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INTRODUCTION

Toledo Public Schools ("the Employer") continues and re-states the PPO Dental Benefits of the Toledo Public Schools Dental Plan (the "Plan") in this document, or Summary Plan Description. The re-stated PPO Dental Benefits are re-stated effective January 1, 2011. The Employer has duly authorized the adoption of this amended and restated Summary Plan Description and the execution thereof.

The medical benefits provided under this Plan and the general terms and conditions governing the same are contained in this Summary Plan Description a copy of which is provided to the Participants in the Plan, and may also be governed by the provisions of certain insurance contracts purchased on behalf of the Plan. The Summary Plan Description, Plan Document and all such insurance contracts, if any, as the same may be amended from time to time, are hereby incorporated herein by this reference and made a part of this Plan.

This Summary Plan Description contains a description of the PPO Dental Benefits available under the Plan. The Plan’s Non-PPO Dental Benefits are described in separate Summary Plan Descriptions. In addition, the Plan provides coverage for medical and prescription drug benefits. These benefits are also described in separate Summary Plan Descriptions.

This Summary Plan Description contains a summary in English of the Covered Person’s rights and benefits under the Plan. If the Covered Person has difficulty understanding any part of this Summary Plan Description because (s)he requires assistance in understanding English, contact the Plan Administrator at Toledo Public Schools, 420 East Manhattan Blvd., Toledo, Ohio 43608.

Under this Plan, the Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Plan Fiduciary under ERISA unless another individual or entity is appointed by the Employer. By affixing his signature and date to this document, the Plan Sponsor does hereby certify that the Plan Sponsor has reviewed the Summary Plan Description and that it represents the terms and conditions of the Plan adopted by the Plan Sponsor.
GENERAL PLAN INFORMATION

1. NAME OF THE PLAN

Toledo Public Schools Dental Plan

This Summary Plan Description, which is a part of the Plan Document, describes one of the available options of health care benefits available under the Plan. This Plan option is referred to as PPO Dental Benefits.

2. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN SPONSOR

Toledo Public Schools
Attn: Employee Benefits
420 E. Manhattan Blvd.
Toledo, OH 43608
(419)671-8348

3. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR

Same as Plan Sponsor

4. NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS

Office of the Treasurer
Toledo Public Schools
420 E. Manhattan Blvd.
Toledo, OH 43608

5. PLAN YEAR

July 1 through June 30

6. UNION PLAN(S)

Upon request, a copy of the collective bargaining agreement(s) is/are available from the Plan Administrator.

7. CLAIMS ADMINISTRATOR

HealthSCOPE Benefits Administrators, Inc.
27 Corporate Hill Drive
Little Rock, AR 72205

Claims should be submitted to:
HealthSCOPE Benefits Administrators, Inc.
PO Box 99006
Lubbock, TX 79490-9006

Send PPO Claims to the PPO Network appearing on the Identification Card.
NOTE: Claims Administrator performs claims administration and other administrative duties on behalf of the Plan and is not a Fiduciary under any law; therefore any act performed by the Claims Administrator shall not imply any Fiduciary responsibility on the Claims Administrator.

8. EFFECTIVE DATE OF THE RESTATEMENT OF THE PLAN

January 1, 2011

9. TYPE OF PLAN

Group health benefits which include dental benefits. Dental benefits are provided primarily by the Employer with claims being paid on behalf of the Employer by the Claims Administrator from the Plan assets of the Employer. Contributions for these benefits are also made in part by employees.

The Plan’s PPO Dental Benefits are described in this Summary Plan Description.

10. TYPE OF ADMINISTRATION

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Administrator to provide claims payment and ministerial administration.

11. SOURCES OF CONTRIBUTIONS

Contributions for Plan expenses are obtained from the Employer and from the participating employees. The Employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the participating employees.
NOTICE OF EXTENSION OF DEPENDENT COVERAGE TO AGE 28

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 28 are eligible to enroll in the Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Coverage for individuals who enroll within the prescribed enrollment period will be effective retroactively to January 1, 2011. For more information contact the Plan Administrator.
**SCHEDULE OF BENEFITS**

**DENTAL SCHEDULE OF BENEFITS**

<table>
<thead>
<tr>
<th>GENERAL INFORMATION</th>
<th>In-Network DenteMax Provider</th>
<th>Out-of-Network Non-DenteMax Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Requirement</td>
<td>None</td>
<td>\n</td>
</tr>
<tr>
<td>Coinsurance Requirement</td>
<td>Varies depending on procedure. Refer to the Schedule of Benefits.</td>
<td>Varies depending on procedure. Refer to the Schedule of Benefits.</td>
</tr>
<tr>
<td>Maximum Benefit for Emergency Palliative Treatment, Essential Services and Complex Services</td>
<td>$1,000 per Covered Person per Calendar Year Applies only to Emergency Palliative Treatment, Essential Services and Complex Services</td>
<td>\n</td>
</tr>
<tr>
<td>Orthodontia Maximum Benefit</td>
<td>$1,500 per Covered Person’s lifetime</td>
<td>\n</td>
</tr>
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<table>
<thead>
<tr>
<th>COVERED SERVICES INFORMATION</th>
<th>In-Network DenteMax Provider</th>
<th>Out-of-Network Non-DenteMax Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Palliative Treatment</td>
<td>Plan pays 100% of Provider’s Allowable Charge subject to the Maximum Benefit</td>
<td>Plan pays 100% of Provider’s Allowable Charge subject to the Maximum Benefit</td>
</tr>
<tr>
<td>Preventative Services</td>
<td>Plan pays 100% of Provider’s Allowable Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Essential Services</td>
<td>Plan pays 100% of Provider’s Allowable Charge subject to the Maximum Benefit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Complex Services</td>
<td>Plan pays 80% of the Provider’s Allowable Charge subject to the Maximum Benefit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Orthodontia Services Installation of orthodontia appliance and consultation charges in connection therewith</td>
<td>Plan pays 100% of Provider’s Allowable Charge subject to the Orthodontia Maximum Benefit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Orthodontia Services First banding after orthodontia appliance in place</td>
<td>Plan pays up to 25% of the DenteMax Orthodontic Fee Schedule up to the Orthodontia Maximum Benefit (Maximum Benefit of $375 per Covered Person)</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Note**

Certain dental procedures have limitations concerning the intervals after which coverage will be provided. Refer to the Covered Services section for details.
DENTAL BENEFITS

This section describes the Covered Person’s Dental Benefits. The Plan will provide Dental Benefits when services:

1. Are authorized by a Dentist;
2. Are rendered by a Dentist or Dental Hygienist;
3. Are billed by or on behalf of a Dentist;
4. Qualify as a Covered Service; and
5. Are based on accepted standards of dental practice as determined by the American Dental Association.

DENTEMAX PROVIDERS

Under the Plan, except for the exceptions noted below, dental services will only be covered when rendered by a DenteMax Provider. The exceptions are:

1. Emergency Palliative Treatment;
2. Covered Services that cannot be rendered by a DenteMax Provider.

Payment of the Provider’s Allowable Charge will be provided for all Covered Services. Under the Plan, the Provider’s Allowable Charge for a Non-DenteMax Provider is the Customary and Reasonable Charge. For a DenteMax Provider the Provider’s Allowable Charge will be based on a reduced rate (“Negotiated Rate”). DenteMax Providers must accept the Negotiated Rate as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate. All payments will be subject to any applicable Deductible, Coinsurance, and Maximum Benefits in this Summary Plan Description and the Schedule of Benefits.

PRE-DETERMINATION OF BENEFITS

If the Covered Person’s Dentist plans a course of dental treatment which will cost $200 or more, the Covered Person’s Dentist is encouraged to obtain a pre-determination of benefits. This is done by submitting a claim form outlining the treatment plan the Dentist intends to follow in treating the Covered Person. This should be provided to the Plan Administrator, or the Plan’s Claims Administrator, prior to the start of the course of treatment. The claim form should include a detailed description of the work to be done and an estimate of the anticipated dental charges.

In addition to the claim form, any existing diagnostic aids and x-rays should be provided. The purpose of a dental pre-determination of benefits is to assist the Dentist and Covered Person in determining what will be covered under the Plan prior to the services being rendered. Coverage must be in effect when the actual dental services are provided in order for the services to be covered under the Plan even if the Covered Person’s Dentist has obtained a pre-determination of benefits. It is important to note that pre-determination of benefits is not required and will not result in a loss of Coverage in the event that a pre-determination of benefits is not submitted to the Plan.
MULTIPLE METHODS OF DENTAL TREATMENT

The Plan may feel that there is more than one way to treat the Covered Person’s dental condition. When there are two or more methods of treatment for the same condition which meet commonly accepted standards of dental practice, the Plan will pay for the least expensive treatment. This applies even if the Covered Person and the Covered Person’s Dentist have chosen a more costly treatment.

In order to determine the benefit amounts for dental covered services, the Plan may ask for x-rays and other diagnostic and evaluative materials. If these materials are not provided, the Plan will determine the benefit amounts on the basis of the information that is available. This may reduce the amount of benefits which otherwise would have been payable.

Coverage will be provided for the Covered Services listed below. They must be billed by or for a Dentist.

COVERED SERVICES

The Plan will cover the following dental procedures and services subject to the terms and conditions set forth in this Summary Plan Description.

Preventative Services

1. Initial and periodic oral examinations and evaluations, limited to 2 exams per Benefit Period;
2. Bitewing x-rays, limited to 2 x-rays per Benefit Period;
3. Full mouth series x-rays, limited to 2 x-rays per Benefit Period;
4. Periapical x-ray;
5. Prophylaxis, limited to 2 per Benefit Period;
6. Space maintainers, limited to Dependent Children under the age of 19 years; and
7. Topical application of fluoride, limited to 1 treatment per Benefit Period for Dependent Children under the age of 19 years.

Emergency Palliative Treatment

Emergency Palliative Treatment is treatment provided in response to a painful or dangerous situation to relieve pain and remove a Covered Person from immediate danger without rendering a definitive treatment (e.g., such as filling a tooth).

Essential Services

1. Office consultations and examinations with a dental specialist;
2. Extractions, including the removal of impacted teeth;
3. Oral surgery, other than periodontal surgery (e.g., alveoplasty, vestibuloplasty, simple extractions, extractions of impacted teeth);
4. Anesthesia;
5. Fillings;
6. Endodontic treatment;
7. Periodontic treatment, other than periodontal surgery;
8. Repairing, relining or rebasing of prosthetics (e.g., space maintainers and dentures). Relining and rebasing of dentures 6 or more months after initial placement but not more than once in any 36-month period; and
Complex Services

1. Inlays and onlays as restorations, limited to once every 5 years per tooth;
2. Crowns, limited to once every 5 years per tooth;
3. Recementing of inlays, onlays and crowns;
4. Dentures, limited to one replacement of a temporary denture if a permanent denture is installed within 12 months of the issuance of a temporary denture;
5. Bridges, including abutments and pontics;
6. Fixed prosthetics, limited to once every years per unit; and
7. Periodontal surgical procedures.

☞ Note: In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before Coverage goes into effect, even if the prosthetic device or crown is installed after Coverage goes into effect. If impressions are taken while Coverage is in effect, but the prosthetic device or crown is installed after Coverage terminates, then charges for the prosthetic device or crown will not be covered. In the case of the replacement of missing teeth, the Plan will not cover dental services or supplies for the replacement of a missing tooth or teeth that was missing prior to the Effective Date of Coverage.

Orthodontia Services*

For all Covered Persons

1. Office consultations in connection with the establishment of a treatment plan;
2. Installation of tooth straightening appliances; and
3. All treatments for abnormally positioned teeth.

☞ Note: When the Covered Person is already receiving active or retention treatment on his or her Effective Date, only services incurred after the Effective Date will be covered based on a pro-ration of the expected months of treatment.

EXCLUSIONS OR LIMITATIONS

No dental benefits are provided for any of the following:

1. Anesthesia. The Plan will not cover local anesthesia or partial anesthesia, including intravenous sedation;
2. Appliances and Restoration for Vertical Dimension. The Plan will not cover appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion. Full mouth equilibration is one example of such a service;
3. Charges for Certain Non-Dental Treatments/Procedures. The Plan will not cover charges in connection with filling out claim forms, missed appointments, copies of medical records, and telephone consultations;
4. Charges Incurred Due to Non-Payment. The Plan will not cover charges for sales tax, mailing fees and surcharges incurred due to nonpayment;
5. Claims Time Frames and Fraudulent Claims. The Plan will not cover charges for claims not received within the Plan’s filing limit deadlines as specified under the section entitled Claims Information. In addition, the Plan will not cover any claim that is fraudulent or misrepresented;
6. Clinical Necessity. The Plan will not cover any services or treatments that are deemed to be not
Clinically Necessary, as defined herein;

7. **Congenital Malformation.** The Plan will not cover services or supplies for the treatment or correction of a congenital or development malformation unless Clinically Necessary;

8. **Controlled Substance.** The Plan will not cover charges for the care or treatment of an Illness or Injury resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered by a Dentist;

9. **Cosmetic Services.** The Plan will not cover services or supplies primarily cosmetic or aesthetic. Examples include capping teeth to cover stains; charges for personalization or characterization of crowns, full or partial dentures or fixed bridgework;

10. **Court Ordered Treatment.** The Plan will not cover charges for court ordered treatment not specifically mentioned as covered under this Plan;

11. **Criminal Act.** The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act or assault, or by committing or attempting to commit a crime or by participating in a riot or public disturbance;

12. **Dental Services for Which Normally There Is No Charge.** The Plan will not cover dental services or supplies for which the Covered Person would not have been charged if the Covered Person had not been covered by this dental insurance. For example: (a) if the Covered Person would have been charged less if (s)he had no insurance, the Plan will base the payment on the lower charge; or (b) the service would have been provided free by a clinic or health service which is operated by or for the Covered Person’s employer, union or similar group, the Plan will not pay any charges;

13. **Dental Visits to Home or in Hospital.** The Plan will not cover charges for dental visits at home or in a Hospital, unless these visits are in connection with dental surgery or emergency care;

14. **Dentist’s License.** The Plan will not cover services that are not performed within the scope of the Dentist’s license;

15. **Dentist or Physician Directed or Performed Services.** The Plan will not cover services that are not prescribed by or performed under the direction of a Dentist or Physician;

16. **Duplicate Devices.** The Plan will not cover duplicate prosthetic devices or appliances;

17. **Educational and Training Services.** The Plan will not cover charges in connection with educational, training or vocational services;

18. **Effective and Termination Date.** The Plan will not cover charges for services and supplies for which a charge was incurred before the Covered Person was covered under this Plan or after their date of termination, except as specified herein;

19. **Excess Charges.** The Plan will not cover charges that are considered excess charges because: (a) the Covered Person transferred from one Dentist to another during a course of treatment; (b) the Covered Person missed an appointment; (c) services were rendered by more than one Dentist; or (d) services were repeated needlessly;

20. **Exclusions.** The Plan will not cover charges for services and supplies which are specifically excluded
21. **Experimental or Investigative.** The Plan will not cover charges for services and supplies which are either experimental or investigational or not Clinically Necessary, except as provided herein;

22. **Family Member.** The Plan will not cover expenses or services received from a member of the Covered Person’s household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, brother, sister, parent or the Dependent Child. Immediate Family Member also includes the brother sister, parent or Dependent Child of the employee’s spouse;

23. **Fraudulent or Misrepresented Claims.** The Plan will not cover any charges that are fraudulent or misrepresented or for which a fraudulent or misrepresented claim has been submitted;

24. **Government Owned/Operated Facility.** The Plan will not cover charges for services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the Covered Person is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to Federal Law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are eligible herein and which are not incurred during or from service in the Armed Forces of the United States or any other country;

25. **Governmental Agency or Program.** The Plan will not cover supplies and services that are furnished or rendered to a Covered Person, or for which the cost is payable, by governmental agency or governmental program;

26. **Implants.** The Plan will not cover implants or services related to such implants;

27. **Legal Obligation.** The Plan will not cover charges for services and supplies for which the Covered Person has no legal obligation to pay or for which no charge has been made;

28. **Lost or Stolen Supplies.** The Plan will not cover dental services and supplies to replace a lost or stolen space maintainer, crown, bridge or full or partial denture. In addition, the Plan will not cover the repair of a damaged space maintainer;

29. **Maximum Benefit.** The Plan will not cover charges for services and supplies which exceed the Maximum Benefit or Orthodontia Maximum Benefit, as shown in the Schedule of Benefits or Eligible Expenses;

30. **Medical Benefits.** The Plan will not cover dental services or supplies which are covered under any medical benefits or health care coverage;

31. **Medicare.** The Plan will not cover any services for which payment was made or would have been made by Medicare;

32. **Military Related Disability.** The Plan will not cover charges for services and supplies for any military service-related disability or condition;

33. **More than One Dentist.** The Plan will not cover charges for services that are rendered by more than one Dentist. If the Covered Person changes Dentists during a course of treatment or if more than one Dentists treats the Covered Person for a procedure, additional benefits are not provided;
34. **No Charge.** The Plan will not cover dental services or supplies which are provided or made available free of charge or are payable by some other agency;

35. **Non-Covered Service.** The Plan will not cover any service or supply which is not specified as a Covered Service;

36. **Not Under Care of Dentist.** The Plan will not cover charges for services and supplies not recommended and approved by a Physician or a Dentist; or services and supplies when the Covered Person is not under the care of a Physician or Dentist;

37. **Oral Hygiene Instruction or Programs.** The Plan will not cover plaque control programs, oral hygiene or dietary instruction;

38. **Personal Hygiene/Convenience Items.** The Plan will not cover personal hygiene and convenience items;

39. **Porcelain Veneers.** The Plan will not cover porcelain or other veneers of crowns and pontics placed on the molars. If veneers are used, payment will be the same as payment for a full cast gold crown or cast gold pontic;

40. **Professional Dental Standards.** The Plan will not cover charges for services and supplies which are not provided in accordance with generally accepted professional medical standards or for experimental treatment;

41. **Provider’s Allowable Charge.** The Plan will not cover charges for services and supplies for treatment which are in excess of the Provider’s Allowable Charge (except as otherwise stated herein);

42. **Stabilizing Services.** The Plan will not cover services primarily to stabilize the teeth in their supporting structures. Examples include implantology and periodontal splinting;

43. **Subrogation Failure.** The Plan will not cover charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified under Subrogation;

44. **Suicide or Self-Inflicted Injury.** The Plan will not cover expenses for attempted suicide or an intentionally self-inflicted injury, while sane or insane, unless the injury was sustained as a result of a medical condition or domestic violence. As used herein, a medical condition includes a physical and mental health condition;

45. **Topical Dental Sealant.** The Plan will not cover topical dental sealants;
46. **Unnecessary or Inappropriate Services or Supplies.** The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed unnecessary or inappropriate by the ADA or is otherwise deemed unnecessary or inappropriate in accordance with accepted dental standards and practice;

47. **War.** The Plan will not cover any charge for services, supplies or treatment related to Illness, Injury, or disability caused by or attributed to an act of war, act of terrorism, riot, civil disobedience, insurrection, nuclear explosion or nuclear accident. “War” means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces; and

48. **Work-Related Illness or Injury.** The Plan will not cover charges for services and supplies for any condition, disease, defect, ailment, or accidental Injury arising out of and in the course of employment (for wage or profit) whether or not benefits are available under any Workers’ Compensation Act or other similar law. This exclusion applies if the Covered Person receives the benefits in whole, part or even if there is no Workers’ Compensation coverage in place. This exclusion also applies whether or not the Covered Person claims the benefits or compensation.
ELIGIBILITY PROVISIONS

ELIGIBILITY PROVISIONS FOR THE EMPLOYEE

Employees must meet the following eligibility requirements in order to be considered an Eligible Employee:

1. The employee must receive a wage or salary from the Employer, as reported on the Employer’s federal and state payroll reports; and/or

2. The employee is provided Coverage under the terms of an applicable collective bargaining agreement or applicable law or regulations; or

3. The employee is a member of the Board of Education elective Coverage pursuant to Ohio Revised Code 3313.202, and who is eligible to be a Participant under the terms of the Plan.

All such individuals are referred to as Eligible Employees.

An employee will retain eligibility for Coverage under the Plan if absent on an approved leave of absence, with the expectation of returning to work following the approved leave of absence as determined by the Employer. The Employer’s classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan.

ELIGIBILITY PROVISIONS FOR THE DEPENDENT

The following persons are considered to be eligible Dependents:

1. The Spouse of the Covered Employee;

2. A Dependent Child Under the Plan, a Dependent Child is:

   a. An Employee’s child, regardless of the child’s dependency, residency, student or financial dependence status, who is the natural child, step child, legally adopted child of the employee or spouse or a child who is in the legal guardianship of the employee or employee’s spouse pursuant to an interlocutory order of adoption and who is under the age of 26;

   b. An Employee’s child who is less than 28 years of age, who is unmarried, an Ohio resident or full-time student at an accredited public or private institution of higher education, not employed by an employer that offers any health benefits, and who is not eligible for coverage under Medicaid or Medicare. However, in order for Coverage to continue until the end of the month in which the child reaches the age of 28, the employee is required to notify the Plan Administrator of his or her election to continue Coverage for the child when the child reaches the age of 26. If the employee chooses not to continue Coverage reaches the age of 26, Coverage will end at the end of the month in which the Dependent Child reaches the age of 26.

With respect to a child who is in the legal guardianship of the employee or employee’s spouse pursuant to an interlocutory order of adoption, the child must be under Dependent Limiting Age at time of placement (Coverage eligibility begins from time of placement in the home for adoption whether or not the adoption proceedings have been completed).
c. A child who is subject of a National Medical Support Notice will be considered a Dependent Child under this Plan. The NMSN entitles such child to Coverage even if (a) such child does not reside with the Covered Employee or is not dependent on the employee for support, and (b) even if the employee does not enroll for Coverage under the Plan or does not have legal custody of the child. If the Eligible Employee has not satisfied the applicable Waiting Period, the Plan must cover the Dependent Child upon the Eligible Employee’s completion of such Waiting Period. All other applicable enrollment provisions of the Plan (e.g., Dependent Limiting Age, benefit options, right to continued Coverage, etc.) which are available to Covered Employees or other Covered Dependents shall be made available to the Dependent Child who is eligible pursuant to a National Medical Support Notice; and

d. An unmarried child who is over the Dependent Limiting Age of the Plan, who is permanently disabled upon attainment of the Dependent Limiting Age and who meets the dependency requirements set forth in this paragraph. The Dependent Child must be incapable of self-sustaining employment by reason of mental retardation or mental or physical handicap and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must notify the Employer of the child’s disability within 31 days after the Dependent Child reaches the Dependent Limiting Age. Such notification shall include proof satisfactory to the Employer of the Dependent Child’s incapacity and dependence upon the Covered Employee. After a two-year period following the date the Dependent Child meets the Dependent Limiting Age, the employee may be required to provide additional proof of the child’s continued dependence and incapacity.

The Plan Administrator has the right to request information needed to determine the patient's eligibility when a claim is filed.

**ELIGIBILITY DETERMINATIONS UNDER HIPAA**

Federal Law, under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), prohibits the Plan Sponsor from denying Coverage under the Plan based on any of the following health-related factors:

1. Health status;
2. Medical condition (including both physical and mental Illnesses);
3. Receipt of healthcare;
4. Medical history;
5. Genetic information;
6. Evidence of insurability (including conditions arising out of acts of domestic violence); and
7. Disability.
APPLYING FOR COVERAGE AND EFFECTIVE DATES

ENROLLMENT PERIOD FOR NEW HIRES

For an Eligible Employees who is newly hired or newly eligible, the Eligible Employee must complete and submit an enrollment application to the Employer within 30 days following the Eligible Employee’s date of hire. For an employee who submits an enrollment application to the Employer within this 30-day enrollment period, the Effective Date of Coverage will be the date of hire.

After the employee has submitted the enrollment application, (s)he will be informed of the Effective Date. Coverage will not begin until the application has been approved and the employee has been provided with the Effective Date. Under Individual Coverage, only the Eligible Employee is covered. Under Family Coverage, the Eligible Employee and all Dependents who have been enrolled under the Plan are covered.

**Note:** If an Eligible Employee is not Actively Working on the day Coverage would otherwise become effective, the Effective Date of Coverage will be postponed to the day the Eligible Employee returns to work. This does not apply if the Eligible Employee is not Actively Working due to the existence of a health condition.

SPECIAL ENROLLMENT PERIODS

There are a number of circumstances that qualify as Special Enrollment Periods under the Health Insurance Portability Act of 1996 (“HIPAA”). A Special Enrollment Period is an additional enrollment opportunity for the employee to enroll for Coverage following his or her initial eligibility date due to loss of other coverage. This special enrollment opportunity also applies to adding Dependents following the date of marriage, birth or adoption of a child. The specific conditions and limitations that apply to the Special Enrollment Period are described below.

1. **Loss of Other Coverage:** Eligible Employees who are covered under another health plan and subsequently lose such coverage are eligible for Coverage following the loss of the other coverage provided they submit a completed application to the Employer within 30 days following termination of the other coverage (please note: there is a separate 60-day enrollment period when loss of eligibility under Medicaid under Title XIX of the Social Security Act or CHIP program). If an employee submits application within the enrollment period set forth herein, Coverage will be effective the day following the loss of other coverage. As used herein, loss of the other coverage must be due to: (a) exhaustion of COBRA benefits; (b) Loss of Eligibility under the prior coverage; (c) loss of eligibility under Medicaid under Title XIX of the Social Security Act or the state children’s health insurance program (CHIP). In this event, the individual has 60 days to request coverage under the Plan; or (c) termination of contributions by the employer under the prior plan of coverage.

This Special Enrollment Period also applies to Dependents of Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, provided application is submitted within the time frame set forth above and loss coverage under the other plan was for one of the reasons set forth above.

This Special Enrollment Period also applies to Dependents of Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, provided application is submitted
within the time frame set forth above and loss coverage under the other plan was for one of the reasons set forth above.

2. **Birth or Adoption:** In the event of a birth of a child or adoption or placement for adoption of a child, the child will be eligible to enroll for Coverage under this provision. In this event, a completed application must be submitted to the TPS Employee Benefit Department no later than 31 days following the birth of the child, adoption or placement for adoption. In the event application is completed no later this 31-day enrollment period, Coverage shall be made effective on the first day of the month following the birth date the child, the adoption date of the child or the date the child is placed for adoption.

In this instance, the Eligible Employee and Spouse, if not already covered, will also be eligible to enroll for Coverage.

- **Note Regarding Additional Premium Payment:** If payment of a specific premium (or premium contribution) is required to add a Dependent Child to the employee’s Coverage (e.g., the employee is changing from Individual to Family Coverage), the additional premium or premium contribution and enrollment application must be provided to the TPS Employee Benefit Department within the 31-day enrollment period described above in order for the Dependent Child to be covered beyond the first 31 days following his or her birth, adoption or placement for adoption.

- **Note Regarding Disruption of Legal Adoption:** If a legal adoption is disrupted following a child’s placement in the home, the child will no longer be eligible. In this event, the employee should notify the TPS Employee Benefit Department so that the appropriate Coverage changes may be made.

3. **Marriage:** In the event Covered Employee marries after his or her Coverage has become effective, the employee may add his or her Spouse to the Coverage by submitting to the Employer a completed application within 30 days of the event. In this event, Coverage will be effective on the date of the marriage. In this instance, the Eligible Employee, the Spouse and any Dependent Children who are newly acquired as the result of the marriage, who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, are permitted to enroll during this Special Enrollment Period.

**ENROLLMENT DUE TO BECOMING ELIGIBLE FOR MEDICAID OR CHIP COVERAGE**

Becoming eligible for state premium assistance under Medicaid under Title XIX of the Social Security Act or the state children’s health insurance program (CHIP) under Title XXI of the Social Security Act will result in a Special Enrollment Period under HIPAA. An employee who is eligible, but not enrolled, for Coverage under the Plan (or a Dependent who is eligible, but not enrolled) may enroll in the Plan upon becoming eligible for premium assistance provided enrollment is requested within 60 days of becoming eligible for the assistance.

**ENROLLMENT PERIOD FOR NMSN DEPENDENT**

In addition to enrolling Dependent Children for Coverage when the employee is initially eligible to enroll or during a Special Enrollment Period, a Dependent Child may be enrolled for Coverage at a later date when a National Medical Support Notice (“NMSN”) has been issued. In this event, the Eligible Employee should submit an enrollment application for such child to the Employer and Coverage shall be effective in accordance with the date specified on the NMSN.

**ADDITIONAL SPECIAL ENROLLMENT RIGHTS UNDER PATIENT PROTECTION AND AFFORDABLE CARE ACT**
If, prior to January 1, 2011, the Plan provided Coverage for Dependent Children and the limiting age was less
than the age 28, a Dependent Child who was previously covered under the Plan but lost Coverage or was not
eligible for Coverage due to exceeding the former limiting age will be eligible to enroll during a One-Time
Open Enrollment Period.

The opportunity to enroll in this One-Time Open Enrollment Period must be communicated in writing to the
Dependent Child or parent-employee of the Dependent Child. This Special Enrollment Right begins on
November 1, 2011. For Dependent Children who enroll within the prescribed period of time, Coverage will
become effective on January 1, 2011.

The lifetime limit on the dollar value of benefits under the Plan (i.e. the Lifetime Maximum Benefit) no longer
applies. A Covered Person whose Coverage ended by reason of reaching a prior lifetime limit under the Plan
are eligible to enroll in the Plan. In this event, the individual has 30 days from the date of this notice to
request enrollment. This Special Enrollment Right begins on November 1, 2011. For an individual who
enroll within the prescribed period of time, Coverage will become effective on January 1, 2011.

**LATE ENROLLMENT**

Employees or Dependents who fail to submit an enrollment application when initially eligible under the Plan
or during a Special Enrollment Period will be considered Late Enrollees. Late Enrollees will be permitted to
enroll for Coverage during the Plan’s Open Enrollment Period

**OPEN ENROLLMENT PERIOD**

Open Enrollment Period is the period designated by the Employer during which the Employee may elect
Coverage for himself and any eligible Dependents if (s)he did not enroll when initially eligible or during a
Special Enrollment Period. During this Open Enrollment Period, an Employee and his Dependents who are
not covered under this Plan must complete and submit an enrollment application to TPS Employee Benefits
Department.

The Open Enrollment Period under this Plan occurs during the month(s) specified in the applicable collective
bargaining agreement.

**NOTIFICATION FOLLOWING MEDICARE ELIGIBILITY**

It is important that the Covered Employee notify the Plan Administrator immediately when the employee or a
covered family member becomes eligible for Medicare benefits. Contact the TPS Employee Department for
details concerning how this notification process works.
ISSUANCE OF IDENTIFICATION CARDS AT TIME OF ENROLLMENT

The Eligible Employee will receive identification cards at time of enrollment. The identification card(s) have the Covered Employee’s name and identification number on them. The identification card should be presented when receiving Covered Services under the Plan because it contains information the Dentist needs when submitting a claim or making an inquiry. The identification card(s) is/are the property of Toledo Public Schools and must be returned if Coverage ends for any reason. Use of the identification card is not permitted after Coverage ends and may subject the individual to legal action.
TERMINATION OF EMPLOYEE COVERAGE

Coverage will terminate for the Covered Employee and his/her Covered Dependents on the earliest of the following:

1. The date the Plan terminates;
2. The date the Covered Employee ceases to be an Eligible Employee. This includes an employee who loses eligibility as the result of losing his or her Actively Working status or failing to meet any other eligibility criteria set forth herein. In the event that the employee ceases to be Actively at Work as the result of an Employer approved leave of absence, a leave of absence under the Family Medical Leave Act, or a leave of absence under USERRA, Coverage will terminate at the end of the leave of absence subject to the condition outlined below;
3. The date the Covered Employee dies;
4. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due;
5. Upon notice if the Covered Employee materially misrepresents information provided to the Plan Administrator or commits fraud or forgery.

**Conditions In Connection With Terminations Following Leaves of Absence:** Notwithstanding the above, Coverage will be extended beyond the date the employee ceases to be Actively Working or terminates employment under the following conditions:

1. The employee is on an approved leave of absence due to disability or other approved leave of absence if the Employer offers continued Coverage during such leave of absence and continues making contributions for the employee’s Coverage. Contact the Employer for the Employer’s policy concerning continued Coverage during an employer-approved leave of absence;

2. The employee is on a leave of absence as defined under the Family Medical Leave Act (“FMLA”). In this event, Coverage will continue for the period of time and in accordance with the requirements of FMLA. The Employer may also require the employee to use such other paid sick leave or other paid leave of absence as may be available under the Plan prior to the FMLA period. In addition, the Employer may require that the employee substitute accrued paid time under the Employer’s sick leave or other paid leave of absence policy for the FMLA period provided the Employer has notified the employee in writing that such leave of absence is being counted as an FMLA leave of absence;

3. The employee is on a leave of absence as the result of service in the Uniformed Services, Coverage for Medical Benefits may be continued for the Covered Employee in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. In this event, Coverage will continue for the period of time and in accordance with the requirements of USERRA. As used herein, Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.
TERMINATION OF DEPENDENT COVERAGE

Coverage will terminate for the following Covered Person(s) on the earliest of the following:

1. The date the Plan terminates;
2. The date the Employee’s Coverage terminates;
3. The date of the Employee’s death;
4. The date a Dependent loses dependency status under the Plan; or
5. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due.

The Dependent and employee may be eligible for continued Coverage under COBRA as described in the section entitled “COBRA Coverage.”
COBRA COVERAGE

The Employer will offer employees and their families the opportunity for a temporary extension of benefit ("COBRA Coverage") at group rates in certain instances where Coverage under the Plan would otherwise end. This notice is intended to inform the Covered Person, in a summary fashion, of the rights and obligations under the COBRA Coverage provisions. If the Covered Person does not choose COBRA Coverage, the Coverage under the Plan will end.

COBRA Coverage applies to the medical benefits under the Plan and also applies to any dental coverage if covered under the Plan prior to the Qualifying Event. The Covered Person will only be entitled to receive COBRA Coverage for the coverage(s) (s)he elects to continue during the election process as described herein.

Qualified Beneficiaries

As used herein, a Qualified Beneficiary is a Covered Person who loses Coverage under the Plan as the result of a Qualifying Event.

Qualifying Events

Qualifying Events are any one of the following events, which would normally result in termination of Coverage. These events will qualify a Covered Person to continue coverage as a Qualified Beneficiary beyond the termination date described in the Summary Plan Description. The Qualifying Events are listed below.

1. Death of the Covered Employee;

2. The Covered Employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for Coverage under the Plan. This includes Covered Employees whose employment has been adversely affected by international trade and who is eligible for trade adjustment assistance (TAA) or an individual whose employment has terminated following the last day of leave under the Family Medical Leave Act;

3. Divorce or legal separation from the Covered Employee;

4. The Covered Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan;

5. A Dependent child no longer meets the eligibility requirements of the Plan; and

6. A covered Retiree and their covered Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

Notification Requirements

There are a number of notification requirements under COBRA. First, the Plan Administrator must be alerted to a Qualifying Event in order to offer COBRA Coverage to Qualified Beneficiaries. This notice must be submitted in writing to the Plan Administrator, either by the Employer, or by the Covered Employee or a Dependent. The nature of the Qualifying Event determines which party must notify the Plan Administrator. Second, once the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will provide notices to the COBRA Beneficiary. The notification requirements established under COBRA are described in this COBRA Coverage section.
Notification by Covered Employee or Dependent

The Covered Employee or Dependent must notify the Plan Administrator when eligibility for COBRA Coverage results from one of the following events:

1. Divorce or legal separation from the Covered Employee; or

2. A Dependent child no longer meets the eligibility requirements of the Plan.

The Covered Employee or Dependent must provide this notice to the Plan Administrator within sixty (60) days of either the Qualifying Event or date of loss of Coverage, as applicable to the Plan.

For individuals who are requesting an extension of COBRA Coverage due to a disability, the individual person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial 18 month COBRA Coverage period and no later than 60 days after the Social Security Administration's determination. When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

These notification requirements also apply to an individual who, while receiving COBRA Coverage, has a second or subsequent Qualifying Event. Refer to the section entitled Period of Continued Coverage for additional information.

The Covered Employee or Dependent, or their representative, must deliver this notice in writing to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within the time limit set forth above the Plan Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to COBRA Coverage.

To protect their rights, it is very important that Covered Employees and Dependents keep the Plan Administrator informed of their current mailing address. Any notices will be sent to individuals at their last known address. It is the responsibility of Covered Employees and Dependents to advise the Plan Administrator of any address changes in a timely manner, in order to ensure that notices, such as those regarding their rights under COBRA, are deliverable.

Failure to provide notice to the Plan Administrator in accordance with the provisions of this notice requirement will result in the person forfeiting their rights to COBRA Coverage under this provision.

Notices should be sent to the Employee Benefits Department at Toledo Public Schools.
Notification by Employer

The Employer is responsible for notifying the Plan Administrator when eligibility for COBRA Coverage results from any events other than divorce or legal separation, or a Dependent becoming ineligible.

The Employer shall provide this notice to the Plan Administrator within 30 days of either the Qualifying Event or date of loss of coverage, as applicable to the Plan. The Employer must include information that is sufficient to enable the Plan Administrator to determine the Plan, the Covered Employee, the Qualifying Event, and the date of the Qualifying Event.

Notification of Event Must Be In Writing

All notices of an event must be provided in writing. Oral notices, including notice by telephone, are not acceptable. The employee or Dependent must mail, fax or hand-deliver the notice to the following:

Employee Benefits Department
Toledo Public Schools
420 E. Manhattan Blvd.
Toledo, Ohio 43608

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice must state: (1) the name of plan or plan under which the individual is losing Coverage; (2) the name and address of the employee; (3) the name(s) and address of the qualified beneficiary(ies); and (4) the qualifying event and the date the event occurred.

If the event is a divorce or legal separation, the notice must include a copy of the divorce decree or legal separation agreement.

The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted.

Notification by Plan Administrator

Election Notice: Once the Plan Administrator receives proper notification that a Qualifying Event has occurred, COBRA Coverage shall be offered to each of the Qualified Beneficiaries by means of a COBRA Election Notice. The time period for providing the COBRA Election Notice shall generally be 14 days following receipt of notice of the Qualifying Event. This time period may be extended to 44 days under certain circumstances where the Employer is also acting as the Plan Administrator.

Notice of Ineligibility: In the event that the Plan Administrator determines that the Covered Employee and/or Dependent(s) are not entitled to COBRA coverage, the Plan Administrator shall notify the Covered Employee and/or Dependent(s). This notice shall include an explanation of why the individual(s) may not elect COBRA Coverage. A notice of ineligibility shall be sent within the same time frame as described for a COBRA Election Notice.

Notice of Early Termination: The Plan Administrator shall provide notice to a Qualified Beneficiary of a termination of COBRA Coverage that takes effect on a date earlier than the end of the maximum period of COBRA Coverage that is applicable to the Qualifying Event. The Plan Administrator shall notify the Qualified Beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.
Election of Coverage

Upon receipt of Election Notice from Plan Administrator, a Qualified Beneficiary has 60 days from the date the notice is sent to decide whether to elect COBRA Coverage. Each person who was covered under the Plan prior to the Qualifying Event has a separate right to elect COBRA Coverage on an individual basis, regardless of family enrollment. For example, the employee’s spouse may elect COBRA Coverage even if the employee does not select the coverage. COBRA Coverage may be elected for one, several or all dependent children who are Qualified Beneficiaries and a parent may elect COBRA Coverage on behalf of any dependent child.

In considering whether to elect COBRA Coverage, the Qualified Beneficiary should take into account that a failure to continue coverage may affect future rights under federal law. For example, the Covered Person may lose the right to be provided with a reduction in a pre-existing condition limitation if the gap in coverage is greater than 63 days. The Covered Person also has special enrollment rights under HIPAA which allow him or her to enroll in another group health plan for which (s)he is otherwise eligible when Coverage under this Plan terminates due to a Qualifying Event. The Covered Person also has the same special enrollment rights at the end of the COBRA Coverage if (s)he receives continued coverage for the maximum period available under COBRA.

If the Qualified Beneficiary chooses to have continued coverage, (s)he must advise the Plan Administrator in writing of this choice. This is done by submitting a written COBRA Election Notice to the Plan Administrator. The Plan Administrator must receive this written notice no later than the last day of the 60 day period. If the election is mailed, the election must be postmarked on or before the last day of the 60 day period. This 60 day period begins on the later of the following:

1. The date coverage under the Plan would otherwise end; or
2. The date the notice is sent by the Plan Administrator notifying the person of his or her rights to COBRA Coverage.

Second Election Period for TAA-Eligible Covered Employees

Covered Employees, whose employment is terminated and who become entitled to receive trade adjustment assistance (TAA) in accordance with the Trade Act of 1974 are provided a second 60 day COBRA election period. TAA-eligible individuals who did not elect COBRA Coverage during the initial sixty day COBRA election period, which followed the TAA-related loss of coverage, may elect COBRA Coverage during the 60 day period that begins on the first day of the month in which the individual is determined to be eligible for TAA, provided this election is made no later than 6 months after the date of the TAA-related loss of coverage. Any COBRA Coverage elected during the second election period shall be effective on the first day of the second election period, and not on the date on which Coverage originally lapsed. The time between the loss of Coverage and the start of the second election period shall not be counted for purposes of determining whether the individual has had a 63-day break in Creditable Coverage with regard to application of any Pre-existing Condition limitation.

Period of Continued Coverage

The law requires that a Qualified Beneficiary who elects COBRA Coverage be afforded the opportunity to maintain COBRA Coverage for 36 months unless (s)he loses Coverage under the Plan because of a termination of employment or reduction in hours. In that case, the required COBRA Coverage period is 18 months.

This 18-month period may be extended if a subsequent or second Qualifying Event (for example, divorce, legal separation, an employee becoming entitled to Medicare or death) occurs during that 18-month period. A
second event may be a valid Qualifying Event only if it would have been a valid first Qualifying Event. That is, a second Qualifying Event shall qualify only if it would have caused a Covered Person to lose Coverage under the Plan if the first Qualifying Event had not occurred. A second or subsequent Qualifying Event is therefore limited to the following Qualifying Events:

1. Death of a Covered Employee;
2. Divorce or legal separation between the spouse and the Covered Employee; and
3. Dependent Child’s loss of Dependent status under the Plan.

The Covered Employee’s Medicare entitlement may also be considered a subsequent or second Qualifying Event for any Dependents who are Qualified Beneficiaries following the first Qualifying Event, but only if the Medicare entitlement would have resulted in loss of Coverage under the Plan had the first Qualifying Event not occurred.

Under no circumstances, however, will Coverage last beyond 36 months from the date of the event that originally made the Covered Person eligible to elect Coverage. Only a person covered prior to the original Qualifying Event or a child born to or Placed for Adoption with a Covered Employee during a period of COBRA continuation is eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event. Any other Dependent acquired during COBRA Coverage is not eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event.

Period of Continued Coverage For Disabled Person

A person who is totally disabled may extend COBRA Coverage from 18 months to 29 months. Non-disabled family members may also elect to extend COBRA Coverage even if the disabled individual does not elect to extend his coverage.

The disabled person must be disabled for Social Security purposes at the time of the Qualifying Event or within 60 days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial 18 month COBRA Coverage period and no later than 60 days after the latest of the following:

1. The date of the Social Security Administration's determination;
2. The date of the Qualifying Event;
3. The date the Qualified Beneficiary would lose Coverage under the plan; or
4. The date the Qualified Beneficiary is informed of the obligation to provide the disability notice, either through this Summary Plan Description or the initial COBRA Notice provided by the Employer.

Refer to the guidelines set forth in the subsection Notification Requirements.

When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

Cost of Coverage and Payments

The Employer requires that Qualified Beneficiaries pay the entire costs of their COBRA Coverage, plus a two
percent administrative fee. This must be remitted to the Employer or the Employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

The premium for an extended COBRA Coverage period due to a total disability may also be higher than the premium due for the first 18 months. If the disabled person elects to extend coverage the Employer may charge 150% of the contribution during the additional 11 months of COBRA Coverage. If only the non-disabled family members elect to extend coverage the Employer may charge 102% of the contribution.

For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to a Covered Employee if Coverage is continued for himself alone. Each child continuing Coverage independent of the family unit will pay the rate applicable to a Covered Employee.

Timely payments must be made for the continued Coverage. The initial payment must be made within 45 days after the date the person notifies the Employer that he has chosen to continue Coverage. The initial payment must be the amounts needed to provide Coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for continued Coverage are to be made monthly. These monthly payments are due on the first day of each month. If the premium is not received by the first day of the month, the Employer will consider that Coverage has been allowed to terminate until the monthly payment has been received. However, a 30 day grace period is allowed for receipt of this monthly payment before the termination becomes final. Claims will be denied until the monthly premium payment is received.

There shall be no grace period for making payments, other than the grace period described above.

If the initial payment, or any subsequent monthly payment, received is short by an insignificant amount (the lesser of $50 or 10% of the premium), the Covered Person will be sent a notice at the Covered Person’s last known address stating that the remaining amount due must be sent within 30 days to continue Coverage under COBRA if the Plan Administrator requires the payment to be made in full. The Plan Administrator may also choose to accept the payment, which was short by an insignificant amount, as payment in full. Should you have any questions in regards to how payment short by an insignificant amount will be handled under this Plan, please contact the Plan Administrator.

**Tax Credit for TAA-Eligible Individuals:** In accordance with the Trade Act of 2002, individuals who become eligible for TAA assistance may take a tax credit of 65% of premiums paid for qualified health coverage, which includes COBRA Coverage. The Trade Act of 2002 provides for advance payment of the tax credit to the health plan.

**The American Recovery and Reinvestment Act:** The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, provides for premium reductions for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. The premium assistance is also available for continuation coverage under certain State laws. “Assistance Eligible Individuals” pay only 35 percent of their COBRA premiums; the remaining 65 percent is reimbursed to the coverage provider through a tax credit. The premium reduction applies to periods of health coverage that began on or after February 17, 2009 and lasts for up to 15 months.

**Eligibility for the Premium Reduction:** An "assistance eligible individual" is the employee or a member of his/her family who elects COBRA coverage timely following a qualifying event related to an involuntary termination of employment that occurs at any point from:
• September 1, 2008 through May 31, 2010; or
• March 2, 2010 through May 31, 2010 if:
  - the involuntary termination follows a qualifying event that was a reduction of hours; and
  - the reduction of hours occurred at any time from September 1, 2008 through May 31, 2010 (a reduction of hours is a qualifying event when the employee and his/her family lose coverage because the employee, though still employed, is no longer working enough hours to satisfy the group health plan’s eligibility requirements).

Generally, the maximum period of continuation coverage is measured from the date of the original qualifying event (for Federal COBRA, this is generally 18 months). However, ARRA, as amended, provides that the 15 month premium reduction period begins on the first day of the first period of coverage for which an individual is “assistance eligible.” This is of particular importance to individuals who experience an involuntary termination following a reduction of hours. Only individuals who have additional periods of COBRA (or state continuation) coverage remaining after they become assistance eligible are entitled to the premium reduction.

For purposes of ARRA, COBRA continuation coverage includes continuation coverage required under Federal law (COBRA or Temporary Continuation Coverage) or a State law that provides comparable continuation coverage (for example, so-called "mini-COBRA" laws).

Those who are eligible for other group health coverage (such as a spouse's plan or new employer’s plan) or Medicare are not eligible for the premium reduction. There is no premium reduction for periods of coverage that began prior to February 17, 2009.

Assistance eligible individuals who pay 35 percent of their COBRA premium must be treated as having paid the full amount. The premium reduction (65 percent of the full premium) is reimbursable to the employer, insurer or health plan as a credit against certain employment taxes.

**When Continuation Coverage Begins**

When COBRA Coverage is elected and the contributions paid within the time period required coverage is reinstated back to the date of the Qualifying Event or loss of coverage, as applicable to the Plan, so that no break in Coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

**Dependents Acquired During Continuation**

A spouse or Dependent child newly acquired during COBRA Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA Coverage. A Dependent acquired and enrolled after the original Qualifying Event, other than a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of Coverage.

**End Of COBRA Coverage**

COBRA Coverage will end on the earliest of the following dates:

1. 18 months from the date continuation began because of a reduction of hours or termination of employment of the Covered Employee;
2. 36 months from the date continuation began for Dependents whose coverage ended because of the death of the Covered Employee, divorce or legal separation from the Covered Employee, the child's loss of Dependent status, or Medicare entitlement;

3. The end of the period for which contributions are paid if the Covered Person fails to make a payment on the date specified by the Employer or by the end of the grace period;

4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan;

5. The date the Covered Person first becomes entitled to Medicare after the COBRA election;

6. The date the Covered Person first becomes covered under any other group health plan without regard to a pre-existing condition after the COBRA election. If the replacing group health plan has a pre-existing condition limitation, the Covered Person may remain covered under the Plan until he or she has satisfied the pre-existing condition limitation under the new group health plan, or until he or she is no longer eligible under the COBRA Coverage, as set forth herein;

7. The date the Covered Person is terminated from the Plan for cause, provided an active Covered Employee would be terminated under the Plan for the same cause; or

8. 36 months from the date continuation began for the surviving spouse and Dependent children of a Retiree who dies, when the Retiree’s Qualifying Event was the Employer’s bankruptcy filing;

The Plan Administrator shall provide notice of any early termination. Refer to subsection Notification Requirements, Plan Administrator;

The COBRA law also requires that an individual who has elected COBRA Coverage be permitted to enroll in any individual conversion health plan which is provided under the Plan. Contact the Plan Administrator about the availability of a conversion policy.
The Plan Administrator and Contact Information

An employee may obtain additional information about his or her COBRA Coverage rights from the Employee Benefits Department at Toledo Public Schools, 420 E. Manhattan Blvd., Toledo, Ohio 43608. If the employee has any questions concerning his or her COBRA Coverage rights, or if (s)he wants a copy of the Summary Plan Description, (s)he should contact the Plan Administrator.

The individual may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA’s web site at www.dol.gov/ebsa.

Finally, in order to protect the employee’s and his or her family’s rights, the Covered Person should keep the Plan Administrator informed of any changes to his or her address and the addresses of family members. The employee should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.
CLAIMS INFORMATION

When the Covered Person receives Covered Services, a claim must be filed on the Covered Person’s behalf to obtain benefits. In some cases, the Dentist will file the claim for the Covered Person (e.g. when the Dentist is a Preferred Dentist). If the Covered Person receives services from a Non-DenteMax Provider, the Dentist may not submit the claim on behalf of the Covered Person. If the Covered Person submits the claim, (s)he should use a claim form. It is in the Covered Person’s best interest to ask the Dentist if the claim will be filed on his or her behalf by the Dentist.

CLAIM FORMS

When the Covered Person is submitting the claim on his or her own behalf, (s)he may obtain a claim form from the Employer. If forms are not available, send a written request for claim forms to HealthSCOPE Benefits Administrators. Written notice of services rendered may also be submitted to HealthSCOPE Benefits Administrators without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

1. Name of patient;
2. Patient's relationship to the Covered Employee;
3. Identification number;
4. Date, type and place of service;
5. Name of Dentist; and
6. The Covered Person’s signature and the Dentist's signature.

TIMEFRAME FOR SUBMITTING CLAIM

The claim form must be submitted within 24 months of receiving Covered Services and must have the data needed to determine benefits. An expense is considered incurred on the date the service or supply is given. Failure to submit the claim form within 24 months will not reduce any benefit if the Covered Person shows that the claim was submitted as soon as reasonably possible. Unless the individual is legally incapacitated, claim forms submitted after this 24-month filing period will not be accepted by the Plan Administrator.

The claim form should be submitted to the address shown on the Covered Person’s Identification Card.

In the event of termination of the agreement between the Claims Administrator and the Plan Sponsor, all notices of claims for Covered Services received after the termination of such agreement should be provided to the Plan Sponsor.

CLAIMS REVIEW PROCEDURE

This section describes the claims review procedures under the Plan. A claim is defined as any request for a benefit made by a Covered Person or by a Provider on behalf of the Covered Person that complies with the Plan’s reasonable procedure for making a claim for benefits. The times shown in this section are maximum times only. A period of time begins at the time the claim is filed. The days shown in this section are counted as calendar days.

Under the Plan, the Covered Person can check on the status of a claim at any time by contacting the Customer Service number appearing on the Covered Person’s Identification Card.
There are different time frames for reviewing a claim and providing notification concerning the claim. The time frames are based on the category of the claim. For the purpose of this provision, there are three categories of claims: Pre-Service Claims, Pre-Service Urgent Care Claims and Post-Service Claims.

As defined by the Department of Labor, a decision an adverse benefit determination is 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 a determination of a Covered Person’s eligibility to participate in a Plan.

**Pre-Service Claims** - Pre-Service Claims are those claims that require prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification, pre-authorization or pre-determination. As used herein, Pre-Service Claims do not include Pre-Service Urgent Care Claims.

For Pre-Service Claims (other than Pre-Service Urgent Care Claims), the following time frames apply concerning review and notification of the benefit determination:

1. **Notification Concerning Failure to Follow Procedure** - In the event the Covered Person, or Provider on behalf of the Covered Person, fails to follow the proper procedure for providing notification of a Pre-Service Claim, the Covered Person or Provider will be notified within 5 days.

2. **Benefit Determination Period** – The Covered Person will be notified of the benefit determination within 15 days following receipt of notification concerning the Pre-Service Claim.

3. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 15-day benefit determination period due to matters beyond the Plan Administrator’s control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 15-day benefit determination period. Only one extension is permitted for each Pre-Service Claim.

   If a benefit determination cannot be made within the standard 15-day benefit determination period due to the Covered Person’s failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 15-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

**Pre-Service Urgent Care Claims** – Pre-Service Urgent Care Claims are those pre-service claims in which the time periods for making claim determinations for non-Pre-Service Urgent Care Claims could seriously jeopardize the Covered Person’s life, health or ability to regain maximum function or when a Physician with knowledge of the Covered Person’s medical condition determines that the Covered Person would be subject to severe pain that cannot be adequately managed or controlled without the treatment that is the subject of the claim. For Pre-Service Urgent Care Claims, the following time frame applies concerning review and notification concerning the benefit determination:

1. **Notification Concerning Incomplete Claim** - In the event the Covered Person, or Provider on behalf of the Covered Person, fails to submit complete information in connection with a Pre-Service Urgent Care Claim, the Covered Person or Provider will be notified of the specific information needed to complete the claim within 24 hours.
2. **Benefit Determination Period** – The Covered Person will be notified of the benefit determination concerning a Pre-Service Urgent Care Claim within 24 hours following receipt of notification concerning the Pre-Service Urgent Care Claim.

3. **Extension of Benefit Determination Period** - In the event additional information is needed in order to make a benefit determination, the Covered Person must be notified within 24 hours following receipt of notification concerning the Pre-Service Urgent Care Claim. Notification of the extension will include a detailed explanation of the information needed to make the benefit determination. Upon receipt of the notification of the required extension, the Covered Person has 48 hours to provide the requested information. The determination will be made within 48 hours following receipt of the requested information from the Covered Person. If the Covered Person fails to provide the requested information, the benefit determination will be made within 48 hours following the end of the period allowed for providing said information.

4. **Benefit Determination Period For Request of Continuation of Treatment** - Any request to continue the course of treatment that is a Pre-Service Urgent Care Claim, shall be decided as soon as possible. The Covered Person will be notified of the benefit determination within 24 hours of the receipt of the claim, provided that such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

**Post-Service Claims** - Post-Service Claims are those claims for services, other than Pre-Service and Pre-Service Urgent Care Claims, that have been rendered by a Provider. For Post-Service Claims, the following time frames apply concerning review and notification of the benefit determination:

1. **Benefit Determination Period** - The Covered Person will be notified of the benefit determination within 30 days following receipt of notification concerning the Post-Service Claim.

2. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 30-day benefit determination period due to matters beyond its control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 30-day benefit determination period. Only one extension is permitted for each Post-Service Claim.

   If a benefit determination cannot be made within the standard 30-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 30-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

**INTERNAL CLAIMS APPEAL PROCESS**

The Plan has an internal claims appeal process. The internal claims appeal process and the time limits associated with requesting and responding to a request for Claims Appeal are described in this section. The Covered Person and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office.

Under the Plan, the Covered Person can check on the status of a claim appeal at any time by contacting the
Requesting a Claims Appeal - The Plan has a claims appeals process that allows the Covered Person to submit a request for appeal to the fiduciary who has been named by the Plan Administrator to review a claims appeal (“Named Fiduciary”). Under the Plan, the Plan Administrator will serve as the Named Fiduciary, unless the Plan Administrator has specifically delegated this responsibility to another party. The Named Fiduciary has the sole responsibility for making the decision on an appeal of an adverse benefit determination.

Under the claims appeal process, the Covered Person will be provided with a full and fair review of an adverse benefit determination. This review of an adverse benefit determination must be done by an individual who is neither the individual who made the original adverse benefit determination nor the subordinate of such individual. In addition, if the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary, the Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the event the Covered Person disagrees with a claims decision concerning the denial of a benefit or scope of benefits, the Covered Person or the Covered Person’s authorized representative may submit a request for appeal within 180 days from receipt of the notice of denial or adverse benefit determination. Absent an express written authorization by the Covered Person providing otherwise, the authorized representative includes a medical provider only for an Urgent Care Claims Appeal.

Under the claims appeal process:

1. The Covered Person is permitted to submit written documents, comments, records, evidence, testimony and other information relating to the claim;
2. The Covered Person is allowed reasonable access to any copies of documents, records and other information relevant to the claim, including his or her claim file;
3. The Covered Person is permitted to request the name of the medical provider used in making the initial adverse benefit determination; and
4. All comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the initial determination will be taken into account.

The Covered Person’s request for an appeal of an adverse benefit determination for a Pre-Service and Post-Service Claims must be submitted in writing and should be submitted to:

   Named Fiduciary c/o HealthSCOPE Benefits, Inc.  
P.O. Box 2860  
Little Rock, Arkansas 72205

For appeal of an Urgent Care Claim, the request for appeal may also be submitted verbally to the Named Fiduciary by contacting 501-218-7865.

If the Covered Person’s request for appeal is not submitted to the Named Fiduciary in the manner described in this section, it will not be considered a “claims appeal” under the Plan.

Under this Plan, HealthSCOPE Benefits Administrators, Inc. is not the Named Fiduciary for purposes of reviewing claims appeals under the Plan, but is instead acting strictly at the request of the Plan Administrator to coordinate receipt of appeals on behalf of the Plan.
The time frame for reviewing an Urgent Care Claim Appeal, Pre-Service Claim Appeal or Post-Service Claim Appeal is outlined in the following table:

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Time Frame for Appeal Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Claim Appeal</td>
<td>30 days after receiving the request for appeal</td>
</tr>
<tr>
<td>Urgent Care Claim Appeal</td>
<td>72 hours of receiving the request for appeal</td>
</tr>
<tr>
<td>Post-Service Claim Appeal</td>
<td>60 days of receiving the request for appeal</td>
</tr>
</tbody>
</table>

Because of the urgency related to Urgent Care Claim Appeals, all notifications concerning an appeal decision may be made verbally, or by fax or other electronic means.

Note: If the Plan Fiduciary is a multi-employer plan which has a committee or board of trustees designated as the appropriate Named Fiduciary which holds regular meetings (at least once a quarter), and if the appeal request is received within 30 days preceding the date of the next scheduled meeting, then the Named Fiduciary will make the determination concerning the claims appeal no later than the date of second meeting following receipt of the request. If special circumstances (such as the need to hold a hearing, if the Plan’s procedures allow for such a hearing) require a further extension of time for processing an appeal request, a determination shall be rendered not later than the third meeting of the committee or board of trustees following the Plan’s receipt of the request for review. In this instance, the Plan Administrator shall provide to the Covered Person written notification of the extension and such notice shall describe the special circumstances and the date as of which the determination will be made, prior to the commencement of the extension. The Covered Person will be notified of the Named Fiduciary’s decision concerning the appeal no later than 5 days after the determination is made by Named Fiduciary.

**Information Included in an Adverse Appeal Determination** - All adverse appeal determinations will include the following information:

1. The reason for the determination;
2. The reference to the specific plan provision(s) on which the benefit determination is based;
3. A statement that the Covered Person is entitled to receive free of charge access to and copies of documents and records pertinent to the claim;
4. A statement of the Covered Person’s right to obtain free of charge, internal rules, guidelines, protocols, or other similar criterion used in making the adverse determination; and
5. Either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan, or a statement that such explanation may be obtained free of charge upon request if the claim was denied on the basis of medical necessity or Experimental or Investigative grounds.

The decision of the Named Fiduciary with regard to an appeal is final.

**STANDARD EXTERNAL CLAIM REVIEW PROCEDURE**

This section applies to the standard external review process.

**Requesting a Standard External Review.** Covered Persons are permitted to request an external review with the Plan, provided the request is filed within 4 months after the date of receipt of the adverse benefit
determination. If there is not a corresponding date that is 4 months after receipt of the benefits denial notice, the external review request must be filed by the first of the 5th month following receipt of the notice. The external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Covered Person or beneficiary fails to meet the requirements for eligibility under the terms of the Plan.

The external review process applies only to:

1. An adverse benefit determination (including a final internal adverse benefit determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

**Preliminary Review by the Plan.** The Plan must complete a preliminary review of the Covered Person’s external review request within 5 business day, and the review must determine whether:

1. the Covered Person is (or was) covered under the Plan when the health care service was requested. For retroactive reviews, the Plan must determine whether the individual was covered under the Plan when the health care service was provided;
2. the benefit denial does not relate to the Covered person’s failure to meet the Plan’s eligibility requirements;
3. the Covered Person has exhausted the Plan’s internal claims appeal process (unless the Covered Person is not required to so under Federal law); and
4. the Covered Person has provided all the information and forms needed to process the external review.

The Plan must provide the Covered Person with written notice of its preliminary review determination within 1 business day after completing the review. If the request is complete but not eligible for external review, the notice must state the reason for ineligibility. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The Plan must permit the Covered Person to complete the external review request with the 4-month filing period or, if later, 48-hours after receipt of the notice.

**Referral to IRO.** The Plan is then required to select an accredited independent review organization (IRO) to perform the external review. The Plan must ensure against bias and ensure independence relative to the review. Toward this end, the Plan must contract with a minimum of 3 IROs for assignments and rotate claims assignments among the IROs. The Plan may also select other permitted methods, as permitted by the Department of Labor, for selecting an IRO. The Covered Person should contact the Plan Administrator to request assistance in determining the Plan’s IRO for the Covered Person’s external review process.

The IRO is required to provide the Covered Person with written notice of the eligibility and acceptance for external review. The notice must inform Covered Persons that they can submit additional written information to the IRO within 10 business days following receipt of the notice and that that the IRO must consider the additional information in its external review. The IRO may also accept and consider additional information that is submitted after 10 days, though it is not required to do so.

Within 5 business days after the date the IRO is assigned, the Plan must provide the IRO documents and information considered in making the benefit denial. The Plan’s failure to timely provide such documents or information, however, is not cause for the delaying the external review. Rather, if the Plan fails to provide the documents and information on a timely basis, the IRO may terminate the external review and decide to reverse
the benefit denial. If the IRO elects to reverse the benefits denial, the IRO must notify the Covered Person and the Plan within 1 business day after making the decision.

**Reconsideration of Benefits Denial by the Plan.** Upon receiving any information submitted by the Covered Person, the IRO must forward the information to the Plan within 1 business day. The Plan may then reconsider its benefits denial, though such reconsideration may not delay the external review. If the Plan decides, on reconsideration, to reverse its benefits denial and provide Coverage or payment, then the external review can be terminated. The Plan must provide written notice to the Covered Person and the IRO within 1 business day after making this decision. On receiving the Plan’s notice, the IRO must terminate its external review.

**Standard of Review and Documents Considered.** The IRO will review all information documents timely and will not give deference or a presumption of correctness to the Plan’s decisions or conclusions. Furthermore, the IRO is not bound by any decisions or conclusions reached under the Plan’s internal claims and claim appeals process.

In addition to documents and information provided by the Covered Person, the IRO will consider the following items in reaching its decision:

1. The Covered Person’s medical records;
2. The recommendation of the attending health care professional;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, Covered Person, or treating provider;
4. The governing Plan terms;
5. Appropriate practice guidelines, which must include applicable evidence-based standards;
6. Any applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO’s clinical reviewer(s).

**IRO’s Final External Review Decision.** Within 45 days after the IRO receives the external review request, it must provide written notice of the final external review decision. The notice must be delivered to the Covered Person and the Plan and must include:

1. A general description of the reason for the external review request, including information sufficient to identify the claim. This information includes the date(s) of service, the provider, claim amount (if applicable), diagnosis and treatment codes, and the reason for the prior denial;
2. The date the IRO received the assignment to conduct the external review, and the date of the IRO’s decision;
3. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;
4. A discussion of the principal reason(s) for the IRO’s decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;
5. A statement that the IRO’s determination is binding, unless other remedies are available to the Plan or Covered Person under state and/or federal law;
6. A statement that judicial review may be available to the Covered person; and
7. The phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the IRO’s decision is to reverse the Plan’s benefits denial, the Plan must immediately provide Coverage or payment for the claim. This includes immediately authorizing or paying benefits.

**Deadlines for Standard External Review.** The following chart identifies the key steps and timelines for the
external review process.

<table>
<thead>
<tr>
<th>External Review Procedure</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Person’s filing period to request standard external</td>
<td>Within 4 months after receipt of benefits</td>
</tr>
<tr>
<td>review</td>
<td>denial notice</td>
</tr>
<tr>
<td>Plan’s preliminary review determination</td>
<td>Within 5 business days following receipt of</td>
</tr>
<tr>
<td></td>
<td>external review request from Covered Person</td>
</tr>
<tr>
<td>Plan’s notice to Covered Person regarding preliminary review</td>
<td>Within 1 business day after completion of</td>
</tr>
<tr>
<td>determination</td>
<td>preliminary review</td>
</tr>
<tr>
<td>Covered Person’s time period for perfecting incomplete</td>
<td>Remainder of 4-month filing period or, if</td>
</tr>
<tr>
<td>external review request</td>
<td>later, 48 hours following receipt of notice</td>
</tr>
<tr>
<td>Notice by IRO to Covered Person (of acceptance for review</td>
<td>In timely manner</td>
</tr>
<tr>
<td>and deadline for submissions of additional information)</td>
<td></td>
</tr>
<tr>
<td>Time period for Plan to provide IRO documents and information</td>
<td>Within 5 business day of assignment of IRO</td>
</tr>
<tr>
<td>and information considered in making benefit determination</td>
<td></td>
</tr>
<tr>
<td>Submission of additional information by Covered Person</td>
<td>Within 10 business days following Covered</td>
</tr>
<tr>
<td></td>
<td>Person’s receipt of notice from IRO</td>
</tr>
<tr>
<td>IRO forwards to the Plan any additional information submitted</td>
<td>Within 1 business day of receipt</td>
</tr>
<tr>
<td>by the Covered Person</td>
<td></td>
</tr>
<tr>
<td>Notice to Covered Person and IRO if Plan reverses its denial</td>
<td>Within 1 business day of decision</td>
</tr>
<tr>
<td>ad provides Coverage</td>
<td></td>
</tr>
<tr>
<td>Decision by IRO</td>
<td>Within 45 days of receipt of request for</td>
</tr>
<tr>
<td></td>
<td>review</td>
</tr>
</tbody>
</table>

EXPEDITED EXTERNAL REVIEW PROCESS

Requesting an Expedited External Review. An expedited external review process must be made available when the Covered Person receives:

1. A benefits denial involving a Covered Person’s medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize the Covered Person’s life or health or jeopardize the Covered Person’s ability to regain maximum function and the Covered Person has filed an expedited internal appeal request; or

2. A final internal benefits denial involving (a) a Covered Person’s medical condition where the timeframe for completing the standard external review would seriously jeopardize the Covered Person’s life or health or jeopardize the Covered Person’s ability to regain maximum function, or (b) an admission, availability of care, continued stay, or health care service for which the Covered Person received emergency services, but has not been discharged from a facility.

Immediately upon receiving the external review request, the Plan must assess whether the request meets the reviewability requirements and send the Covered Person a notice regarding the Plan’s reviewability assessment.

Referral to an IRO. Following a preliminary determination that a request is eligible for external review, the Plan will assign an IRO. The same process for selecting an IRO as is applicable under the standard external review process is applicable under the expedited external review process. The Plan must transmit all necessary documents and information considered in making the benefits denial to the assigned IRO. The documents and information can be provided electronically, by telephone or fax, or in any other expeditious manner. The IRO must consider the information or documents as listed under the standard external review.
process.

**Standard of Review and Documents Considered.** The IRO will review all information documents timely and will not give deference or a presumption of correctness to the Plan’s decisions or conclusions. Furthermore, the IRO is not bound by any decisions or conclusions reached under the Plan’s internal claims and claim appeals process.

**IRO’s Final External Review Decision.** The IRO must provide notice of its final external review decision. The notice must meet the requirements that apply in the context of a standard external review process and response. The notice must be provided as expeditiously as the Covered Person’s medical condition or circumstances require, but in no event, more than 72 hours after the IRO receives the request for an expedited external request. If the IRO fails to provide written notice within 48 hours after it provides notice of its decision, the IRO must provide written confirmation of the decision to both the Covered Person and the Plan.

**ADDITIONAL CLAIM PAYMENT PROVISIONS**

The Covered Person may request that payments be made directly to a Dentist; however, the Plan reserves the right to make payments to the Dentist or directly to the Covered Person. The Covered Person cannot request that payment be directed to anyone else. Once a Dentist renders a Covered Service, the Plan will not honor the Covered Person’s request to withhold payment of the claims submitted.

If a benefit is owed when the Covered Person is not able to handle his or her affairs, the benefit may be paid to a relative by blood or marriage. This would happen if the Covered Employee had died or become mentally incompetent. The Plan will make payment to a relative whom it judged to be entitled in fairness to the money. Any such payment would discharge any obligation to the extent of such payment.

**RIGHTS TO AN ITEMIZED BILL**

The Covered Person has the right to receive a copy of an itemized bill. This bill would identify the services and supplies rendered to the Covered Person. To receive a copy of the bill, send a written request to the Dentist that rendered services. It is in the Covered Person’s best interest to exercise this right so that (s)he has a copy of the bill for his or her personal files.
COORDINATION OF BENEFITS & SUBROGATION

COORDINATION OF BENEFITS PROVISION

All benefits provided as described in this Summary Plan Description are subject to Coordination of Benefits (COB). COB determines when a benefit plan is primary or secondary when a Covered Person is covered by more than one benefit plan.

This coordination of benefits provisions (“COB”) applies when the Covered Person is also covered by an Other Benefit Plan. When more than one coverage exists, one plan will pay its benefits in full according to the terms of that plan. This plan is considered the primary plan. Any Other Benefit Plan is referred to as the secondary plan and pays a reduced benefit to prevent duplication of benefits.

By coordinating benefits under this provision, the total benefits payable by all Other Benefits Plans and this Plan will not exceed 100% of this Plan’s Allowable Expenses, as defined herein. A common set of rules is used to determine the order of benefits determination Other Benefit Plan.

When the Plan is primary, the Plan will pay benefits without regard to any Other Benefit Plan. When this Plan is secondary, the benefits payable under this Plan will be reduced so that the sum of benefits paid by all Other Benefits Plan and this Plan do not exceed 100% of this Plan’s total Allowable Expenses.

Definitions: As used in this section, the following terms are defined as:

“Other Benefit Plan” means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

“Allowable Expenses” shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a Plan. When some Other Benefit Plan pays first in accordance with this section, this Plan’s Allowable Expenses shall consist of the Covered Person’s responsibility, if any, after the Other Benefit Plan has paid but shall in no event exceed the Other Benefit Plan’s Allowable Expenses. When some Other Benefit Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit. Benefits payable under any Other Benefit Plan include the benefits that would have been payable had claim been duly made therefore.

Automobile Limitations: When medical payments coverage is available under the vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles or other out-of-pocket requirements under the vehicle plan. This Plan shall always be considered secondary regardless of the Covered Person’s election under PIP (personal injury protection) or any no-fault coverage with the automobile carrier.

Motor-Vehicle Related Injury: The Plan will not cover the cost of health care expenses resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent that such services or expenses are payable under any Personal Injury Protection, no-fault, medical payments provision, or any other category (including such benefits mandated by law) of any automobile or vehicle insurance plan.
ORDER OF BENEFITS DETERMINATION (OTHER THAN MEDICARE)

Which plan provides primary or secondary Coverages will be determined by using the first of the following rules that applies:

1. **No COB.** If the Other Benefit Plan contains no COB provision, it will always be primary.

2. **Employee or Member.** The benefit plan covering the Covered Person as an employee, member or subscriber (other than a Dependent) is primary.

3. **Medicare Eligible.** If a Covered Person is eligible for Medicare, benefits will be coordinated with Medicare as set forth in the section entitled “Order of Benefits Determination for Medicare.”

4. **Dependent Child of Parents (Not Divorced or Legally Separated).** When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. If a Dependent is covered by two benefit plans and the Other Benefit Plan does not have coordinate benefits based on the birthday of the parent (e.g., benefits are coordinated based on the gender of the parents), the rule of the Other Benefit Plan will determine the primary and secondary contract.

5. **Dependent Child of Parents Divorced or Legally Separated.** When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the following rules apply:
   
   a. If the parent with custody has not remarried, his or her coverage is primary;
   
   b. If the parent with custody has remarried, his or her coverage is primary, the stepparent's is secondary and the coverage of the parent without custody pays last; or
   
   c. If a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent is primary.

6. **Active Employees vs. Laid Off or Retired Employees.** When a plan covers the Covered Person as an active employee or a Dependent of such employee and the Other Benefit Plan covers the Covered Person as a laid-off or retired employee or as a Dependent of such person, the plan that covers the Covered Person as an active employee or Dependent of such employee is primary.

7. **Above Rules Do Not Apply.** When the rules above do not apply, the plan that has covered the Covered Person longer is primary.

8. **Special Note About Continued Coverage.** If the Covered Person is covered under an Other Benefit Plan that is primary but also has continued Coverage under this Plan (e.g., COBRA) due to the Other Benefit Plan’s pre-existing condition exclusion, then this Plan will be primary for expenses incurred in connection with such pre-existing condition only.
ORDER OF BENEFITS DETERMINATION FOR MEDICARE

For individuals who are Medicare eligible (e.g., individual who are Medicare eligible due to age or disability) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

THIRD PARTY RECOVERY AND SUBROGATION

What Is Subrogation?

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another’s property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person’s injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the Covered Person’s substitute in the event any payment made by this Plan for dental benefits, including any payment for a pre-existing condition, is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

Right of Reimbursement and Recovery

Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers’ compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage (“Recovery”), the Covered Person must repay the Plan in full for any medical, dental, vision, or disability benefits which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.
Pursuant to Sereboff v. Mid Atlantic Med. Servs., 126 S.Ct. 1869 (2006), the Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all monies or properties: (1) paid; (2) payable to; or (3) for the benefit of, a Covered Person to the extent of benefits paid by the Plan (“Subrogated Amount”), whether or not the Covered Person has been “made whole” for the injuries received. This right 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 partial recovery, and applies to funds paid for non-dental charges or attorney fees, or other costs and expenses. This right for first priority in contravention of the “make whole” doctrine shall not be affected or limited in any way by the manner in which the Covered Person or any person or entity responsible for paying any Recovery attempts to designate or characterize the Recovery, regardless of whether the recovery itemizes or identifies an amount awarded for Plan benefits for dental expenses, or is specifically linked to certain kinds of damages or payments. Payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorney’s fees or costs incurred by the Covered Person in the collection of damages. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The equitable lien shall also attach to the first right of Recovery 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 for the direct or indirect benefit of the Insured or for his/her “special needs”, as a result of an exercise of the Covered Person’s rights of Recovery.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan’s right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys’ fees and costs from the Covered Person.

The following provisions apply to the Plan’s right of subrogation, reimbursement, and creation of an equitable lien:

1. **“Pursue and Pay.”** At its sole discretion, the Plan Administrator may elect to “pursue and pay” in connection with the subrogation, reimbursement and equitable lien rights for claims involving Eligible Expenses. Pursuant to the election of “pursue and pay,” the Plan Administrator has the right to apply the subrogation, reimbursement and equitable lien rights prior to making any benefit payments under the Plan, and such payment shall be reduced by any amounts that were paid by any other party as described in this section.

2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:
   a. Any no-fault insurance;
   b. Medical benefits coverage under any automobile liability plan. This includes the Covered Person’s Plan or any third party’s policy under which the Covered Person is entitled to benefits;
   c. Under-insured and uninsured motorist coverage;
   d. Any automobile medical or dental payments and personal injury protection benefits;
e. Any third party’s liability insurance
f. Any premises/guest medical payments coverage;
g. Any medical malpractice recovery;
h. Workers’ compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers’ compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services 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.
i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

4. Excess Payments. If the Plan erroneously makes total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan, the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.

5. Reduction of Future Benefits. The Plan provides that recovery of excess amounts may include a reduction of future benefit payments available to the Covered Person under the Plan of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed by the Plan.

6. “Make Whole” and “Common Fund” Rules Do Not Apply. The provisions of the Plan concerning subrogation, reimbursement, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines and/or state laws commonly referred to as the “make whole” rule and the “common fund” rule.

7. No Deductions for Costs or Attorneys’ Fees. The reimbursement required under the Plan shall not be reduced to reflect any costs or attorneys’ fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator at the exercise of its sole discretion.
GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through Toledo Public Schools. Toledo Public Schools is the Employer and Plan Sponsor and also functions as the Plan Administrator, unless another individual or entity is appointed by the Employer. The Plan Administrator shall have full charge of the operation and management of the Plan. The Employer has retained the services of HealthSCOPE Benefits Administrators to administer the benefits described in this Summary Plan Description.

The Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Plan Fiduciary unless the Employer appoints another individual or entity to act in this capacity. Refer to the section entitled “Operation and Administration of the Plan” for more details concerning the administration of the Plan.

ALTERATION OF APPLICATION

An enrollment application may not be altered by anyone other than the applicant unless the applicant has given his or her written consent allowing alterations.

AMENDMENT OF THE PLAN

Amendment: The Employer reserves the right to amend this Plan at any time by an instrument duly executed by an authorized officer or representative. Such amendment shall be binding upon the Employer and all Covered Persons. The Employer shall furnish to each Covered Employee a summary, written in a manner calculated to be understood by the average Covered Employee, of any modification to the Plan or change in the information required to be included in the Summary Plan Description.

Retroactive Amendments: An amendment to this Plan may be made retroactively effective so long as it does not adversely affect the rights of Covered Persons to benefits under this Plan for covered health care expenses which are incurred after the effective date of the amendment but before the amendment is adopted.

Material Reduction: Amendments that are a material reduction in Covered Services or benefits not later than 60 days after the date of adoption of the modification or change. A “material reduction in covered services or benefits” means any modification to the plan or change in the information required to be included in the Summary Plan Description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Covered Employee to be an important reduction in Covered Services or benefits under the Plan. A “reduction in covered services or benefits” generally would include any Plan modification or change that: eliminates benefits payable under the Plan; reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, Deductibles, Coinsurance, Copayments, or other amounts to be paid by a Covered Employee.

APPLICABLE LAW

This Plan shall be construed in accordance with the laws of the State of Ohio and of the United States of America. Any provision of this Plan that is in conflict with applicable law is amended to conform with the minimum requirements of that law.

ASSIGNMENT OF BENEFITS
No assignment of the Plan, or any rights or benefits under the Plan, shall be valid unless permitted under the terms of the Plan or the Plan Sponsor has consented to such assignment in writing.

The Plan will pay benefits under this Plan to the Employee unless payment has been assigned to a Dentist of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the Claims Administrator is notified in writing of such assignment prior to payment hereunder.

**BENEFITS NOT TRANSFERABLE**

Except as otherwise stated herein, no person other than an eligible Covered Person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

**BONDING**

Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

**COUNTERPARTS**

This Plan may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together constitute one instrument, which may be sufficiently evidenced by any counterpart.

**EFFECTIVE DATE**

Except where specifically stated otherwise in this Plan, the provisions of this amended and restated Plan are effective January 1, 2011 and this Summary Plan Description shall supersede and replace all prior versions of the Plan as of that date.

**EMPLOYMENT RIGHTS**

The establishment of the Plan and the Covered Employee’s participation in the Plan does not affect in any way the employee’s employment rights. Nor does the establishment of or employee’s participation in such Plan confer any right upon any employee to be retained in the service of the Employer.

**ERRONEOUS INFORMATION**

If any information pertaining to any Covered Person is found to have been reported erroneously to the Plan Sponsor or to HealthSCOPE Benefits Administrators, as the claims administrator, and such error affects his or her Coverage, the facts will determine to what extent, if any, the Covered Person was or is covered under the Plan.

**EXEMPTION FROM ATTACHMENT**

To the full extent permitted by law, all rights and benefits under the Plan are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Covered Employee or other Covered Person.
FREE CHOICE OF DENTIST

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to make a free choice to select a Dentist. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of Non-Preferred Dentist.

INCONTESTABILITY

All statements made by the Employer or by the Covered Employee shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the Employer or by the Covered Person, as the case may be. A statement made shall not be used in any legal contest unless such statement is made in writing and signed by such person and a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

INTEREST IN PLAN ASSETS

Except with respect to the right of a Covered Person to receive benefits under this Plan, no employee or any other person shall have any right, title or interest in or to the assets of the Plan or in or to any contributions thereto, such contributions being made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms. Neither the board of directors nor the board of trustees, if applicable, the Claims Administrator, nor the Employer in any way guarantees the Plan from loss or depreciation, nor guarantees the payment of any benefits that may be or become due to any person under the Plan. The liability of the Employer for payment of benefits under the Plan as of any date is limited solely to the then assets of the Plan. The liability of the Claims Administrator for the administration of claims under the Plan as of any date is limited solely to the funds have been provided by the Plan for the express purpose of funding claims or as of that date. Any unclaimed property will remain an asset of the Plan and will not be forfeited to the state.

INTERPRETATION OF PLAN PROVISIONS

All provisions of this Plan shall be interpreted and administered in accordance with the provisions of applicable law in a non-discriminatory manner and in a manner that will assure compliance of the Plan's operation therewith. All persons in similar circumstances shall receive uniform, consistent, and non-discriminatory treatment hereunder.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of 60 days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of 3 years from the date the expense was incurred.

LIABILITY AND LIMITATION OF ACTION

This Plan will not give the Covered Person any claim, right, action or cause of action against any person or entity other than the Dentist rendering Covered Services to the Covered Person for acts or omissions of such Dentist.

Contributions made to and held by the Plan are for the sole purpose of providing benefit payments under the
Plan in accordance with its terms; provided, however, no Covered Person shall have any right or interest in or to the assets of the Plan or in or to any contributions to the Plan.

The Plan Sponsor and HealthSCOPE Benefits Administrators do not actually furnish health care services as described in this Summary Plan Description. Rather, Coverage will be provided for the health care services covered under the Plan when rendered by a Dentist to the Covered Person.

**PHYSICAL EXAMINATION AND AUTOPSY**

By accepting Coverage, as described in this Summary Plan Description, the Covered Person agrees that (s)he may be required to have one or more physical examinations. Performance of an autopsy may also be required in the case of death where it is not forbidden by law. These examinations and/or autopsy will help to determine what benefits will be payable, particularly when there are questions concerning services on a claim.

**PLAN RIGHT TO RECOVERY**

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the Plan, the Plan will have the right to recover these excess payments. Whenever, according to the terms of the Plan, payments have been made from the Plan that should not have been made, the Plan will have the right to recover these incorrect payments. The Plan has the right to recover any such overpayment or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether or not such payment was made due to the Plan Administrator’s own error.

**RESOLUTIONS BY THE EMPLOYER**

All resolutions or other actions taken by the Employer that has been appointed to assist with the administration of the Plan at any meeting shall be handled as set forth in the Plan Document.

**REVERSION OF ASSETS**

No part of the Plan assets shall revert to the Employer, or be used for, or diverted to, purposes other than the provision of welfare benefits as described herein for the exclusive benefit of Covered Employees.

**RIGHTS OF PLAN**

To the full extent permitted by law, all rights and benefits under the Plan are exempt from attachment or garnishment or other legal process for the debts or liabilities of any Covered Person.

**RIGHT TO ENFORCE PLAN PROVISIONS**

Failure by the Plan Sponsor or HealthSCOPE Benefits Administrators to enforce any provision of the Plan provision shall not affect the Plan Sponsor’s or HealthSCOPE Benefits Administrators’ right thereafter to enforce such provision or any other provisions of the Plan.
SOURCE OF BENEFITS

All benefits under the Plan shall be provided solely from the Plan and applicable insurance contracts, if any, and neither the Employer nor its officers, directors, or agents (including, but not limited to, the Claims Administrator) shall have any liability or responsibility therefor. The Claims Administrator shall not be liable in any manner should there be insufficient funds in the Plan to provide for the payment of any benefit under the Plan.

TERMINATION OF THE PLAN

Right to Terminate: It is the intention of the Employer to continue this Plan indefinitely. However, the Plan Sponsor reserves the right to terminate this Plan at any time by an instrument duly executed by it.

Effect of Termination: Unless otherwise provided, upon the effective date of Plan termination, the Coverage of all Covered Persons shall cease and no person shall become entitled to any benefits hereunder for any expenses incurred after the effective date of Plan termination. The Plan shall remain liable to pay benefits for expenses incurred prior to the effective date of Plan termination, but only to the extent of the assets set aside for that purpose.

TITLES ARE FOR REFERENCE ONLY

The titles used in the Plan are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section shall control.

WORKERS’ COMPENSATION COVERAGE

The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

WORD USAGE

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

WRITTEN DIRECTIONS

Whenever a person must or may act upon the written direction of another, he shall not be required to inquire into the propriety of such direction, and he shall follow the direction unless it is clear on its face that the actions to be taken under that direction are prohibited by law or the terms of this Plan. Moreover, such person shall not be responsible for failure to act without such written direction.
OPERATION AND ADMINISTRATION OF THE PLAN

PLAN SPONSOR AND PLAN ADMINISTRATOR

The Plan is administered through Toledo Public Schools which has been established and shall be maintained for the exclusive benefit of the employees. Toledo Public Schools is the Employer and Plan Sponsor and also functions as the Plan Administrator, unless another individual or entity is appointed by the Employer. The Plan Administrator shall have full charge of the operation and management of the Plan. The Employer has retained the services of HealthSCOPE Benefits Administrators to administer the claims for benefits described in this Summary Plan Description.

PLAN FIDUCIARY

The Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Plan Fiduciary unless the Employer appoints another individual or entity to act in this capacity. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the Plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the Clinical Necessity of dental services, supplies and treatment, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Fiduciary will be final and binding on all interested parties. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

CLAIMS ADMINISTRATOR

Under the Plan, HealthSCOPE Benefits Administrators has agreed to provide certain administrative services on behalf of the Plan Sponsor according to the terms and limitations of the Plan. The responsibilities of HealthSCOPE Benefits Administrators are spelled out in an agreement between the Plan Sponsor and HealthSCOPE Benefits Administrators (“Administrative Agreement”) and include but are not limited to the administration of claims on behalf of the Plan Sponsor. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Summary Plan Description.

Except as otherwise provided by law, the appeal procedures set forth in this Summary Plan Description shall be the sole and exclusive remedy.

HealthSCOPE Benefits Administrators does not furnish health care services and is not liable for the quality of health care services received by a Covered Person. HealthSCOPE Benefits Administrators does not provide insurance coverage or benefits nor does HealthSCOPE Benefits Administrators underwrite the liability of this Plan. HealthSCOPE Benefits Administrators will not act nor assume the responsibility to act as the Plan Administrator or Plan fiduciary on behalf of Plan Sponsor. HealthSCOPE Benefits Administrators is merely providing assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan.
ADMINISTRATIVE COMMITTEE

The Employer, at its option, shall appoint a committee to oversee the administration of the Plan on behalf of the Employer. The members of the Administrative Committee shall serve at the pleasure of the Employer that appointed them.

DELEGATION OF RESPONSIBILITIES

The Employer and the Administrative Committee, if applicable, may delegate its/their responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities. In the event the Plan is administered under the direction of a Board of Directors or Board of Trustees, such delegation must be authorized by said Board of Directors or Trustees.

ADMINISTRATIVE DUTIES

The following responsibilities shall be performed in the administration of the Plan. These duties may be performed by the Employer or by a committee of individuals appointed by the Employer to assist in the administration of the Plan:

1. Maintaining all Plan records;

2. Filing tax returns and reports required under federal and state law and complying with all other governmental reporting and disclosure requirements;

3. Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan’s provisions related to benefits and eligibility;

4. Hiring outside professionals to assist with Plan Administration and render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, consultants and other specialists to render advice concerning any responsibility they have under the Plan;

5. Establishing policies, interpretations, practices and procedures of the Plan;

6. Receiving all disclosures required of fiduciaries and other service Dentists under any federal or state law;

7. Acting as the Plan's agent for service of legal process;

8. Administering the Plan, including but not limited to the Plan's claims procedures as set forth in this Summary Plan Description and the Plan Administrator’s Plan Document;

9. Paying benefits under the Plan, by drawing checks, or instructing others to draw checks, against the Plan established for this purpose. With respect to claims that are administered by the claims administrator, HealthSCOPE Benefits Administrators, this responsibility includes instructing the claims administrator to withdraw monies from the funding account for the purpose of administering claims incurred under the Plan; and

10. Performing all other responsibilities allocated to the Plan Administrator.
DEFINITIONS

Actively Working/Actively At Work - Means the employee is performing his or her regular duties on behalf of, and in the regular business of the Plan Sponsor for the hours as set forth in this Summary Plan Description and is reasonably being compensated by the Plan Sponsor on a regular basis for such duties. An employee will retain eligibility for Coverage under the Plan if absent on an approved leave of absence, with the expectation of returning to work following the approved leave of absence as determined by the Employer. The Employer’s classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan.

Benefit Period – Means the period beginning on January 1st and ending on December 31st of each year.

Coinsurance - Means a percentage of the Provider’s Allowable Charge that a Covered Person pays for Covered Services. The percentage paid by the Plan is the Plan’s Coinsurance.

Clinically Necessary (or Clinical Necessity) - Means the criteria used to determine the Clinical Necessity of health care services under this Summary Plan Description. To be Clinically Necessary, Covered Services must:

1. Must be appropriate with regard to the standards of good dental practice;
2. Must not primarily be for the Covered Person’s convenience or the convenience of the Dentist; and
3. Must be the most appropriate supply or level of service which can be safely provided to the Covered Person.

Coverage - Means the payment for Covered Services as specified and limited by this Summary Plan Description.

Covered Dependent Child(ren) – Means the Dependent Child(ren) who is (are) covered under this Plan.

Covered Employee - Means the employee of the Employer (also referred to as the Participant) who has satisfied the eligibility requirements under the Plan and is covered under the Plan.

Covered Person - Means the Covered Employee, the Covered Spouse and/or Covered Dependent Child(ren).

Covered Services - Means services or supplies which are considered eligible for payment under this Plan.

Covered Spouse – Means the Spouse who is covered under this Plan.

Customary and Reasonable Charge – Customary and Reasonable is the name for the method used by the Plan for determining the maximum amount of charges to consider in determining benefit payments for Dentists under the Plan. The Customary and Reasonable fee is the fee assessed by a Non-DenteMax Provider for a service, treatment or supply which shall not exceed the general level of charges assessed by Dentists rendering the same type of service, treatment or supplies. The Customary and Reasonable fee is established using historical data collected for charges by Dentists within specific geographic areas for the same or similar services, treatment or supplies. The data may be supplemented with information provided by independent research firms who specialize in the collection of Dentist charge data. Unusual circumstances that reasonably require additional time, skill or experience for a Dentist’s service, are taken into consideration by the Plan and may result in reimbursement of an amount above the Customary and Reasonable maximum but not exceeding the actual charge.
**DenteMax Provider** – Means a Dentist or Physician designated by DenteMax as a DenteMax Provider.

**DenteMax Orthodontic Fee Schedule** – Means a maximum allowable amount for an orthodontic course of treatment, as established by the Plan in conjunction with the designated Toledo-area DenteMax Providers that specialize in orthodontic care.

**Dentist** - Means a Physician who is licensed to practice dentistry in the state in which (s)he is rendering services.

**Dependent** - Means the Spouse and/or the Dependent Child(ren).

**Dependent Child** – Means:

1. An Employee’s child, regardless of the child’s dependency, residency, student or financial dependence status, who is the natural child, step child, legally adopted child of the employee or spouse or a child who is in the legal guardianship of the employee or employee’s spouse pursuant to an interlocutory order of adoption and who is under the age of 26;

2. An Employee’s child who is less than 28 years of age, who is unmarried, an Ohio resident or full-time student at an accredited public or private institution of higher education, not employed by an employer that offers any health benefits, and who is not eligible for coverage under Medicaid or Medicare. **However**, in order for Coverage to continue until the end of the month in which the child reaches the age of 28, the employee is required to notify the Plan Administrator of his or her election to continue Coverage for the child when the child reaches the age of 26. If the employee chooses **not** to continue Coverage reaches the age of 26, Coverage will end at the end of the month in which the Dependent Child reaches the age of 26.

   With respect to a child who is in the legal guardianship of the employee or employee’s spouse pursuant to an interlocutory order of adoption, the child must be under Dependent Limiting Age at time of placement (Coverage eligibility begins from time of placement in the home for adoption whether or not the adoption proceedings have been completed).

3. A child who is subject of a National Medical Support Notice will be considered a Dependent Child under this Plan. The NMSN entitles such child to Coverage even if (a) such child does not reside with the Covered Employee or is not dependent on the employee for support, and (b) even if the employee does not enroll for Coverage under the Plan or does not have legal custody of the child. If the Eligible Employee has not satisfied the applicable Waiting Period, the Plan must cover the Dependent Child upon the Eligible Employee’s completion of such Waiting Period. All other applicable enrollment provisions of the Plan (e.g., Dependent Limiting Age, benefit options, right to continued Coverage, etc.) which are available to Covered Employees or other Covered Dependents shall be made available to the Dependent Child who is eligible pursuant to a National Medical Support Notice; and

4. An unmarried child who is over the Dependent Limiting age of the Plan, who is permanently disabled upon attainment of the Dependent Limiting Age and who meets the dependency requirements set forth in this paragraph. The Dependent Child must be incapable of self-sustaining employment by reason of mental retardation or mental or physical handicap and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must notify the Employer of the disability within 31 days after the Dependent Child reaches the Dependent Limiting Age. Such notification shall include proof satisfactory to the Employer of the Dependent Child's incapacity and dependence upon the Covered Employee. After a two-year period following the date the Dependent Child meets the Dependent Limiting Age, the employee may be required to provide additional proof of the child’s continued...
dependence and incapacity.

**Dependent Limiting Age** - Means the age limit for Dependent Children under the Plan. The Dependent Limiting Age is age 26 or 28.

**Effective Date** - Means the date on which Coverage begins.

**Eligible Employee** - Means an employee of the Employer who satisfies the eligibility criteria set forth in this Summary Plan Description.

**Eligible Expenses** - Means expenses for Covered Services which are incurred by a Covered Person. Eligible Expenses do not include expenses in excess of the Provider’s Allowable Charge.

**Experimental or Investigative** - Means a drug, device, dental treatment or procedure that:

1. Cannot be lawfully marketed with approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, treatment or procedure is furnished;
2. Based on reliable evidence, the drug, device, treatment or procedure is the subject of ongoing phase I, II or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis; or
3. Based on reliable evidence, there is a consensus of opinion among experts regarding the drug, device, treatment or procedure that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

“Reliable evidence” means only published reports and articles in the authoritative dental and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, dental treatment or procedure; or the written informed consent used by the treatment facility or by another facility studying substantially the same drug, device, dental treatment or procedure. Determination will be made by the Plan at its sole discretion and will be final and conclusive.

Although a Dentist may have prescribed treatment, such treatment may still be considered Experimental or Investigative within this definition.

**Family Coverage** - Means Coverage for the Covered Employee and one or more Dependents.

**Family or Medical Leave of Absence** - Means an unpaid leave of absence to care for a newborn, newly adopted Dependent Child, a sick Dependent Child, spouse or parent, or an unpaid leave of absence due to a serious health condition pursuant to the Family and Medical Leave Act.

**Individual Coverage** - Means Coverage for the Covered Employee only.

**Loss of Eligibility** – As it relates to the HIPAA Special Enrollment Period described herein, Loss of Eligibility includes, but is not limited to the following types of losses:

1. Loss of eligibility under the other coverage due to divorce, dissolution, legal separation. In this instance, the Eligible Employee and any Dependent Children would be eligible to enroll;
2. Loss of eligibility under the other coverage due to cessation of dependency status. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
3. Loss of eligibility under the other coverage due to death of the employee. In this instance, the Eligible
Employee (whose spouse has died) and any Dependent Children would be eligible to enroll;
4. Loss of eligibility under the other coverage due to termination of employment or reduction of hours. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
5. Loss of eligibility under the other coverage because the individual no longer resides in the service area. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
6. Loss of eligibility under the other coverage because the overall Maximum Benefit has been reached. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll; and
7. Loss of eligibility under the other coverage because the other employer ceases to provide health care benefits to similarly situated individuals. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll.

Maximum Benefit – Means the maximum amount the Plan will pay for a given benefit. The Maximum Benefit can be stated as a dollar amount or the maximum number of days or visits for a specific benefit. In addition, Coverage is subject to a lifetime Maximum Benefit for covered orthodontia services. This is referred to as the Orthodontia Maximum Benefit. Refer to the Schedule of Benefits for Maximum Benefit amounts.

Medicare - Means the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Negotiated Rate – Means the rate or amount that a DenteMax Provider has agreed to accept as payment in full for Covered Services. The DenteMax Provider cannot bill for the difference between the charge and the Negotiated Rate.

National Medical Support Notice (or “NMSN”) - means a notice that contains the following information:
1. Name of an issuing State agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

Other Benefit Plan - Refers to COB and means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

Physician – Means an individual who is licensed and legally authorized to practice medicine in the state in which (s)he is rendering services.

Plan Administrator – Means Toledo Public Schools.


Plan Fiduciary – Means Toledo Public Schools

Plan Sponsor – Means Toledo Public Schools.

Protected Health Information - Means information that is created or received by Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that
identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code. Protected Health Information includes Electronic Protected Health Information as defined at 45 C.F.R. §160.103 that is received from, or created or received on behalf of the Plan.

**Provider’s Allowable Charge** – Means the method used by the Plan for determining the maximum amount of charges to consider in determining benefit payments under the Plan. Payment will be subject to any applicable Deductible, Coinsurance and other applicable Plan provisions. The Plan will determine the Provider’s Allowable Charge for all Dentists. With respect to the DenteMax Providers, the Provider’s Allowable Charge will be based on the Negotiated Rate that the DenteMax Provider has agreed to accept as payment in full. For Non-DenteMax Providers, the Provider’s Allowable Charge will be the Customary and Reasonable Charge.

**Schedule of Benefits** - Means a separate schedule showing vital information with respect to the Coverage under this Plan.

**Special Enrollment Period** – Means a period during which an enrollment application may be submitted following an event that qualifies the Eligible Employee or Eligible Dependent for a Special Enrollment Period. The events that qualify an employee or dependent for a Special Enrollment Period and the time periods during which an enrollment application must be submitted during such period is addressed in the section entitled “Applying for Coverage and Effective Dates.”

**Spouse** – Means the individual of the opposite sex who is married to the Eligible Employee in accordance with the laws of the state in which they reside.

**Summary Health Information** - Means information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

**Summary Plan Description** – Means the document that is provided by the Plan Administrator and that describes, in understandable terms, the Covered Person’s rights, benefits and responsibilities under the Health Plan. This document serves as the Summary Plan Description for the Health Plan administered by the Plan Administrator and sponsored by the Plan Sponsor.

**HIPAA PRIVACY NOTICE**

1. **Introduction.** The Plan Sponsor sponsors the Plan. Members of the Employer’s workforce have access to the individually identifiable health information of the Plan Participants for
administration functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information and, if it is transmitted in electronic media, it is Electronic Protected Health Information.

The Health Insurance Portability and Accountability of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor’s ability to use and disclose Protected Health Information and Electronic Protected Health Information. The following HIPAA definitions apply to this provision:

a. Protected Health Information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or conditions of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected Health Information includes information of persons living or deceased.

b. Electronic Protected Health Information means Protected Health Information that is transmitted by or maintained in electronic media.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information or Electronic Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

Under the American Recovery and Reinvestment Act of 2009 (ARRA), the Plan will be required to limit its distribution, use or requests for Protected Health Information, to the extent practicable, to a limited data set, or if more information is needed, to the minimum necessary amount of information needed to accomplish the intended purpose of the data use. The Secretary of HHS shall issue guidance on what constitutes minimum necessary for the purposes of this provision no later than 18 months following the enactment of this provision under ARRA.

The Plan Sponsor shall have access to Protected Health Information and Electronic Protected Health Information from the Plan only as permitted under this provision or as permitted by HIPAA.

2. Permitted Uses and Disclosure of Summary Health Information. The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

a. Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or

b. Modifying, amending, or terminating the Plan.

Summary Health Information means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under the Plan; and (b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described at 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

3. Permitted Uses and Disclosure of Enrollment and Disenrollment Information. The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor, provided such enrollment and disenrollment information is only used by the
Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Plan.

4. **Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes.** Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph 5 and obtaining written certification pursuant to paragraph 6, the Plan or a health insurance issuer or HMO with respect to the Plan may disclose Protected Health Information or Electronic Protected Health Information to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such Protected Health Information or Electronic Protected Health Information only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment relation actions or decisions.

Enrollment and disenrollment functions performed by the Plan Sponsor are performed on behalf of the Plan Participant and are not Plan administration functions. Enrollment and disenrollment information held by the Plan Sponsor is held in its capacity as an employer and is not Protected Health Information. Refer to section 3 of this provision for more details on enrollment and disenrollment functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information or Electronic Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

5. **Conditions of Disclosure.** The Plan or a health insurance issuer or HMO with respect to the Plan, shall not disclose Protected Health Information to the Plan Sponsor unless the Plan Sponsor agrees to:
   a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
   b. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information, including implementing reasonable and appropriate security measures to protect Electronic Protected Health Information.
   c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
   d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
   e. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with 45 CFR §164.524.
   f. Make available to a Plan participant who requests an amendment the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with 45 CFR §164.526.
   g. Make available to a Plan participant who request an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528. To the extent the Health Plan uses or maintains Electronic Health Records (EHRs), the Health Plan must be able to account for uses and disclosures of that information, even for treatment, payment and/or health care operations purposes. This detail must be retained for a period of at least three years. You have a right to obtain a copy of the record in an electronic format and to direct the Health
Plan to transmit a copy of the record to any entity or person designated by you. This provision is effective January 1, 2011 or the date EHR is acquired for all EHRs acquired after January 1, 2009. For EHRs acquired on or before January 1, 2009, the provision will be effective January 1, 2014.

h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).

i. If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the 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 feasible.

j. Ensure that the adequate separation between Plan and Plan Sponsor required in 45 CFR §164.504(f)(2)(iii) is satisfied, including ensuring reasonable and appropriate security measures.

k. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

l. Report to the Plan any security incident relating to Electronic Protected Health Information of which it becomes aware. A security incident is defined at 45 C.F.R. § 164.304 as "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system."

6. **Certification of Plan Sponsor.** The Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 2 of this section as contained in the Covered Person’s Summary Plan Description.

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

8. **Other Disclosures and Uses of PHI.** With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

9. **Adequate Separation Between Plan and Plan Sponsor.** The Plan Sponsor shall only allow certain employees, or classes of employees, access to the Protected Health Information. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor’s employee discipline and termination procedures. Contact the Plan Sponsor for a listing of those individuals or classes of employees who are permitted access to Protected Health Information as set forth in this paragraph. The Plan Sponsor has appointed the Director of Employee Benefits and Workers’ Compensation as the Privacy Officer under HIPAA.
10. **Breach.** The Plan is required to notify each Participant whose unsecured PHI or EPHI is the subject of a breach, or is reasonably believed to be subject of a breach. Notification must occur within 60 days of the discovery of the breach. In addition, the Plan must notify the Secretary of the Department of Health and Human Services (“DHHS”). If the breach involves 500 or more individuals, the Plan is required to notice the DHHS immediately and is also required to notify a local media outlet serving the state or jurisdiction in which the affected Participants reside.

**Note:** Toledo Public Schools will furnish the employee with a Statement of Privacy Rights under separate cover.