Medicare**	This plan pays benefits first, **Medicare** pays second, and your spouse's retiree medical plan pays third.
Coverage through **Medicare** as the result of age (65 or older) and is not actively employed	If your employer has less than 20 **employees**: **Medicare** pays benefits first and this plan pays benefits second. If your employer has 20 or more **employees**: This plan pays benefits first, **Medicare** pays benefits second.
Coverage through **Medicare** as the result of end-stage renal disease	Your spouse's current employer's plan pays benefits first and **Medicare** pays benefits second during the first 30 months of **Medicare** coverage. If your spouse's coverage is provided as an inactive **employee** or a retiree, **Medicare** may pay benefits before this plan. After 30 months, **Medicare** pays benefits first, your spouse's other plan pays benefits next, and this plan may or may not pay a benefit (depending on the amount the other plan and **Medicare** pay).
Coverage through **Medicare** as the result of a disability and is not actively employed	If your employer has less than 100 **employees**: **Medicare** pays benefits first and this plan pays benefits second. If your employer has 100 or more **employees**: This plan pays benefits first, **Medicare** pays benefits second.
Coverage through Medicaid	Your spouse's current employer's plan pays benefits first, this plan pays benefits second (depending on the amount the other employer's plan pays), and Medicaid pays benefits last. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through another government-sponsored program (e.g., TRICARE)	Any other plan through which your spouse may have coverage pays benefits first, this plan pays benefits second, and the government-sponsored program pays benefits last. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage under this plan through **COBRA**	This plan pays second to any coverage covering your spouse as an employee or dependent. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.

IMPORTANT NOTE REGARDING MEDICARE: If you or your covered **dependent** is eligible for Medicare Parts A and/or B, this plan will assume you have enrolled in **Medicare** coverage and will coordinate benefits accordingly, regardless of whether you actually enrolled in **Medicare**.

If Your Child Has…	Here's How This Plan Pays Benefits...
Coverage under this plan through **COBRA**	This plan pays second to any coverage covering your child as a dependent. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through Medicaid	This plan pays first. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through another government-sponsored program (e.g., TRICARE)	Any other plan through which your child may have coverage pays benefits according to the priority previously described, and the government-sponsored program pays benefits last. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored.
Coverage through **Medicare** as the result of end-stage renal disease	The plan responsible for your child's primary coverage (as previously explained) pays benefits first and **Medicare** pays benefits last during the first 30 months of **Medicare** coverage. After 30 months, **Medicare** pays benefits first, and the above rules governing the order of benefit payments apply next. This plan may or may not pay a benefit (depending on the amount any other plan and **Medicare** pay).

IMPORTANT NOTE REGARDING MEDICARE: If you or your covered **dependent** is eligible for Medicare Parts A and/or B, this plan will assume you have enrolled in **Medicare** coverage and will coordinate benefits accordingly, regardless of whether you actually enrolled in **Medicare**.

If you or any member of your family has more than one source of coverage, contact the **Plan Supervisor** to get a complete understanding of how the COB feature applies.

How The Plan Coordinates With Automobile Insurance Coverage

This plan's liability for automobile accidents is based on the type of automobile insurance act or law enacted in your state.

You or your **dependents** are considered to be covered under an automobile insurance policy if you or your **dependents** are:

- an owner and principal named insured individual of the automobile insurance policy
- a family member or member of the household of the person who is insured by the automobile insurance policy
- a person who would be eligible for medical expense benefits under an automobile insurance policy if this plan did not exist

Coverage under this plan will be secondary to any automobile coverage or personal injury protection coverage. Coverage provided by this plan is not intended to reduce the level of coverage that would normally be available through automobile insurance or personal injury protection coverage policy, nor does this coverage intend to provide benefits as primary in order to reduce any premium cost for automobile coverage or personal injury protection coverage.

If you or a **dependent** are involved in an automobile accident, all charges must be submitted to the automobile insurance. You will be asked to provide this plan with information concerning your automobile insurance or automobile coverage of any other party involved and information regarding all charges paid by any automobile coverage. This plan may, at its discretion, advance payment in order to prevent financial hardship. However, the plan will have an equitable lien against these parties up to the amount of the payment advanced. Please refer to the section titled "Reimbursement of Plan Payments" for further information.

IMPORTANT NOTE: If you live in a state that requires automobile coverage or personal injury protection coverage, and you fail to maintain coverage that is required by your state, you and/or your **dependents** will not be entitled to any benefits that would otherwise be payable by this plan.

No-Fault Automobile Insurance

In the event you or a covered **dependent** incur medical expenses as a result of an automobile accident, either as an operator or passenger of the vehicle or as a pedestrian, this plan has secondary liability for covered services, with payment limited to:

- any deductible under the automobile coverage
- any co-payment under the automobile coverage
- any expenses excluded by the automobile coverage that are covered plan benefits

Financial Responsibility Laws

Coverage under this plan will be secondary to any medical expense benefits available under your automobile insurance policy. If your state does not allow this plan to pay benefits as secondary or advance payment with the intent of subrogation, or recovering an overpayment, this plan will not cover any services related to an automobile accident for you or your **dependent**.

Coordination With Other Automobile Liability Insurance

If your state does not have no-fault automobile coverage or personal injury protection coverage or a "financial responsibility law," this plan will still be secondary and will coordinate payment for services with your automobile insurance coverage or with any other party who may have liability for medical expenses.

HIPAA PRIVACY RULES

The Gaylord Community School District Employee Vision Benefit Plan is providing the following in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

As used in this section, HIPAA Privacy Rules refers to those provisions of the Health Insurance Portability and Accountability Act of 1996 that relate to the safe handling of Protected Health Information and the regulations issued thereunder in 45 CFR Parts 160 and 164.

Protected Health Information (PHI)

PHI includes information that the plan creates or receives that relates to the past, present, or future health or medical condition of an Individual that could be used to identify the Individual.

Use And Disclosure Of PHI

The plan can use or disclose PHI for purposes of Payment and Health Care Operations. Payment means activities to obtain and provide reimbursement for the health care provided to an Individual, including determinations of eligibility and coverage under the plan, and other health care utilization review activities.

Health Care Operations means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaint, **physician** reviews, compliance programs, audits, business planning, development, management, and administrative activities.

Business Associates Of The Plan

A Business Associate of the plan is a person or organization to whom the plan or another covered entity discloses PHI so that the Business Associate can carry out or assist with the performance of a function or activity of the plan. The activities might include claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management, and repricing. Business Associates of the plan must contractually agree to abide by the HIPAA Privacy Rules and must require their subcontractors and agents to agree to abide by the HIPAA Privacy Rules.

Workforce Of The Plan

The plan has designated the Director of Business the Privacy Official. The Privacy Official is the Privacy Fiduciary responsible for the plan's compliance with the HIPAA Privacy Rules. This includes ensuring that appropriate administrative procedures and safeguards are in place to protect PHI and ensuring that the Workforce of the plan and the Business Associates of the plan comply with the rules, are trained in the HIPAA Privacy Rules and the appropriate handling of PHI, and understand the sanctions for violations.

Certain associates of the Plan Sponsor that serve on the Workforce of the Plan are also considered Privacy Fiduciaries, including:

Payroll Specialist and Personnel Coordinator

The plan has also designated CoreSource, Inc. as the Privacy Fiduciary for the following services: keeping PHI related to medical, dental and vision claims; tracking the use and disclosure of PHI when it is necessary for accounting purposes; coordinating requests from an Individual for Access, Amending, Accounting and Restriction of PHI.

Certain associates of the Plan Sponsor whose duties include administrative and management functions on behalf of the plan are also considered part of the Workforce of the Plan. Their access to PHI is limited to the minimum necessary information needed to perform their designated duties.

The plan has appointed the above associates of the Plan Sponsor as associates of the plan's Workforce when they are performing functions related to Health Care Operations or Payment:

Individual Rights

Each Individual covered under the plan ("the Individual") is entitled to the protections set forth in this provision. For purposes of administration, "Individual" shall mean:

1. In the case of the **employee**, former **employee**, surviving spouse or head of any family continuing coverage under COBRA ("Primary Covered Person"), the Primary Covered Person may act as the Individual for purposes of all Individual Rights and may receive PHI, such as claims correspondence and Explanation of Benefit forms on behalf of all covered family members unless a restriction is otherwise requested and accepted by the plan.
2. In the case of any Individual who has attained the age of 18, the Individual may exercise their own Individual Rights as described in this Notice.
3. In the case of a covered **dependent** child who has not attained the age of 18, the Primary Covered Person or other parent may request and receive PHI on the **dependent** child or exercise Individual Rights on behalf of the **dependent** child, unless applicable state law requires otherwise.
4. In the case of a valid personal representative appointment on behalf of an Individual, the personal representative shall be treated as the Individual.
5. In the case of a person designated as an **Alternate Recipient** through a **Qualified Medical Child Support Order (QMCSO)**, that person has these rights to the PHI for the designated Individual(s).

If an Individual requests Access, Amending, Accounting or Restriction of PHI for someone for whom they do not have the right, such as a spouse requesting an Accounting of PHI for the **employee** or the **employee** requesting an Accounting of PHI for a **dependent** over age 18, he/she must present a completed Personal Representative Affidavit or another legal document granting him/her authority.

An Individual has the right to request Access to PHI, request an Amendment to PHI, request an Accounting of PHI disclosures and request a Restriction in the handling of your PHI as set forth below.

Process To Request Access, Amending, Accounting Or Restriction Of PHI

Any request to exercise Individual rights to Access, Amending or Accounting or restriction of PHI must be made in writing by completing the appropriate Request Form. The form must be provided to the appropriate Privacy Fiduciary.

Access To PHI

An Individual has the right to access the following PHI from the plan within a Designated Record Set:

- Medical records
- Billing records
- Enrollment information
- Payment information
- Claim adjudication records

Designated Record Set means: the plan's official records containing enrollment, medical and billing records, and case management records that are used to make decisions about an Individual's health care benefits. This would include:

1. Paper records stored in individual folders maintained by our claims payer.
2. Electronic records stored by individual family record within the claim payer's system, including Participant Enrollment, Coverage Detail, Individual and Family Accumulations and Totals, Paid Claims History, Patient Notes and the Image Retrieval System.
3. Working records only if used to make a decision about the Individual's benefits under the plan and not available elsewhere in the Designated Record Set.
4. Documentation of phone inquiries or information obtained via telephone call only if used to make a decision about the Individual's benefits under the plan and maintained via telephone recording.

The following types of information are not included in the Designated Record Set:

1. Health information that was not used to make decisions about Individuals or their benefits.
2. Psychotherapy Notes (as defined in the HIPAA Rule)
3. Copies of documents wherein the source documentation is maintained in an 'official' record maintained by the plan or plan's Business Associate. Copies of PHI maintained in more than one location must be protected but only the source document is included in a Designated Record Set.
4. Information compiled in reasonable anticipation of, or for use in civil, criminal, or administrative action or proceeding (e.g., Incident Reports - used to identify problems and implement corrective action).

A plan representative will respond to the request to access PHI within 30 days from the date the request is received. If the PHI is not on site, the plan representative may obtain the information and furnish it within 60 days from the date of the request. If additional time is needed, the plan representative will notify the requesting Individual of a 30-day extension and reasons for delay and advise him/her of the date the request should be completed.

If the plan representative is aware that the PHI is held by another entity, the plan representative will advise the name and address of the entity and how the Individual may contact them for the PHI. There may be a reasonable charge for obtaining, copying, and mailing the requested information. The PHI will be provided in the format requested if possible. If the Individual agrees in advance, a summary form of the record will be provided.

Denial Of Access

If access of PHI is denied, the plan representative will furnish a written denial. The denial will provide the reason as well as the Individual's rights, if any, to have the denial reviewed. The denial will contain the name and address of the person to whom the Individual can send their complaint and request for review.

Denials made for the following reasons will not be given subsequent review:

- An inmate requests access and that access would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or others
- The Individual consented to access rights during the course of research involving treatment until the completion of the research
- The HIPAA Privacy Rules permit denial
- The PHI was received from a source with a promise of confidentiality and access is likely to breach that confidentiality
- The PHI is not part of the Designated Record Set maintained by the plan where the Individual who is the subject of the PHI is an Individual who has attained the age of 18 or the personal representative of an Individual under the age of 18 and has filed and the plan has accepted a restriction on access that would be violated by providing the requested access

Denials for the following reasons may be reviewed, upon request, by a licensed **health care professional** not involved in the decision to deny access:

- A licensed **health care professional** reasonably believes that access will endanger the life or safety of the individual or others
- The PHI refers to others and the **health care professional** determines that access is likely to substantially harm the other person

Amending PHI

An Individual has the right to request that PHI in a Designated Record Set be amended.

Once an amendment to PHI is requested, the plan representative will make a decision regarding the request within 60 days from receipt. If additional time is needed, the plan representative will notify the Individual requesting the amendment and take an additional 30 days to make a decision.

If the plan representative is aware that the PHI is held by another entity, the plan representative will advise the requesting Individual the name and address of the entity and how they may contact them to amend the PHI.

If the plan representative grants the amending of PHI, a copy of the request and decision will be placed in any Designated Record Set maintained by the plan with information relating to the Individual.

If the plan representative has furnished information concerning the amended information to another entity, they will contact the Individual to obtain consent to advise that entity of the amended information and will make reasonable efforts to inform that entity of the amendment.

Denial Of Request To Amend PHI

If access of PHI is denied, the plan representative will furnish a written denial. The denial will provide the reasons as well as the Individual's rights to have the denial reviewed. The denial will contain the name and address of the person to whom the Individual can send their complaint and request for review.

Denial to amend PHI may be made for the following reasons:

- The plan did not create the PHI
- The PHI is not part of the Designated Record Set maintained by the plan
- The PHI would not be available for access according to the HIPAA Privacy Rules
- The PHI is accurate and complete

If an Individual disagrees with the denial, they may submit a statement of disagreement. The plan representative will review that statement. If the plan representative agrees, the PHI will be amended. If the plan representative does not agree, they will notify the Individual requesting the amendment.

If a disagreement is filed, it and all subsequent responses will be included or summarized in future disclosure of the Individual's PHI.

If an Individual does not submit a statement disagreeing with the denial, they can request that the request for amendment and the denial be included in any future disclosures of PHI.

Amending PHI When Notified By Another Entity

If another entity notifies the plan that they have amended PHI previously given, the PHI in the Designated Record Set will be amended.

Accounting For The Use Of PHI

An Individual can request an accounting of any disclosures of PHI made by the plan for up to 6 years prior to the date of the request, except disclosures made:

- To carry out treatment, payment, and health care operations or made pursuant to an authorization
- Upon request of and made to the Individual
- For facility directory, or persons involved in the Individual's care
- For national security or intelligence purposes
- To correctional institutions or law enforcement officials
- Made prior to the compliance date of the HIPAA Privacy Rules

The plan representative will furnish the following information:

- The date of the disclosure
- The name of any entity of person who received PHI and their address, if known
- A brief description of the PHI disclosed
- A brief statement on the basis of the disclosure

A response to a request will be given within 60 days from the receipt of the request. The plan representative will notify the Individual if more time is needed and the reason for the delay as well as the date by which the accounting will be provided. The plan representative will not take more than an additional 30 days to furnish the accounting.

Requesting Restriction Of Use Of PHI

An Individual may request the plan restrict the use or disclosure of PHI.

The plan will accept an individual's reasonable request to release information to an alternate address in the event that access to the PHI will endanger the life and/or safety of the individual or others. In the event of a minor child being the subject of abuse or endangerment, a letter from a licensed **health care professional** shall be treated as the individual's request for confidential communications. Such reasonable request will be honored for all information released until the plan is notified in writing that the alternate address should not be used.

As the plan procedures are designed to comply with the HIPAA Privacy Rules, the plan does not grant restrictions other than the one listed above.

Applicability Of State Laws

The plan will follow the health information privacy laws of the State of Michigan to the exclusion of the health information privacy laws of all other States.

The administration of the plan involves resources, individuals, services and activities in several states. In the interest of a uniform and consistent administration of benefits, the plan has chosen to look to the laws of the State of Michigan without regard to the actual location(s) in which a particular privacy concern may arise, subject to applicable rules governing "conflict of laws" principles. Therefore, the plan will observe the health information privacy laws of the State of Michigan to the extent that the State law in question is not pre-empted by HIPAA because it meets either of the following HIPAA requirements:

a. It is possible for the plan to comply with both HIPAA and that State law; or

b. While it is impossible for the plan to comply with both HIPAA and that State law, the State law still applies because one (or more) of the following applies:

   i. The State law relates to the privacy of Individually Identifiable Health Information, and the State law requirements are "more stringent" than the requirements under HIPAA. For this purpose, "more stringent" generally means that the State privacy law provides for any of the following when compared to HIPAA:
      - Greater restriction in use or disclosure;
      - Greater access or amendment by an individual to Individually Identifiable Health Information;
      - Greater amount of information about a use, disclosure, right and remedies to be provided to an individual;
      - Narrower scope or duration of an express legal permission for use or disclosure of Individually Identifiable Health Information;
      - Longer record retention or more detailed reporting; or
      - Greater privacy protection for the individual with respect to any other matter.

   ii. The State law provides for health reporting for certain public health purposes.

   iii. The State law requires the plan to report or provide access to information for purposes of certain audits, licensure and certification.

iv. The secretary determines that the State law is necessary to (A) prevent certain fraud and abuse, (B) to ensure appropriate State regulation of insurance and Health Plans to the extent expressly authorized by statute or regulation, (C) for state reporting on health care delivery or costs, or (D) to service compelling public, health, safety ore welfare interests.

Separation Of Plan And Plan Sponsor

The Plan Sponsor has provided a certification that requires assurance that the Plan Sponsor will appropriately safeguard and limit the use and disclosure of PHI that the Plan Sponsor may receive from the plan to perform plan Administration Functions. Specifically, Plan Sponsor has agreed:

- not to use or further disclose PHI other than as permitted or required by the **Plan Document** or as required by law;
- to ensure that any agents, including a subcontractor, to whom it provides PHI received from the plan agree to the same restrictions and conditions that apply to Sponsor with respect to such information;
- not to use or disclose PHI for employment related actions and decisions or in connection with any other benefit or associate benefit plan;
- to report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware;
- to make available information in accordance with the HIPAA Rules regarding individual access to PHI;
- to make available PHI for amendment in accordance with the HIPPA Rules;
- to make available the information required under the HIPAA Rules to provide an accounting of non routine disclosures to the Individual;
- to make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules;
- to, if feasible, return or destroy all PHI received from the plan that Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible
- ensure the separation of the plan and Sponsor as set forth under “Workforce of the Plan”

Permitted associates may also use the PHI for plan Administrative Functions that Plan Sponsor performs for the plan such as:

- Summary Health Information for the purpose of obtaining premium bids, including bids in connection with the placement of stop loss coverage;
- Summary Health Information for use in making decisions to modify, amend or terminate the plan.

Plan Administrative Functions means administrative functions performed on behalf of the plan and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

Any controversy or claim arising out of or relating to a violation of any of the separation and/or disclosure provisions agreed to in the certification and described in this plan may be reported to the HIPAA Privacy Official.

What Other Types Of Activities Involve The Collection Or Use And Disclosure Of PHI?

1. Activities required or permitted by Law. The following examples provide information on uses and disclosures required or permitted by law:

    - The plan may share PHI with government or law enforcement agencies when we are required to do so. The plan also may share PHI when required to in a court or other legal proceeding.
    - The plan may share PHI to obey workers' compensation laws.
    - The plan may share PHI with the Individual if the Individual requests access to PHI as described previously in the Individual Rights section of this provision.

2. Activities Performed with Authorization

In other situations, the plan will ask for the Individual's written authorization before using or disclosing PHI.

An Individual may decide later that they no longer want to agree to a certain use of PHI for which the plan received authorization. If so, the Individual may write to the plan and revoke their authorization. If the plan had authorization to use PHI when used, the revocation will not apply to those past situations.

Our Legal Obligations

This plan is legally required to maintain the privacy of PHI as set forth in this provision. The plan is required to send a Notice of Privacy Practices to the Primary Covered Person and abide by its contents. If an Individual feels that their rights have been violated in this regard, they may file a complaint with the plan's Privacy Official at the address below. An Individual may also file a complaint with the Secretary of the Department of Health and Human Services.

1. A complaint must be filed in writing, either on paper or electronically.
2. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements.
3. A complaint must be filed within 180 days of when the complainant knew or should have known of the act or omission.

Privacy Policy Changes

The plan may change privacy policies from time to time to comply with the **Plan Administrator's** understanding of applicable laws and to provide the best service possible under the plan. Any change in policy will be made available to Plan Participants.

For information or questions about our policies or to file a complaint, write the Privacy Official at the following address:

Gaylord Community School District
c/o Privacy Fiduciary
615 S. Elm Street
Gaylord, MI 49735
(989) 705-3002.

The Contact Office If an Individual wishes to exercise their rights to request access or amend PHI, or receive an accounting of disclosures or a restriction on use or disclosure of PHI, the Individual may contact the plan's Privacy Official or the Contact Office listed above or the organization listed below:

CoreSource, Inc.
P.O. Box 2310
Mt. Clemens, MI 48046
(800) 999-0114

HELP FIGHT FRAUD

Combating fraud and abuse takes a cooperative effort from each of us. One way for you to help is by reviewing your Explanation of Benefits (EOB) to be sure that the services billed to us were reported properly. If you should see a service and/or supply billed to us that you did not receive, please report that immediately in writing. Indicate in your letter that you are filing a potential fraud complaint and document the following facts:

- The name and address of the provider,
- The name of the beneficiary who was listed as receiving the service or item,
- The claim number,
- The date of the service in question,
- The service or item that you do not believe was provided,
- The reason why you believe the claim should not have been paid, and
- Any additional information or facts showing that the claim should not have been paid.

Detection Tips

You should be suspicious of practices that involve:

- Providers who routinely do not collect your cost share (co-payment).
- Billing by your provider for services that you did not receive.
- Providers billing for services or supplies that are different from what you received.

Prevention Tips

- Always protect your CoreSource, Inc. identification card. Know to whom you are giving your Member ID Number. Do not provide your member number to someone over the phone if they call you.
- Be skeptical of providers who tell you that a particular item or service is not usually covered by us, but knows how to bill for the item or service to get it paid.

Who Do I Contact If I Suspect Fraud, Waste Or Abuse?

Mail: CoreSource, Inc.
P.O. Box 2310
Mt. Clemens, MI 48046
Phone: (800) 999-0114

HOW TO FILE VISION CLAIMS

A General Overview

A claim is defined as any request for a plan benefit made by a **claimant** that complies with the plan's reasonable procedure for making benefit claims.

There are different types of claims. Reasonable claim filing procedures, which are different for each type of claim, are described below. Each type of claim has a specific timetable for approval, payment, request for further information, denial of the claim and for review of any **adverse benefit determination**.

The times listed below for response and appeals are maximum times only. A period of time begins at the time the claim is received, as explained in the claim filing procedures for each type of claim. Decisions will be made within a reasonable period of time appropriate to the circumstances. Throughout this section, "days" means calendar days.

What Should You Know About Pre-Service Claims?

Whenever the plan requires advance approval of a service or treatment, the purpose of a **pre-service claim** is to provide the **claimant** with a determination of whether or not the approval process will prevent payment of the claim and to give you the opportunity to appeal any **adverse benefit determination** made during the pre-approval process. However, the claim determination made on a **pre-service claim** review does not guarantee payment of any **post-service claim**.

This plan does not condition benefit payment, whether an urgent care claim or a non-urgent care claim, on any advance notification. Plan inquiries regarding benefits will be responded to as a courtesy and are not a guarantee of payment. Inquiries may be made in writing to the **Plan Supervisor**, CoreSource, Inc. P.O. Box 2310, Mt. Clemens, MI 48046, (800) 999-0114.

What Should You Know About Post-Service Claims?

Plan Procedures For Filing A Post-Service Claim

The **claimant** may file a **post-service claim** by mail or electronic media directly with the **Plan Supervisor**. The plan does not require the filing of a claim form. When a provider files a claim, they will be considered the **authorized representative** of the patient.

For vision **post-service claims**, your **Plan Supervisor** is CoreSource, Inc. P.O. Box 2310, Mt. Clemens, MI 48046, (800) 999-0114.

Original bills and/or receipts with the complete claims information listed below should be sent to CoreSource, Inc. In the case of a bill from a network provider where the Network requires claims be submitted through them, the bill will not be considered a claim until it is received by the Network. In addition to bills filed by hard copy, CoreSource, Inc. will consider claims filed electronically as original claims.

Required Information

When submitting a vision claim, the following information must be presented:

- The **employee's** name, name of the **employer** and four-digit division code; this information is embossed on your CoreSource, Inc. identification card.
- The **employee's** unique identification number.
- The name of the patient and relationship to the **employee**.
- The date of service.
- The provider's name and degree.
- The charge for each specific service.

Unless you submit proof that you have paid for the services billed, payment will be made to the provider as your **authorized representative**.

This plan intends, through CoreSource, Inc., to promptly acknowledge and make a claims determination on claims submitted. In order to do this, the plan needs your cooperation. In most cases when a bill is sent to CoreSource, Inc. directly by the provider, the claims information listed above will be on the bill. If you send a bill or receipt to CoreSource, Inc., you should be sure the above claim information is given.

Providing Additional Information

Additional information provided at the time of the claim will help in making a determination. For example, if the bill is for your covered **dependent** that has other vision coverage, send a copy of the other coverage's proof of payment or denial.

If the bill is for services rendered due to an accidental bodily **injury**, please provide the following details:

- How the accident happened?
- When the accident happened?
- The name and address of anyone who was responsible for the **injury**.

Time Periods For The Plan And You

The **Claims Administrator** must reply to a claim request within a certain time period. The **claimant** must also respond to the request for additional information from the **Claims Administrator** within certain time periods.

When a **post-service claim** is filed, and all information needed to make a claim determination is present, the **Claims Administrator** must notify the **claimant** of a claims decision within 30 days from the date the claim is received.

If a **post-service claim** is filed and additional information is needed, the **Claims Administrator** must notify the **claimant** within 30 days.

The **claimant** will have up to 45 days from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 15 days from the receipt of the response. If the **claimant** does not respond to the request for information, the claim will be denied within 60 days after the request for information. Should the required information be submitted subsequently, the claim will be considered a new request and will be reviewed in accordance with the above guidelines, if filed within the claim filing timeframe. See the section titled "What is Not Covered?" for additional information regarding the claims filing timeframe.

If an **adverse benefit determination** is given, the **claimant** may appeal that decision. Please see the section titled "Adverse Benefit Determinations and Appeals" for further information.

ADVERSE BENEFIT DETERMINATIONS AND APPEALS

What If My Claim Is Denied?

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

1. The specific reason or reasons for the **adverse benefit determination**.
2. Reference to the specific plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the **claimant** to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the plan's review procedures and the time limits applicable to such procedures.
5. A statement that the **claimant** is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the **adverse benefit determination** was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion which was relied on will be provided free of charge to the **claimant** upon request.
7. If the **adverse benefit determination** is based on medical necessity or **experimental** or **investigational** treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the **claimant's** medical circumstances, will be provided free of charge to the **claimant** upon request.

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 the plan 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.

How Do I File An Appeal?

If a **claimant** receives an **adverse benefit determination** for an urgent **pre-service claim**, the **claimant** or **authorized representative** may appeal that decision in writing, via mail, facsimile, or electronically to the Formal Grievance Review Board. If a **claimant** receives an **adverse benefit determination** for a non-urgent **pre-service claim** or a **post-service claim**, the **claimant** or **authorized representative** may appeal the decision within 180 days of the date of the **adverse benefit determination** to the Grievance Review Board and request a personal appearance before the Grievance Review Board. The written request should contain the issues, all additional information and comments pertinent to the appeal and mail to:

CoreSource, Inc.
Grievance Review Board
P.O. Box 2310
Mt. Clemens, MI 48046
(800) 521-1555

The **claimant** has the right to attend the meeting of the Grievance Review Board. If requested, the **claimant** will be informed of the date and time of the meeting seven days in advance.

The following describes the review process and rights of the **claimant**:

1. The **claimant** or **authorized representative** has the right to submit documents, information and comments and to present evidence and testimony.
2. The **claimant** or **authorized representative** has the right to access, free of charge, relevant information to the claim for benefits. A document, record, or other information shall be considered relevant to a claim if it:
    a. Was relied upon in making the benefit determination;
    b. 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;
    c. 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

d. Constituted a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit.

3. Before a final determination on appeal is rendered, the **claimant** or **authorized representative** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the **claimant** or **authorized representative** a reasonable opportunity to respond prior to that date.
4. The review takes into account all information submitted by the **claimant**, even if it was not considered in the initial benefit determination.
5. The review will not afford deference to the original denial.
6. If original denial was, in whole or in part, based on medical judgment:
    a. The Grievance Review Board will consult with a **health care professional** who has appropriate training and experience in the field involving the medical judgment; and
    b. The **health care professional** utilized by the Grievance Review Board will be neither:
        i. An individual who was consulted in connection with the original denial of the claim, nor
        ii. A subordinate of any other **health care professional** who was consulted in connection with the original denial.
7. If requested, the Grievance Review Board will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

Notice Of Benefit Determination On Appeal

The Grievance Review Board shall provide the **claimant** or **authorized representative** with a written notice of the appeal decision within the applicable time period. If a **claimant** receives an **adverse benefit determination** for an urgent **pre-service claim**, the Grievance Review Board will provide a decision regarding the appeal within 72 hours. If a **claimant** receives an **adverse benefit determination** for a non-urgent **pre-service claim**, the Grievance Review Board will review the appeal and respond within 35 days. If a **claimant** receives an **adverse benefit determination** for a **post-service claim**, the Grievance Review Board will review the appeal and respond within 35 days. The Grievance Review Board may take an additional 10 days if the Board is waiting receipt of requested information from a health care facility or **health care professional**.

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.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific plan provisions on which the denial is based.
3. A statement that the **claimant** or **authorized representative** has the right to access, free of charge, relevant information to the claim for benefits. A document, record, or other information shall be considered relevant to a claim if it:
    a. Was relied upon in making the benefit determination;
    b. 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; or constituted a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit.
4. A statement of the **claimant's** right to request an external review and a description of the process for requesting such a review, including applicable time limits.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the denial was based on medical necessity, **experimental/investigational** treatment or similar exclusion or limit, the Grievance Review Board will supply either:
    a. An explanation of the scientific or clinical judgment, applying the terms of the plan to the **claimant's** medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

Is The Decision On Review Final?

If the claim for medical services is denied at the Grievance Review Board level, the **claimant** has the right to request an External Review.

External Review

A **claimant** or **authorized representative** may request an external review of a denied claim by making written request to the Michigan Commissioner of Insurance (Commissioner) or his designee, or an Independent Review Organization (IRO) within 60 days after the date of the final adverse determination by the Grievance Review Board. A request for an External Review must be submitted in writing to:

Michigan Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
(877) 999-6442

When requesting an External Review, the **claimant** or **authorized representative** must authorize CoreSource, Inc. to disclose protected health information, such as medical records, that are pertinent to the External Review.

The Commissioner will review the **claimant's** or **authorized representative's** request for an External Review, and the **claimant** or **authorized representative** will be notified by the Commissioner within 5 business days if the **claimant's** or **authorized representative's** request has been sent to an IRO.

The assigned IRO shall provide its recommendation to the Commissioner not later than 14 days after assignment by the Commissioner of the request for an external review.

If the claim is sent to an IRO, the Commissioner will contact the **claimant** or **authorized representative** with the final determination within 7 business days after receiving the selected IRO's recommendation. The External Review determination is the final determination. If the **claimant** or **authorized representative** is not satisfied with the External Review determination, the **claimant** or **authorized representative** may pursue available legal remedy.

Expedited External Review: Within 10 days after receiving an adverse determination, the **claimant** or **authorized representative** have the right to request an Expedited External Review by the Commissioner or his designee or an IRO designated by the Commissioner if a **physician** provides substantiation that completion of an expedited internal appeal would seriously jeopardize the life or health of a patient, or the ability to regain maximum function, and the patient or the patient's **authorized representative** has filed a request for an expedited internal grievance. A request for an External Review must be submitted in writing to the Commissioner at the following address:

Michigan Department of Insurance and Financial Services
Office of General Counsel – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
(877) 999-6442

FACILITY OF PAYMENT

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

Plan payments will be made to the provider whenever there is no evidence showing that the provider has been paid. If the provider has been paid and the **employee** authorizes payment to another individual, the plan will pay that individual upon receipt of the **employee's** signed authorization.

If an **employee** dies, the plan will determine payment of claims as follows:

- First, to any providers who have not received payment that would be due under the plan;
- Second, the **employee's** spouse;
- Third, the **employee's** estate.

REIMBURSEMENT OF PLAN PAYMENTS

The plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help you or your covered **dependents** in a time of need, however, the plan may pay covered expenses that may be or may become the responsibility of another person, provided that the plan later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the plan, as well as by applying for payment of covered expenses, you and your covered **dependents** are subject to, and agree to, the following terms and conditions with respect to the amount of covered expenses paid by the plan:

1. Assignment of Rights (Subrogation). You and your covered **dependents** automatically assign to the plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical charges, attorney fees, or other costs and expenses. This assignment also allows the plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the plan’s right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The plan shall have an equitable lien against any rights you or your covered **dependent** may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the **employer** will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds"). The plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the **Plan Administrator**, the plan may reduce any future covered expenses otherwise available to the covered person under the plan by an amount up to the total amount of Reimbursable Payments made by the plan that is subject to the equitable lien.

   This and any other provisions of the plan concerning equitable liens and other equitable remedies are intended to meet any applicable standards for enforcement (including those that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002); and Sereboff v. Mid Atlantic Medical Services, Inc. (MAMSI), 547 US 356 (2006). The provisions of the plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule. The plan's rights take priority over your rights and the rights of your **dependents**.

3. Assisting in Plan's Reimbursement Activities. You and your covered **dependents** have an obligation to assist the plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the plan's exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the plan as a co-payee for the amount of the Reimbursable Payments and notifying the plan), (c) sign any document deemed by the **Plan Administrator** to be relevant to protecting the plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the **Plan Administrator** to enforce the plan's rights.

4. Overpayments. This plan will have the right to recover any payments that were made to, or on behalf of, a **covered individual** and which causes an overpayment to be made.

Failure by you or your covered **dependents** to follow the above terms and conditions may result, at the discretion of the **Plan Administrator**, in a reduction from future benefit payments available to the covered person under the plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the plan.

GENERAL PLAN INFORMATION

Plan Name

The name of the plan is the Gaylord Community School District Employee Vision Benefit Plan Effective January 1, 2016.

Type Of Plan

This plan is a welfare benefits plan providing vision benefits.

Plan Administrator And Named Fiduciary

The **Plan Administrator**, named fiduciary and agent for service of legal process is Gaylord Community School District, 615 S. Elm Street, Gaylord, MI 49735, (989)705-3002.

Employer Identification Number

The **employer** identification number for Gaylord Community School District is 38-6003246.

Cost Of The Plan

Gaylord Community School District shares in the cost of providing benefits for you and your eligible **dependents**. Information regarding the specific cost for coverage can be obtained from your Human Resources Department.

Plan Effective Date

The original effective date of the plan is January 1, 2016.

Plan Distribution Date

Benefits described in this **SPD** will only apply to claims incurred on or after the plan effective date or the date on which the plan is distributed whichever is later.

Plan Year

The fiscal year of this plan commences on the first day of January and ends on the last day of the following December.

Plan Supervisor

The **Plan Supervisor** is CoreSource, Inc. P.O. Box 2310, Mt. Clemens, MI 48046, (800) 999-0114

The Plan Is Not A Contract Of Employment

This plan does not constitute or provide a promise or guarantee of employment or continued employment, to any **employee** of the Plan Sponsor or of any participating **employer**. Nor do these documents change any such employment relationship to be other than employment "at will."

DESIGNATION OF FIDUCIARY RESPONSIBILITY

Who Are The Fiduciaries Of The Plan?

Gaylord Community School District is the **Plan Administrator** and named fiduciary with respect to the plan, for everything not delegated to another fiduciary in this document. Gaylord Community School District shall exercise all discretionary authority and control with respect to management of the plan.

Gaylord Community School District may delegate certain fiduciary responsibilities under the plan to persons who are not named fiduciaries of the plan. If fiduciary responsibilities are delegated to any other person, such delegation of responsibility should be made by written instrument executed by Gaylord Community School District. A copy of the written instrument delegating the responsibility will be kept with the records of the plan.

CoreSource, Inc. has, by written instrument, been designated as the Fiduciary for Final Claims Determination for medical **post-service claims** submitted to the plan. By making this designation, it is the **Plan Administrator's** intention that CoreSource, Inc. make final claim determinations and have final discretion in construing the terms of the plan with respect to final claim determinations. CoreSource, Inc. shall not be responsible for any fiduciary responsibilities other than those outlined in this paragraph.

What Are The Fiduciaries' Responsibilities?

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

No fiduciary shall be liable with respect to a breach of fiduciary duty if such breach is committed before it became a fiduciary, and nothing in this plan shall be deemed to relieve any person from liability for his or her own misconduct or fraud.

What If The Plan Is Modified, Amended Or Terminated?

Gaylord Community School District, by a duly **authorized representative**, may modify, amend, or terminate the plan at any time at its sole discretion.

Any such modification, amendments, or terminations that affect plan participants or beneficiaries of the plan will be communicated to them. If the plan is terminated, benefits will only be paid for claims incurred before the date of termination up to the time funds are no longer available.

Who Is Responsible For The Administration Of The Plan?

Gaylord Community School District is the **Plan Administrator**. As **Plan Administrator**, Gaylord Community School District is required to supply you with this booklet and other information, and to file various reports and documents with government agencies. In its role of administering the plan, the **Plan Administrator** also may make rulings, interpret the plan, prescribe procedures, gather needed information, receive and review financial information of the plan, employ or appoint individuals to assist in any administrative function, and generally do all other things which need to be handled in administering the plan.

The **Plan Administrator** shall have any and all powers of authority, which shall be proper to enable him/her to carry out his/her duties under the plan and full discretionary authority to make regulations with respect to this plans and to determine, consistently therewith, all questions that may arise as to the status and rights of participants and beneficiaries and any and all other persons..

The **Plan Administrator** shall have full discretionary authority to interpret all provisions of this plan, including resolving an inconsistency or ambiguity or correcting an error or an omission. The plan shall be governed by the Internal Revenue Code and the laws of the State of Michigan.

How Is The Plan Funded?

The plan is funded through the general assets of Gaylord Community School District, and contributions as required. In the event of plan termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the plan should be terminated, claims incurred prior to the date of such termination would be paid until the time funds are no longer available. Claims incurred after the date of such termination would not be paid.

Is This Plan Considered Vision Insurance?

Under Michigan law, the **Plan Supervisor** is required to disclose the following information.

Gaylord Community School District Employee Vision Benefit Plan is a self-funded plan. You and your covered **dependents** are not insured. In the event this plan does not ultimately pay vision expenses that are eligible for payment under this plan for any reason, you or your covered **dependents** may be liable for those expenses.

The **Plan Supervisor**, CoreSource, Inc., merely processes claims and does not insure that any vision expenses of individuals covered by this plan will be paid.

When you or your covered **dependent** file complete and proper claims for benefits, those claims will be promptly processed. In the event of a delay in processing, the you or your covered **dependent** shall have no greater right or interest or other remedy against the **Plan Supervisor**, CoreSource, Inc., than as otherwise afforded by law.