OEBB

Vision Plan 1

Effective Date October 1, 2008

Member handbooks and other services are available at **www.odscompanies.com.**

Insurance products provided by ODS Health Plan, Inc.

Welcome

We are pleased that you have chosen the ODS Vision Benefit Plan. This Member Handbook is designed to provide you with important information about your Plan's benefits, limitations and procedures.

If you have any questions about your plan please call the ODS Customer Service Department, or you may also visit our website at **www.odscompanies.com** to access your myODS account.

Thanks for choosing ODS as your vision plan!

ODS Customer Service Department

Portland	503-265-2909
Toll-Free	1-866-923-0409
TDD/TTY	1-800-433-6313
	(for the hearing and speech impaired)
En Español	503-265-2961
Llamado Gratis	1-888-786-7461

ODS reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by ODS. The monitoring is to ensure the quality and accuracy of the service provided by employees of ODS to their customers.

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Please note: This handbook may be changed or replaced at any time, by OEBB or ODS, without the consent of any enrollee. All plan provisions are governed by OEBB's policy with ODS. This handbook may not contain every plan provision.

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General Plan Information

1. **Plan Name:**
   OEBB Benefit Plan

2. **Plan Sponsor:**
   Oregon Educators Benefit Board
   1225 Ferry Street SE
   Salem, Oregon 97301
   503-378-3329

3. **Employer Identification Number:** 41-2246536

4. **Agent for Legal Process:** The Plan Sponsor named above.

5. **Type of Plan:** Employee Vision Benefit Plan.

6. **Plan Year:** October 1st through September 30th.

7. **Plan Administrator:** The Plan Sponsor is the administrator of the Plan.

8. **Funding Medium and Type of Plan Administration:** Benefits are provided under a group insurance policy entered into between OEBB and ODS Health Plan, Inc. Claims for benefits are sent to ODS. ODS, not OEBB, is responsible for paying claims.

   The Plan is funded by employer and/or employee contributions. The amount of total contributions is determined by the use of sound actuarial and underwriting methods. The portion an employee pays toward the total contribution is determined by OEBB or the Participating District.

9. **Provider of Benefits:** Benefits are provided in accordance with a policy of insurance between ODS Health Plan, Inc. and Oregon Educators Benefit Board.

Definitions

The following are definitions of some important terms used in this Member Handbook.

Affidavit of Dependency means a notarized document that attests that a child meets the criteria in the definition of Dependent Child.

Affidavit of Domestic Partnership means a notarized document that attests the Eligible Employee and one other eligible individual meet the criteria definition of Unregistered Domestic Partner.

Condition means a medical condition.

Co-pay or Co-payment means the fixed dollar amounts or percentages of covered expenses to be paid by an enrollee.

Covered Service is a service or supply that is specifically described as a benefit of this Plan.

Dependent means any individual who is or may become eligible for coverage under the terms of this Plan because of a relationship to a participant.

Domestic Partners see Registered Domestic Partner and Unregistered Domestic Partner.

Eligible Employee means an:

- **Active Employee** of a Participating District who is employed on a half-time or greater basis or is in a job-sharing position or meets the definition of an Eligible employee under an OEBB rule or under a collective bargaining agreement; or a
- **Retired Employee** who was a previously active Eligible Employee as described on page 11.

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective) without regard to when the individual may have completed or filed any forms that are required in order to become covered under the Plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the Plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrolled Dependent means an eligible dependent of an enrolled employee of the Participating District, whose application has been accepted by OEBB and who is enrolled in this Plan.

Enrolled Employee means an employee of a Participating District, who is enrolled in this Plan following acceptance by OEBB of that employee's application.

Enrollee means an employee, dependent of the employee or an individual otherwise eligible who has enrolled for coverage under the terms of this Plan.

Enrollment date means, for new hires and others who enroll when first eligible, the date coverage begins or, if earlier, the first day of the waiting period. For all others, the enrollment date is the date the plan coverage actually begins.

Group Health Plan means any plan, fund or program established and maintained by an employer or an employee organization, or both, for the purpose of providing healthcare for its participants or their beneficiaries through insurance, reimbursement or otherwise. This vision Plan is a group health plan.

In-Network refers to physicians and vision providers that have contracted with ODS to provide benefits to persons covered under this Plan.

Late Enrollee means an individual who enrolls subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. If you decline coverage for yourself and/or your dependents when initially eligible, you will not be allowed to enroll yourself and or your dependents until the next open enrollment period. (See page 14 for complete details.)

An individual is not a late enrollee if:

- The individual qualifies for special enrollment as described on page 14;
- The individual applies for coverage during an open enrollment period;
- A court has ordered that coverage be provided for a Spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order;
- The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or
- The individual's coverage under Medicaid, Medicare, Tricare (formerly known as (CHAMPUS), Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days prior to applying for coverage in a group health benefit plan.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of a condition and which, in the judgment of ODS, are:

- Appropriate and consistent with the symptoms or diagnosis of the enrollee's condition;
- Established as the standard treatment by the medical community in the service area in which they are received;
- Not primarily for the convenience of the enrollee or a physician or provider of services or supplies; and
- The least costly of the alternative supplies or levels of service which can be safely provided to the enrollee.

Please Note:
The fact that a physician or provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service medically necessary or a covered service. Refer to the "General Exclusions" section starting on page 7 for further information regarding medical necessity.

Mental Incapacity, for the purposes of this policy, means intellectual competence usually characterized by an IQ of less than 70.

ODS Plus Network is the Preferred Provider Organization (PPO) selected by OEBB for all Active Employees. Retired Employees and COBRA Enrollees who establish residency outside the ODS Plus Network area may select from the **First Choice Network, Idaho Physicians Network (IPN), Health InfoNet (HIN), or Private HealthCare Systems (PHCS)** depending on where they reside. By using an In-Network Physician or Provider, your covered medical expenses will be paid at a higher rate.

ODS refers to ODS Health Plan, Inc.

Oregon Educators Benefit Board (OEBB) means the state agency and program established in the State of Oregon, Department of Administrative Services by Senate Bill 426 and that is overseen by the OEBB Board.

Out-of-Network refers to physicians and providers that have not contracted with ODS to provide benefits to enrollees.

Participant means any employee or former employee who is or may become eligible to receive a benefit under a plan.

Participating District means a common school district, a union high school district, an education service district, or a community college district that participates in Benefit Plans provided by OEBB

Physical Incapacity, for the purposes of this Plan, means the inability to pursue an occupation or education because of a physical impairment.

Physician means a doctor of medicine.

The **Plan** is the agreement between the OEBB and ODS Health Plan, Inc. which contains all the conditions of the Plan. This Member Handbook is a part of the Plan.

The **Policyholder** is the OEBB, for whose members or employees of Participating Districts these medical benefits are being provided.

Registered Domestic Partner means an individual of the same sex joined with the employee in a partnership that has been registered in Oregon according to the Oregon Family Fairness Act.

The Plan's **Service Area** is the geographical area where the in-network physicians and providers provide their services.

Spouse means a person of the opposite sex who is a husband or wife. The definition of Spouse does not include a former Spouse and a former Spouse does not qualify as a dependent.

Unregistered Domestic Partner means an individual of the same or opposite sex who is not married or registered in Oregon under the Oregon Family Fairness Act, and has entered into a partnership that meets the following criteria:

- Both are at least 18 years of age;
- are responsible for each other's welfare and are each other's sole Domestic Partners;
- Are not married to anyone and either has not had a Spouse, a Registered Domestic Partner or another Unregistered Domestic Partner within the prior six months. If previously married, the six-month period starts on the final date of divorce;
- Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;

- Have jointly shared the same regular and permanent residence for at least six months; and
- Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

Vision Provider means any of the following, when providing medically necessary services within the scope of their license. In all cases, the services must be covered under this Plan to be eligible for benefits.

- A licensed ophthalmologist;
- A licensed optician;
- A licensed optometrist;
- A hardware provider.

The term "vision provider" does not include any class of provider not named above, and no benefits of the Plan will be paid for their services.

Benefit Description

This Plan pays for vision examinations and corrective lenses and frames up to a maximum of $250.00 every plan year. Please see Limitations.

There is **no deductible** for covered vision services or supplies. For an in-network provider, covered benefits are reimbursed at 100% of the provider's contracted fee. For an out-of-network provider, covered benefits are reimbursed at the lesser of billed charges or up to a maximum of $250.00. Please see Limitations.

COVERED PROVIDERS

Covered vision care must be prescribed by a licensed ophthalmologist or licensed optometrist. This Plan allows you to choose any licensed ophthalmologist, optician, optometrist or hardware provider. You can maximize your vision benefits by using an in-network vision provider. ODS has a broad panel of vision providers who participate in the Network. You may choose an in-network vision provider from the Network medical directory, which is available on the ODS website at **www.odscompanies.com** under "Provider Search" or by contacting the ODS Customer Service Department to request a paper copy. Please see page 4 for additional Network information.

COVERED SERVICES AND SUPPLIES

Routine Eye Examination
One complete eye exam, including the charge for refraction, is covered. A $10.00 co-payment is required. See Limitations for additional information.

Frames
Frames for corrective lenses are covered. Please see Limitations.

Lenses
Corrective lenses for either eyeglasses or contact lenses are covered.

Types of covered lenses:

- Single Vision;
- Bifocal;
- Trifocal;
- Standard Progressive;
- Premium Progressive;
- Lenticular lenses;
- Corrective contact lenses (disposable or conventional);
- Oversized lenses (Single Vision, Bifocal, Trifocal, Standard Progressive and Premium Progressive lenses); and
- Tint, any color.

LIMITATIONS

Routine eye exam and lenses are covered as shown above every plan year. Frames are covered every plan year for enrollees under age 17 and every 2 plan years for enrollees 17 years and older. Late Enrollees are only eligible for the routine eye examination during the first 12 continuous months of enrollment.

Exclusions

The following services, procedures and conditions are not covered by this Plan, even if otherwise medically necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a physician or vision provider.

Benefits Not Stated

Services and supplies not specifically described in this Member Handbook as covered expenses under this Plan are excluded.

Experimental or Investigational Procedures

Services and supplies are excluded that, in our judgment:

- Are not rendered by an accredited institution, physician or provider within the United States or by one that has not demonstrated medical proficiency in the rendering of the service or supplies;
- Are not recognized by the medical community in the service area in which they are received;
- Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;
- Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established; and
- Are available in the United States only as part of clinical trial or research program for the illness or condition being treated.

Additionally, this Plan does not provide coverage for any expenses incidental to or incurred as a direct consequence of experimental or investigational procedures.

Inmates

Services and supplies an enrollee receives while in the custody of any state or federal law enforcement authorities or while in jail or prison are not covered.

Missed Appointments

Motor Vehicle Coverage or Other Insurance Liability

Benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, are not payable under this Plan when such contract or insurance is issued to, or makes benefits available to, you or your enrolled dependent, whether or not application is duly made therefore. (See page 24 for complete details).

Reports and Records

This Plan does not cover charges for the completion of reports or claim forms and the cost of records.

Services Otherwise Available

This exclusion includes:

- services and supplies for which payment could be obtained in whole or in part if you or your dependent had applied for payment under any city, county, state, or federal law, except for Medicaid coverage;

- charges for services and supplies for which you or your dependents cannot be held liable because of an agreement between the physician or provider rendering the service and another third party payer which has paid or is obligated to pay for such service or supply;
- services and supplies for which no charge is made, or for which no charge is normally made in the absence of insurance; and
- services or supplies you could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
  -- covered services rendered at any hospital owned or operated by the State of Oregon; or
  -- if you are a veteran of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States and which are not service-related are eligible for payment according to the terms of this Plan.

Services Provided By a Member of Your Immediate Family
ODS will not reimburse services provided by you or any member of your family. Family members would include a Spouse, Registered Domestic Partner or Unregistered Domestic Partner, child, brother, sister, or parent of you or your Spouse, Registered Domestic Partner or Unregistered Domestic Partner.

Services Provided By Volunteer Workers

Service Related Conditions
This Plan does not cover treatment of any condition caused by or arising out of your service in the armed forces of any country or from an insurrection or war.

Surgery to Alter Refractive Character of the Eye
This Plan does not cover refractive surgery, laser vision correction, and any other procedure that alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. This exclusion includes, but is not limited to, radial keratotomy, corneal rings, LASIK, PRK, any procedure using the Excimer Laser or the Holmium: YAG laser, and other procedures of the refractive keratoplasty type. Reversals or revisions of any procedures which alter the refractive character of the eye and any complications of these procedures are excluded.

Taxes

Third-Party Liability
Services and supplies for treatment of illness or injury for which a third party is or may be responsible are not covered. (See page 22 for complete details)

Treatment After Coverage Terminates
This Plan does not cover services or supplies that you or your enrolled dependent receives after coverage ends.

Treatment Not Medically Necessary
This Plan does not cover:

- Services or supplies that are not medically necessary for the treatment of a condition otherwise covered under this Plan;
- Services or supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of your condition;
- Services or supplies that are not established as the standard treatment by the medical community in the service area in which they are received; and/or
- Services or supplies that are primarily rendered for the convenience of you or your dependents or a physician or provider of services or supplies.

Please Note:
The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the charge a covered expense.

Treatment Prior to Enrollment

This Plan does not cover services or supplies that you or your enrolled dependent received before you were enrolled in this Plan.

Vision Care Related Procedures and Services

The following vision related procedures and services are not covered:

- Treatment of eyes for special procedures such as orthoptics and vision training;
- Subnormal vision aids and any associated supplemental testing;
- Any extra charge for lenses with prisms, prism segs, slab-off and other special-purpose vision aids;
- Plane nonprescription lenses and nonprescription sunglasses;
- Medical or surgical treatment of the eyes or supporting structures;
- Charges for hard and/or scratch resisting coating(s);
- Charges for ultra-violet (UV) coating;
- Charges for standard anti-reflective coating;
- Any expense an enrollee did not have to pay due to discounts received or other promotions;
- Examination or corrective eyewear required by an employer and safety eyewear unless specifically covered;
- Lost or broken materials except at normal covered intervals; and
- Replacement of lenses and frames unless enrollee is otherwise eligible.

Work-Related Conditions

This Plan does not cover services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit so long as the enrollee is not exempt from state and federal workers' compensation law. This exclusion applies whether or not the expense for the service or supply is paid under workers' compensation.

Eligibility

This section describes who is eligible to enroll in the Plan. Please be aware that the date you become eligible may be different than the date coverage begins. See "When Coverage Begins" for more specific information. This is located in the "Enrollment" section beginning on page 14.

ACTIVE EMPLOYEES

Employee Eligibility
You are eligible to enroll in the Plan if you:

- Are paid on a regular basis through the payroll system, have federal taxes deducted from such pay, and are reported to Social Security;
- Work for the Participating District on a regularly basis at least:
  - 17.5 hours per week;
  - such number mutually agreed upon by the school district and OEBB; or
  - you are untitled to coverage under an employment contract.
- Satisfy any eligibility waiting period; and
- Apply to and are accepted by OEBB to be included in this Plan.

You are eligible to remain enrolled if you are on an approved leave of absence under the Family and Medical Leave Act of 1993.

Dependents
Your legal Spouse or Registered Domestic Partner is eligible for coverage. Your Unregistered Domestic Partner is eligible for coverage if he or she complies with the Domestic Partner Affidavit provided by the Participating District. Your dependent children are eligible until their 19th birthday. Your dependent children may be eligible until their 26th birthday if they are not married, are not in a Registered Domestic Partnership, are not in an Unregistered Domestic Partnership and:

- Are a full-time student at an accredited college, university, or vocational school;
- Are living in the home of the Eligible Employee over six months of the calendar year and the Eligible Employee provides over half of the yearly support; or
- Are incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability.

Children eligible due to a court or administrative order are also subject to the Plan's child age limits.

For purposes of determining eligibility, the following are considered "children":

- A biological child of, an adopted child of, or a child placed for adoption with the Eligible Employee, Spouse, Registered Domestic Partner or Unregistered Domestic Partner;
- A legal ward by court decree, a dependent by Affidavit of Dependency, or is under legal guardianship of the Eligible Employee, Spouse, Registered Domestic Partner or Unregistered Domestic Partner, and is living in the home of the Eligible Employee;
- The child must not qualify as any other person's Dependent Child, except that a child of divorced or separated parents meeting conditions under IRC 152(e) can be treated as a dependent of both parents; or
- A newborn child of a covered dependent for the first 31 days of the newborn's life.

If you have a child who has sustained a disability rendering him/her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 19 years old. To be eligible, the child must be unmarried not in a Registered or Unregistered Domestic Partnership, principally dependent on you for support, and must have had continuous medical insurance coverage (group or individual) prior to attaining age 26 and until the time of the OEBB insurance effective date. The incapacity must have arisen before the child's 19th birthday. You must provide us with a written physician's statement that confirms that these conditions existed continuously prior to the child's 19th birthday. Documentation of the child's medical condition must be reviewed and approved by the ODS medical consultant. Periodic review by the medical consultant will also be required on an ongoing basis.

Dependents on full-time duty in the active military service of the United States are not eligible. This includes members of the Reserve Components serving on active duty or full-time training duty.

Note:

- **Some Participating Districts may not offer opposite sex domestic partner coverage. Check with your Participating District to determine what domestic partner coverage is available.**
- **Your Participating District may offer other dependent coverage limitations due to a collective bargaining or district policy. Check with your Participating District for dependent coverage limitations.**

Qualified Medical Child Support Order (QMCSO)

This Plan will cover individuals deemed to be alternative recipients under a qualified medical child support order (QMCSO). A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding, and that requires health plan coverage for an alternative recipient. An alternative recipient is a child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Plan Administrator determines that applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You may obtain a copy of such procedures from the Plan Administrator without charge.

RETIREEES

Employee Eligibility

You are eligible to enroll in the Plan if you:

- Were a previously active employee;
- Are receiving a service or disability retirement allowance or pension under the Public Employees Retirement System (PERS) or under any other retirement or disability Benefit Plan or system offered by an OEBB participating organization for its Employees;
- Are eligible to receive a service retirement allowance under PERS and has reached earliest retirement age under ORS Chapter 238;

- Are eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest retirement age as described in ORS 238A.165; or
- Are eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by an OEBB participating organization and has reached earliest retirement age under the plan or system.

Dependent Eligibility
If a retiree becomes eligible for Medicare coverage, but his or her currently-enrolled eligible dependents are not, these eligible individuals may continue OEBB medical and dental insurance coverage until such time as they no longer meet OEBB eligibility requirements or become eligible for Medicare coverage, whichever occurs first. The eligible individuals must submit the application for enrollment to the retiree plan administrator within 60 days of the retiree's eligibility for Medicare.

When Retiree Eligibility Ends
A retiree and eligible dependents enrolled in OEBB retiree insurance plans who become eligible for Medicare coverage may not continue an OEBB retiree medical insurance plan. The exception is for Medicare eligibility as a result of end-state renal disease. Insurance coverage ends the last day of the month that eligibility is lost.

NEW DEPENDENTS

If you marry while you are enrolled in this Plan, your Spouse and his or her children are eligible for coverage. A complete and signed application along with a valid marriage certificate must be submitted within 31 days of the date of the marriage. (See "When Coverage Begins.") All dependents must meet eligibility requirements.

If you register a Declaration of Domestic Partnership under the Oregon Family Fairness Act while you are enrolled in this Plan, your Registered Domestic Partner and his or her children are eligible for coverage. A complete and signed application along with a valid Certificate of Registered Domestic Partnership must be submitted within 31 days of the date the Declaration of Domestic Partnership is registered. (See "When Coverage Begins.") All dependents must meet eligibility requirements.

If you file an Affidavit of Domestic Partnership with the Participating District while you are enrolled in the Plan, your Unregistered Domestic Partner and his or her children are eligible for coverage. A complete and signed application along with a copy of the Affidavit of Domestic Partnership must be submitted within 31 days of the date the Affidavit of Domestic Partnership is filed.

Your newborn child or your enrolled dependent's newborn child will be covered for 31 days after birth. The enrolled employee must submit a complete and signed application, to the Participating District's payroll or personnel officewithin 60 days listing the new child as a dependent. If the Participating District does not receive the application, coverage for the child will end 31 days following birth. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

Adopted children are covered for the first 31 days from the date of the adoption decree. If a child is placed with you pending the completion of adoption proceedings, that child will be covered for the first 31 days from the date of placement. The enrolled employee must submit a complete and signed application, to the Participating District's payroll or personnel office, along with the placement or adoption paperwork within 60 days listing the child as a dependent.

Placement for adoption means you have assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption.

Note: A new dependent may cause a premium increase. Premiums will be adjusted accordingly. Such adjustments will apply during the first 31 days of coverage for newborn or adopted children.

Enrollment

This section explains how to enroll in the Plan.

WHEN YOU FIRST BECOME ELIGIBLE

You must file a complete and signed application for yourself and any dependents you want enrolled within 31 days of when you become eligible to apply for coverage. Employees become eligible to apply on the date of hire or the end of any required waiting period. File the application with the Participating District's payroll or personnel office.

You must notify your School District whenever you change your address.

ENROLLING NEW DEPENDENTS

You may obtain coverage for newly acquired or newly eligible dependents by submitting a complete and signed application, to the Participating District's payroll or personnel office within 31 days of their eligibility. For newborn children and an adopted child or a child placed for adoption, you must submit a complete and signed dependent application along with the placement or adoption paperwork within 60 days of adoption or placement.

You must notify your School District if family members are added or dropped from coverage, even if it does not affect your premiums.

OPEN ENROLLMENT

If you do not enroll yourself and/or your eligible dependents within 31 days (60 days for newborn children and an adopted child or a child placed for adoption) of first becoming eligible, you will be considered a "late enrollee" and must wait for the next open enrollment period to enroll. Open enrollment occurs once a year at renewal. However, an eligible individual shall not be considered a late enrollee if he or she meets one of the eligibility requirements under "Special Enrollment Rights" as described below. Late Enrollees are only eligible for the routine eye examination during the first 12-months of continuous enrollment. When a Late Enrollee has been covered for 12 continuous months, they will be entitled to all benefits of the vision plan.

SPECIAL ENROLLMENT RIGHTS

A. Loss Of Other Coverage

If you decline coverage for yourself or your dependent(s) when eligible to enroll because of other health coverage, you may enroll yourself or your dependent(s) in this Plan outside of the open enrollment period, but only if you satisfy the following criteria:

- The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;
- The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason enrollment was declined;
- The employee requests such enrollment not later than 31 days after the previous coverage ended; and

- One of the following events has occurred:

    1) The employee's or dependent's prior coverage was under COBRA continuation provision and the coverage under such provision was exhausted; this includes reaching the lifetime maximum while on COBRA coverage.

    2) The employee's or dependent's prior coverage was terminated as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
        - legal separation or divorce;
        - loss of dependent status per plan terms;
        - death;
        - termination of employment;
        - reduction in the number of hours of employment;
        - reaching the lifetime maximum on all benefits;
        - the plan ceasing to offer coverage to a group of similarly situated individuals;
        - moving out of an HMO service area that results in termination of coverage and no other option is available under the plan;
        - termination of the benefit packet option, unless a substitute option is offered.

    3) The employer contributions toward the employee's or dependent's other coverage were terminated. (If employer contributions cease, the employee or dependent does not have to terminate coverage under the prior plan in order to be eligible for special enrollment.)

This special enrollment right, as described above, applies:

- To a current employee who loses other coverage;
- To an enrolled employee's dependent who loses coverage under the other plan;
- To both the current employee and the dependent if neither is enrolled in the Plan, and either loses coverage under the other plan.

To enroll yourself or your dependent you will need to submit a complete and signed application.

B. New Dependents

New dependents under the terms of this Plan may enroll outside of open enrollment periods if they request special enrollment within 31 days after the event that caused the employee to gain a new dependent (e.g., marriage, the registration of a Declaration of Domestic Partnership or the filing of an Affidavit of Domestic Partnership). Enrollment must be submitted within 60 days for newborn children and an adopted child or a child placed for adoption. The employee and his or her Spouse or Registered Domestic Partner will also have special enrollment rights if they are eligible but not enrolled at the time of the event that caused the employee to gain a new dependent; however, other existing dependents will not.

To enroll your new dependent you will need to submit a complete and signed application and, when applicable, a marriage certificate, a Certificate of Registered Domestic Partnership, a copy of the filed Affidavit of Domestic Partnership, or adoption or placement for adoption paperwork.

WHEN COVERAGE BEGINS

Coverage will begin for you and any enrolled dependents on the first day of the month following your Participating District's waiting period.

Coverage for new dependents through marriage will begin the first day of the month if the marriage date is the first day of the month. Otherwise, coverage begins on the first day of the month following the date of marriage.

Coverage for new dependents through the registration of a Declaration of Domestic Partnership under the Oregon Family Fairness Act will begin on the first day of the month if the Declaration of Domestic Partnership is registered on the first day of the month. Otherwise, coverage begins on the first day of the month following the date the Declaration of Domestic Partnership is registered.

Coverage for new dependents through the filing of an Affidavit of Domestic Partnership with the Participating District will begin on the first day of the month if the Affidavit of Domestic Partnership is filed on the first day of the month. Otherwise, coverage begins on the first day of the month following the date the Affidavit of Domestic Partnership is filed.

When the new dependent is due to the birth of a newborn, coverage is effective on the date of the newborn's birth. When the dependent is due to an adoption or placement for adoption, coverage is effective on the date of adoption or placement. Court ordered coverage is effective on the date specified by the court order.

The necessary premiums must also be paid for coverage to become effective.

If you apply for coverage as a late enrollee, coverage will begin for you and/or your dependents on the date specified with the acceptance of your application. All other plan provisions will apply.

WHEN INSURANCE ENDS

There are a variety of circumstances in which coverage for you and/or your enrolled dependents will end. These are described in the following paragraphs.

A. Group Plan Termination

If the Plan is terminated for any reason, coverage ends for the Participating District you and your enrolled dependents on the date the Plan ends.

ODS may terminate the agreement with the Group as a whole for fraud, material misrepresentation, concealment by OEBB or OEBB's noncompliance with material provisions of the agreement.

B. Termination By Enrolled Employee

You may terminate your coverage, or coverage for any enrolled dependent, by giving us written notice through OEBB. Coverage will end on the last day of the month through which premiums are paid. If you terminate your own coverage, coverage for your dependents also ends at the same time.

C. Death

If you die, coverage for your enrolled dependents ends on the last day of the month in which your death occurs. Note that your enrolled dependents may extend their coverage for up to 3 years if the requirements for continuation of coverage are met (see page 35 for details). OEBB must notify us of any continuation of coverage and appropriate premiums must be paid along with OEBB 's regular monthly payment.

D. Loss of Eligibility

If your employment terminates, your coverage will end for you and your enrolled dependents on the last day of the month in which termination occurred, unless you choose to continue coverage as provided under this Plan (see page 35 for details).

E. Rescission By Insurer

We may rescind your coverage, and/or the coverage of your enrolled dependents, back to your effective date, or deny claims at any time for fraud, material misrepresentation, or concealment by you or your enrolled dependents. As used herein, fraud, material misrepresentation, or concealment may include, but is not limited to, enrolling ineligible individuals on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and falsification or alteration of claims. We reserve the right to retain premiums paid by you as liquidated damages, and you shall be responsible for the full balance of any benefits paid. Should we terminate coverage under this section, we may, to the extent permitted by law, deny future enrollment of you and your dependents under any ODS Health Plan, Inc. policy or contract, or the contract of any of our affiliates.

F. Family and Medical Leave

If the Participating District grants you a leave of absence under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply:

- You and your enrolled dependents will remain eligible for coverage during your FMLA leave.
- If you and/or your enrolled dependents elect not to remain enrolled during FMLA leave, you (and/or your enrolled dependents) will be eligible to re-enroll in the Plan on the date you return from leave. To re-enroll, you must submit a complete and signed application within 60 days of your return to work. All of the terms and conditions of the policy will resume at the time of re-enrollment as if there had been no lapse in coverage. You will receive credit for any exclusion period served prior to the FMLA leave and you will not have to re-serve any eligibility-waiting period under the Plan. However, you will receive no exclusion period credits for the period of the leave.
- Your rights under FMLA will be governed by that statute and its regulations.

G. Leave of Absence

If you are granted a non-FMLA leave of absence by the Participating District, you may continue coverage for up to three months. Premiums must be paid through OEBB in order to maintain coverage during a leave of absence.

A leave of absence is a period off work granted by the Participating District at your request during which you are still considered to be employed and are carried on the employment records of the Participating District. A leave can be granted for any reason acceptable to the Participating District, including disability and maternity.

H. Strike or Lockout

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, you may continue your coverage for up to six months. You must pay the full premiums, including any part usually paid by the Participating District, directly to the union or trust that represents you, and the union or trust must continue to pay us the premiums when due.

Continuation of coverage during a strike or lockout will not occur if:

- Fewer than 75% of those normally enrolled choose to continue their coverage;
- You accept full-time employment with another employer; or
- You otherwise lose eligibility under the Plan.

I. Termination of Employment

If your employment terminates, your coverage will end for you and all enrolled dependents on the last day of the month in which termination occurs, unless you choose to continue coverage (see page 35).

If you are laid-off by the Participating District and return to active work within six months of being laid off, you and any previously enrolled dependents may re-enroll in the group plan on the date you are rehired. Your coverage will begin on the date of rehire.

If you experience a reduction in hours that causes you to lose coverage, and within six months your hours increase and you again qualify for benefits, you and any previously enrolled dependents may re-enroll in the group plan on the date you qualify. Your coverage will begin on the date you qualify.

OEBB must notify us that you have been rehired following a lay-off or that your hours have been increased, and the necessary premiums for your coverage must be paid.

J. Loss of Eligibility by Dependent

An enrolled child will lose eligibility when he or she no longer meets the requirements to qualify as a dependent as described on page 10 or when the enrolled employee is no longer legally required to provide coverage for the child. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under this Plan (see page 35).

Coverage ends for an enrolled Spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced Spouse continues coverage as provided under this Plan (see page 35).

Coverage ends for a Registered Domestic Partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered, unless the former Registered Domestic Partner continues coverage as provided under this Plan (see page 35).

Coverage ends for an Unregistered Domestic Partner on the last day of the month in which the domestic partnership no longer meets the requirements of the Affidavit of Domestic Partnership filed with the Participating District, unless the former Unregistered Partner continues coverage as provided under this Plan (see page 35).

K. Other

See " Continuation of Health Coverage" section starting on page 35.

Claims Administration & Payment

The following section explains how claims are administered.

SUBMISSION AND PAYMENT OF CLAIMS

A claim must be submitted to ODS within 90 days after the date the expense was incurred. Failure to furnish a claim within the time required shall not invalidate or reduce any claim if it was not reasonably possible to submit the claim within 90 days, provided it is submitted as soon as reasonably possible. In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than one year from the date submission is otherwise required. Claims submitted by Medicaid must be sent to ODS within 3 years after the date the expense was incurred.

A claim for which additional information is received will not be reprocessed after the Plan's claim submission period, as described in the above paragraph.

Your vision provider may bill charges directly to us. If not, please forward the bills directly to us at the address listed below. Be sure the vision provider uses his or her billing form and that the following are shown on the bill:

- The patient's name and the group and identification numbers;
- The date of treatment;
- The diagnosis; and
- An itemized description of services and charges.

The ODS Companies
Attn: Medical
P.O. Box 40384
Portland, Oregon 97240

If the treatment is for an accidental injury, include a statement explaining the date, time, place, and circumstances of the accident when you send us the bill.

A. Explanation of Benefits (EOB)

Soon after you make a claim, we will report to you on the action we have taken by sending you a document called an Explanation of Benefits. We may pay claims or deny them. If we deny all or part of a claim, the reason for our action will be stated in the Explanation of Benefits.

If you do not receive an Explanation of Benefits within a few weeks of the date of service, this may indicate that ODS has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period noted under Submission and Payment of Claims.

B. Claim Inquiries

If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please call us at 503-265-2909 or toll-free at 1-866-923-0409 or write to the ODS Customer Service Department. We will respond to your inquiry within 30 days of receipt.

GRIEVANCE AND APPEALS

A. Grievance

Complaint means an expression of dissatisfaction about a specific problem you have encountered or about a decision by a carrier or an agent acting on behalf of the Plan, and which includes a request for action to resolve the problem or change the decision. A complaint does not include an inquiry.

Grievance means a written complaint submitted by you or on your behalf regarding:

- Availability, delivery, or quality of vision services, including a complaint regarding an adverse determination made pursuant to a utilization review;
- Claims payment, handling, or reimbursement for vision services; or
- Matters pertaining to the contractual relationship between you and the Plan.

Inquiry means a written request for information or clarification about any subject related to your health benefit plan. An inquiry does not in itself constitute a complaint.

Note:
The timelines addressed in the paragraphs below do not apply when:

- The time period is too long to accommodate the clinical urgency of the situation;
- You do not reasonably cooperate; or
- Circumstances beyond the control of either party prevents that party from complying with the standards set but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

If you have a grievance, you must submit it in writing to ODS and ask for a review. If you need assistance on filing a grievance, contact the ODS Customer Service at 503-265-2909 or toll-free at 1-866-923-0409, to discuss the issue as it may be possible to resolve it with a phone call. We will acknowledge receipt of the written grievance within seven (7) days of receipt and conduct an investigation. We will inform you of the results of the investigation and any action we intend to take within 30 days of receiving the grievance. If more time is needed, we will issue a notice of delay, and complete the investigation within an additional 15 days (i.e., 45 days from the date we receive the grievance).

Claims Grievances:
If you disagree with a decision made regarding coverage of services (denial of benefits received, or a disagreement on amount of benefits), your grievance must be filed within 60 days of the date of our action on your claim (the date on the Explanation of Benefits provided upon action/payment for the claim at issue). Claims grievances filed outside the 60 day limit will not be considered.

B. Appeals

If you disagree with our decision made in response to a grievance, you may appeal the decision. The Plan has a two level formal appeal process. Your appeal must be made within 60 days of the date of our action on your initial grievance. You may also call the ODS Customer Service Department at 503-265-2909 or toll-free at 1-866-923-0409, to discuss the issue as it may be possible to resolve it without filing a formal appeal.

First Level Appeal If you request a First Level Appeal, you must submit your appeal in writing along with any additional relevant information you wish to submit. ODS will acknowledge receipt of a written appeal, in writing, within seven days. ODS will conduct an investigation by persons who were not involved in the review of your grievance. ODS will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. Within 30 days of receipt of the appeal, we will send you a written notice of the decision on your appeal, including the basis for the decision. If applicable, the notice will include information on your right to a Second Level of Appeal.

Second Level Appeal If you are still dissatisfied after the First Level Appeal, you may request a Second Level Appeal by persons who were not involved in the review of the grievance or First Level Appeal. You must submit your second appeal in writing within 60 days of the date of our action on your First Level Appeal. ODS will acknowledge receipt of a written appeal, in writing, within seven days and conduct an investigation. ODS will keep you informed of the progress, including if additional time or investigation is required for a full and complete review. Within 30 days of receipt of the appeal, ODS will notify you in writing of the decision.

You have the option to appear before the panel in person or by conference call or other appropriate technology. ODS will allow your representative to act on your behalf in the appeal process if you choose. Your appeal will be reviewed within 23 calendar days of its receipt and a written decision will be sent to you within seven calendar days after the decision is made.

If you are not satisfied with the outcome of the Second Level Appeal, and your complaint meets the specifications outlined under External Review, you may request that the complaint be reviewed by an Independent Review Organization. You will need to exhaust the Grievance and the First and Second Levels of Appeal to proceed to the External Review, unless ODS agrees otherwise.

C. External Review

If you are not satisfied with the outcome of the Second Level Appeal, and your claim meets the criteria below, you may request that the claim be reviewed by an Independent Review Organization, appointed by the Insurance Division.

1. The dispute must relate to an adverse decision on one or more of the following:
   - whether a course or plan of treatment is medically necessary;
   - whether a course or plan of treatment is experimental or investigational;
2. You must apply in writing for External Review, and not later than the 180th day after receipt of ODS' final written decision following the grievance and appeal process as described in this section;
3. You must sign a waiver granting the Independent Review Organization access to your medical records;
4. You must have exhausted the grievance and appeal process described in this section. However, ODS may waive the requirement of compliance with exhausting the process and have a dispute referred directly to the External Review with your consent; and
5. If you apply for External Review of an adverse decision, you shall provide complete and accurate information to the Independent Review Organization in a timely manner.

ODS agrees to be bound by the decision of the Independent Review Organization with respect to whether a course or plan of treatment is medically necessary, notwithstanding the definition of medical necessity in the plan; or whether a course or plan of treatment is experimental or investigational.

D. Additional Enrollee Rights

You have the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available:

By calling: (503) 947-7984
By writing: Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310

By internet http://www.cbs.state.or.us/external/ins/

Information included in the "Additional Enrollee Rights" is subject to change upon notice from the Director of the Oregon Insurance Division.

BENEFITS AVAILABLE FROM OTHER SOURCES

Situations may arise in which your vision care expenses may be the responsibility of someone other than ODS. Here are descriptions of the situations that may arise.

A. Coordination of Benefits (COB)

This provision applies to this Plan when you or your enrolled dependent has healthcare coverage under more than one plan. For a complete explanation of COB see the section titled "Coordination of Benefits."

B. Third-Party Liability

An individual covered by us may have a legal right to recover benefit or vision care costs from another person, organization or entity, or an insurer, as a result of an illness or injury for which benefits or vision care costs were paid by us. For example, an individual who is injured may be able to recover the benefits or vision care costs from an individual or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, an individual may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for vision expenses connected with the illness or injury. Should we make an advance payment of Benefits, as described below, we are entitled to be reimbursed for any benefits paid by us that are associated with any illness or injury that are or may be recoverable from a Third Party or other source. Amounts received by us through these recoveries help reduce the cost of premiums and providing benefits.

Because recovery from a Third Party may be difficult and take a long time, and payment of benefits where a Third Party may be legally liable is excluded under the terms of this Plan/Insurance, as a service to you, we will pay a Covered Individuals' expenses based on the understanding and agreement that the Covered Individual is required to honor our rights of subrogation as discussed below, and, if requested by us, to reimburse us in full from any recovery the Covered Individual may receive, no matter how the recovery is characterized.

Upon claiming or accepting Benefits, or the provision of Benefits, under the terms of this Plan/Insurance, the member agrees that we shall have the remedies and rights as stated in this Section. We may elect to seek recovery under one or more of the procedures outlined in this Section. The Covered Individual agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, our right of reimbursement or subrogation as discussed in this Section. We have the sole discretion to interpret and construe these reimbursement and subrogation provisions.

Definitions:
For purposes of this Section relating to Third Party Liability, the following definitions apply:

Covered Individual means an individual covered by us, including a dependent of a Member/Insured. Covered Individual also includes the estate, heirs, guardian or conservator of the individual for whom benefits have been paid or may be paid by us, and includes any trust established for the purpose of receiving Recovery Funds and paying for the future income, care or vision expenses of such individual.

Benefits means any amount paid by us, or submitted to us for payment to or on behalf of the Covered Individual. Bills, statements or invoices submitted to us by a provider of services, supplies or facilities to or on behalf of a Covered Individual are considered requests for payment of Benefits by the Covered Individual.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Covered Individual, regardless of the characterization of the claims or damages of the Covered Individual, and regardless of the characterization of the Recovery Funds. (For example, a Covered Individual who has received payment of vision expenses from us may file a Third Party claim against the party responsible for the Covered Individual's injuries, but only seek the recovery of non-economic damages. In that case, we are still entitled to recover Benefits as described herein.)

Third Party means any individual or entity responsible for the injury or illness, or the aggravation of an injury or illness, of the Covered Individual. Third Party includes any insurer of such individual or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the Covered Individual including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, PIP coverage, and workers' compensation insurance.

Recovery Funds means any amount recovered from a Third Party.

Subrogation
Upon payment by the Plan/Coverage, we shall be subrogated to all of the Covered Individual's rights of recoveries therefore, and the Covered Individual shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Under this sub-section, we may pursue the Third Party in our own name, or in the name of the member. We are entitled to all subrogation rights and remedies under the common and statutory law, as well as under this Plan/Coverage.

Right of Recovery
In addition to our subrogation rights, we may, at our sole discretion and option, ask that the Covered Individual, and his or her attorney, if any, protect our reimbursement rights. If we elect to proceed under this sub-section, the following rules apply:

1. The Covered Individual holds any rights of recovery against the Third Party in trust for us, but only for the amount of Benefits we paid for that illness or injury.

2. We are entitled to receive the amount of Benefits we have paid for that illness or injury out of any settlement or judgment which results from exercising the right of recovery against the Third Party. This is so regardless of whether the Third Party admits liability or asserts that the Covered Individual is also at fault. In addition, we are entitled to receive the amount of Benefits we have paid whether the vision expenses are itemized or expressly excluded in the Third Party recovery.

3. If, and only if, we ask the Covered Individual, and his or her attorney, to protect our reimbursement rights under this sub-section, then the Covered Individual may subtract from the money to be paid back to us, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.

4. We may ask the Covered Individual to sign an agreement to abide by the terms of this Right of Recovery sub-section. If we elect to proceed under this sub-section we will not be required to pay benefits for the illness or injury until the agreement is properly signed and returned.

5. This right of recovery includes the full amount of the Benefits paid, or pending payment by us, out of any recovery made by the Covered Individual from the Third Party, including, without limitation, any and all amounts from the first dollars paid or payable to the Covered Individual (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or vision expenses of the Covered Individual), regardless of the characterization of the recovery, whether or not the Covered Individual is made whole, or whether or not any amounts are paid or payable directly by the Third Party, an insurer or another source. Our recovery rights will not be reduced due to the Covered Individual's own negligence.

6. If it is reasonable to expect that the Covered Individual will incur future expenses for which Benefits might be paid by us, the Covered Individual shall seek recovery of such future expenses in any Third Party Claim.

Motor Vehicle Accidents
Any expense for injury or illness which results from a motor vehicle accident, and which is payable under a motor vehicle insurance policy is not a covered Benefit under this Plan/Coverage and will not be paid by us.

If a claim for vision expenses arising out of a motor vehicle accident is filed with us, and if motor vehicle insurance has not yet paid, then we may advance Benefits, subject to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, and subject to the next paragraph.

In addition to the rights and remedies outlined in the Subrogation and Right of Recovery sub-sections stated above, in Third Party claims involving the use or operation of a motor vehicle, we, at our sole discretion and option, are entitled to seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538.

Additional Third Party Liability Section Provisions
In connection with our rights to obtain reimbursement, or to exercise our right of subrogation, or direct recovery in motor vehicle accidents, as discussed in the above sub-sections, Covered Individuals shall do one or more of the following and agrees that we may do one or more of the following, at our discretion:

1. If the Covered Individual seeks payment by us of any Benefits for which there may be a Third Party Claim, the Covered Individual shall notify us of the potential Third Party Claim. The Covered Individual has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to us by a Provider to the Covered Individual.

2. Upon request from us, the Covered Individual shall provide to us all information available to the Covered Individual, or any representative, or attorney representing the Covered Individual, relating to the potential Third Party Claim. The Covered Individual and his or her representatives shall have the obligation to notify us in advance of any claim (written or oral) and/or any lawsuit made against a Third Party seeking recovery of any damages from the Third Party, whether or not the Covered Individual is seeking recovery of Benefits paid by us from the Third Party.

3. In order to receive an advance payment of Benefits pursuant to this Section, we require that any Covered Individual seeking payment of Benefits by us, and if the Covered Individual is a minor or legally incapable of contracting, then the Covered Individual's parent or guardian, must fill out, sign and return to our office a Third-Party Questionnaire and Agreement that includes a questionnaire about the accident and the potential Third-Party claim. If the Covered Individual has retained an attorney to represent the Covered Individual with respect to a Third-Party Claim, then the attorney must sign the Third-Party Recovery Agreement, acknowledging the obligations described in that Agreement.

4. The Covered Individual shall cooperate with us to protect our recovery rights under this Section, and in addition, but not by way of limitation, shall:

    - Sign and deliver such documents as we reasonably require to protect our rights;
    - Provide any information to us relevant to the application of the provisions of this Section, including medical information (including doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments; and
    - Take such actions as we may reasonably request to assist us in enforcing our rights to be reimbursed from Third Party recoveries.

5. By accepting the payment of benefits by us, the Covered Individual agrees that we have the right to intervene in any lawsuit or arbitration filed by or on behalf of a Covered Individual seeking damages from a Third Party.

6. The Covered Individual agrees that we may notify any Third Party, or Third Party's representatives or insurers of our recovery rights set forth herein.

7. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of this Section.

8. This Section applies to any Covered Individual for whom advance payment of Benefits is made by us whether or not the event giving rise to the Covered Individual's injuries occurred before the individual became covered by us.

9. If the Covered Individual continues to receive vision treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, we will provide Benefits for the continuing treatment of that illness or injury only to the extent that the Covered Individual can establish that any sums that may have been recovered from the Third Party for the continuing vision treatment have been exhausted for that purpose.

10. If the Covered Individual or the Covered Individual's representatives fail to do any of the foregoing acts at our request, then we have the right to not advance payment of Benefits or to suspend payment of any Benefits for or on behalf of the Covered Individual related to any sickness, illness, injury or medical condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, we may notify medical providers seeking authorization or pre-authorization of payment of Benefits that all payments have been suspended, and may not be paid.

11. Coordination of Benefits (where the Covered Individual has vision coverage under more than one Plan or health insurance policy) is not considered a Third Party Claim.

12. If any term, provision, agreement or condition of this Section is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

Coordination of Benefits

Coordination of Benefits (COB) occurs when you have vision coverage under more than one plan.

DEFINITIONS

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan means any of the following that provides benefits or services for vision care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

- Group insurance contracts and group-type contracts;
- HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group or group-type coverage.

Plan does not include:

- Fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Benefits for non-medical components of group long-term care policies;
- Medicare supplement policies;
- Medicaid policies; or
- Coverage under other federal governmental plans, unless permitted by law.

Each contract or other arrangement for coverage described above is a separate Plan. If a Plan has two parts and COB rules apply to only one of the two, each of the parts is treated as a separate Plan.

Complying Plan is a plan that complies with these COB rules.

Non-complying Plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

Claimant means the enrollee for whom the claim is made.

An **Allowable Expense** means a vision expense, including deductibles, coinsurance, and co-payments, which is covered at least in part by any plan covering the claimant. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the claimant is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a claimant is not an allowable expense.

The following are examples of expenses that are **not** allowable expenses:

- The amount of the reduction by the primary Plan because a claimant has failed to comply with the Plan provisions concerning prior authorization of services or because the claimant has a lower benefit because that claimant did not use an in-network provider;
- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
- Any amount in excess of the highest of the negotiated fees, if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

This Plan is the part of this group contract that provides benefits for vision expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

A **Closed Panel Plan** is a plan that provides vision benefits to covered persons primarily in the form of services through a network of providers that has contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

HOW COB WORKS

If the claimant is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then the other plan(s) pay(s). The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

The **Primary Plan** (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The **Secondary Plan** (the plan(s) that pay(s) benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall provide benefits as if it were the primary plan when an enrollee uses an out-of-network provider, except for emergency services that are paid or provided by the primary plan.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

- If this Plan is primary, it will provide its benefits first.
- If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
- If the non-complying plan reduces its benefits so that the enrollee receives less in benefits than s/he would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that ODS will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the enrollee against the non-complying plan.

WHICH PLAN PAYS FIRST?

The first of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a plan covers the claimant as other than a dependent, for example, an employee, member, subscriber, or retiree, then that plan will determine its benefits before a plan which covers the person as a dependent.
2. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the claimant is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
3. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the claimant is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, then the following rules apply:
    - If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    - If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.
    - If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
        - The plan covering the custodial parent;
        - The plan covering the Spouse or Partner of the custodial parent;

- The plan covering the non-custodial parent; and then
- The plan covering the Spouse or Partner of the non-custodial parent.

This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

4. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of individuals who are not the parents of the child, the first applicable provision (# 2 or #3) above shall determine the order of benefits as if those individuals were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
5. **Active/Retired or Laid Off Employee.** The plan that covers a claimant as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers a claimant as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
6. **COBRA or State Continuation Coverage.** If a claimant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering that claimant as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
7. **Longer/Shorter Length of Coverage.** The plan that covered an employee, member, subscriber, or retiree (non-dependent) longer is the primary plan and the plan that covered the claimant for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
8. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Where part of a plan coordinates benefits and a part does not, each part will be treated as a separate plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.

If a claimant is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

OUR RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

If another plan makes payments we should have made under this coordination provision, we can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them. The term 'payments' includes providing benefits in the form of services, in which case 'payments' means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess payment from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Miscellaneous Provisions

The following describes other procedures and policies in effect when processing your claims.

REQUEST FOR INFORMATION

When necessary to process claims, we may require that you submit information concerning benefits to which you or your dependent is entitled. We may also require that you authorize any physician or healthcare provider to provide us with information about a condition for which you claim benefits.

DISCLOSURE OF BENEFIT REDUCTION

ODS will provide notification of material reductions in covered services or benefits to the OEBB no later than 60 days after the adoption of the change.

CONFIDENTIALITY OF ENROLLEE INFORMATION

The confidentiality of your protected health information is of extreme importance to ODS. Your protected health information includes, but is not limited to enrollment, claims, and medical information. We use your information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. We do not sell your information. For more complete detail about how ODS uses your information, please refer to the Notice of Privacy Practices. A copy of the notice is available on our website at www.odscompanies.com or by calling ODS at 503-243-4492.

TRANSFER OF BENEFITS

Only you and your enrolled dependents are entitled to benefits under this Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on us.

RECOVERY OF BENEFITS PAID BY MISTAKE

If we mistakenly make a payment for you or an enrolled dependent to which you are not entitled, or if we pay a person who is not eligible for payments at all, we have the right to recover the payment from the person we paid or anyone else who benefited from it, including a physician or provider of services. Our right to recovery includes the right to deduct the amount paid by mistake from future benefits we would provide for you or any enrolled dependent even if the mistaken payment was not made on that person's behalf.

PLAN PROVISIONS

OEBB's policy with ODS Health Plan, Inc. and this Member Handbook plus any endorsements or amendments are the entire agreement between the parties. No promises, terms, conditions or obligations exist other than those contained herein. This policy plus such endorsements or amendments, if any, shall supersede all other communications, representations or agreements, either verbal or written between the parties.

RESPONSIBILITY FOR QUALITY OF VISION CARE

In all cases, you or your enrolled dependents have the exclusive right to choose your facility, physician or professional provider. We are not responsible for the quality of vision care you receive, since all those who provide care do so as independent contractors. We cannot be held liable for any claim or damages connected with injuries you or your enrolled dependent suffer while receiving vision services or supplies.

WARRANTIES

All statements made by OEBB, or an enrollee, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting insurance coverage will avoid the insurance or reduce benefits unless contained in a written form and signed by OEBB or the enrollee, a copy of which has been given to OEBB or to the enrollee or the beneficiary of the enrollee.

NO WAIVER

Any waiver of any provision of this Plan, or any performance under this Plan, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. No delay or omission on the part of ODS in exercising any right, power or remedy provided in this Plan, including, without limitation, our delay or omission in denying a claim under the Plan, shall operate as a waiver thereof.

GROUP IS THE AGENT

OEBB is your and your enrolled dependents' agent for all purposes under this Plan. OEBB is not the agent of ODS Health Plan, Inc.

GOVERNING LAW

To the extent this Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the State of Oregon.

WHERE ANY LEGAL ACTION MUST BE FILED

Any legal action arising out of this Plan must be filed in either a state or federal court in the State of Oregon.

TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, this Plan and filed against us by you, any of your dependents, any enrollee or any third party, must be filed in court within three years of the time the claim arose. For example, a claim that benefits were not authorized or provided, and any and all damages relating thereto, would arise when the last level of administrative appeal under the Plan has ended.

EVALUATION OF NEW TECHNOLOGY

ODS develops medical necessity criteria for new technologies and new use of current technologies. ODS physicians and nurses do the reviews. They use medical studies, national, regional or local clinical practice guidelines, and local and national carrier benefits to develop the criteria. The reviews are performed once a year or more often if needed.

Continuation Of Health Coverage

IMPORTANT NOTICE

The following sections on continuation of coverage may apply to you. Please check with the Participating District's benefits manager to find out whether you qualify for this coverage. Both you and your dependents should read the following notices carefully.

OREGON CONTINUATION COVERAGE FOR SPOUSES & DOMESTIC PARTNERS AGE 55 AND OVER

A. Introduction

ORS 743.600 to 743.602 are state regulations requiring certain group health insurance policies to offer enrolled Spouses and Registered Domestic Partners the opportunity to request a temporary extension of health insurance coverage for themselves and their dependents if coverage is lost due to a specific event identified in the statutes ("55+ Oregon Continuation"). OEBB has also elected to extend this coverage to Unregistered Domestic Partners.

55+ Oregon Continuation only applies to employers with 20 or more employees. ODS will provide 55+ Oregon Continuation coverage to those eligible dependents who elect coverage under ORS 743.600 to 743.602, subject to the following conditions:

- Other than the inclusion of Unregistered Domestic Partners, ODS will offer no greater rights than ORS 743.600 to 743.602 requires;
- ODS will not provide 55+ Oregon Continuation coverage for dependents who do not comply with the notice, election, or other requirements outlined below; and
- As the Plan Administrator, OEBB is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If OEBB fails to notify the eligible Spouse or Registered Domestic Partner or Unregistered Domestic Partner, premiums shall be waived from the date the notice was required until the date notice is received by the Spouse or Registered Domestic Partner or Unregistered Domestic Partner. OEBB shall be responsible for such premiums.

B. Eligibility Requirements For 55+ Oregon Continuation Coverage

If you are the Spouse or Registered Domestic Partner or Unregistered Domestic Partner of the employee, you may elect 55+ Oregon Continuation coverage for yourself and your enrolled dependents if you meet the following requirements:

- You lose coverage because of the death of the employee, dissolution of marriage or domestic partnership with the employee, or legal separation from the employee;
- You are 55 years of age or older at the time of such event; and
- You are not eligible for Medicare.

C. Notice And Election Requirements For 55+ Oregon Continuation Coverage

Notice of Divorce, Dissolution, or Legal Separation, Termination. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or registered domestic partnership, or the termination of an unregistered domestic partnership, a legally separated or divorced Spouse, or a legally separated or former Registered or Unregistered Domestic Partner, eligible for 55+ Oregon Continuation who seeks such coverage shall give the Plan Administrator written notice of the legal separation, dissolutionor termination. The notice shall include the mailing address of the legally separated or divorced Spouse, or the legally separated or former Registered or Unregistered Domestic Partner, seeking coverage.

Notice of Death. Within 30 days of the death of the employee whose surviving Spouse or Registered or Unregistered Domestic Partner is eligible for 55+ Oregon Continuation, the Participating District shall give the Plan Administrator written notice of the death and the mailing address of the surviving Spouse or Registered Domestic Partner or Unregistered Domestic Partner.

Election Notice. Within 14 days of receipt of the above notice, the Plan Administrator shall provide notice to the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, that coverage can be continued, along with an election form. If the Plan Administrator fails to notify the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, within the required 14 days, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, must return the election form within 60 days after the Plan Administrator mails it. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

D. Premiums For 55+ Oregon Continuation Coverage

The monthly premiums for 55+ Oregon Continuation is limited to 102% of the premiums paid by a current employee. The first premium shall be paid by the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, to the Participating District within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

E. When 55+ Oregon Continuation Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following:

- The failure to pay premiums when due, including any grace period allowed by the policy;
- The date that the Plan terminates, unless a different group policy is made available;
- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, becomes insured under any other group health plan;
- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, remarries or registers another domestic partnership under the Oregon Family Fairness Act, or files another Affidavit of Domestic Partnership, and becomes covered under another group health plan; or
- The date on which the surviving, legally separated or divorced Spouse, or the surviving, legally separated or former Registered or Unregistered Domestic Partner, becomes eligible for Medicare.

COBRA CONTINUATION COVERAGE

A. Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law requiring certain employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health insurance coverage if coverage is lost due to a qualifying event. For purposes of this section, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the enrolled employee (or retired employee), the enrolled employee's Spouse, and the dependent children of the enrolled employee. Specific qualifying events are listed below.

ODS will provide COBRA continuation coverage to those qualified beneficiaries who elect coverage under COBRA, subject to the following conditions:

- Other than the inclusion of Registered and Unregistered Domestic Partners, ODS will offer no greater COBRA rights than the COBRA statute requires;
- ODS will not provide COBRA coverage for those qualified beneficiaries who do not comply with the notice, election or other requirements outlined below; and
- ODS will not provide COBRA coverage if the Participating District or Plan Administrator fails to provide the required COBRA notices within the statutory time periods, including the initial notice, the election notice, and notice of a qualifying event, or if the Participating District or Plan Administrator otherwise fails to comply with any of the requirements outlined below.

B. Qualifying Events

Employee. As an employee covered by this Plan, you may elect continuation coverage if you lose coverage because of termination of employment (other than termination for gross misconduct on your part, which may include, but is not limited to, misrepresenting immigration status to obtain employment), or a reduction in hours.

Spouse. If you are the Spouse of an employee (or of a retiree qualifying under the last bullet below) covered by the Plan, you have the right to choose continuation coverage for yourself if you lose coverage for **any** of the following four qualifying events:

- The death of your Spouse;
- The termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment with the Participating District;
- Divorce or legal separation from your Spouse; or
- Your Spouse becomes entitled to Medicare.

(Also, if an employee eliminates coverage for his or her Spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the Plan Administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

Domestic Partners. A Registered or Unregistered Domestic Partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under this plan, the Registered or Unregistered Domestic Partner would have the same rights to COBRA continuation coverage as a Spouse does, unless otherwise stated. Where this section refers to divorce or legal separation, termination of an Affidavit of Domestic Partnership for Unregistered Domestic Partners or dissolution of a registered domestic Partnership under the Oregon Family Fairness Act for Registered Domestic Partners would also apply.

Children. A dependent child of an employee (or of a retiree qualifying under the last bullet below) covered by the Plan, has the right to continuation coverage if coverage is lost for **any** of the following five qualifying events:

- The death of the employee parent;
- The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in an employee parent's hours of employment with the Participating District;
- Parents' divorce or legal separation;
- Employee parent becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the Plan.

C. Other Coverage

The right to elect continuation coverage shall be available to individuals who are entitled to Medicare at the time of the election or are covered under another group health plan at the time of the election.

D. Notice And Election Requirements

Qualifying Event Notice. The Plan provides that your family member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (Spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the employee or a family member has the responsibility to notify the Plan Administrator if one of these events occurs by mailing or hand-delivering a written notice to the Plan Administrator. The notice must include the following: 1) the name of the Group for the plan; 2) the name and social security number of the enrollee(s); 3) the affected beneficiary(ies); 4) the event (e.g. divorce): and 5) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not timely given, continuation coverage will not be available.

Election Notice. When the Plan Administrator receives a timely Qualifying Event Notice, you, your Spouse, and/or dependent child will be notified of your right to continuation coverage within 14 days after the Plan Administrator receives the notice.

Otherwise, you, your Spouse and dependent children will be notified by the Plan Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, death of the employee, or the employee's becoming entitled to Medicare.

Election. You or your family member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage. If continuation coverage or Portability coverage (discussed below) is not elected, your, your Spouse's and your dependent's group health insurance coverage will end.

An enrolled employee or the Spouse may elect continuation coverage for eligible family members. However, each family member has an independent right to elect COBRA coverage. This means that a Spouse or child may elect continuation coverage even if the employee does not.

E. COBRA Premiums

If you are eligible for continuation coverage, you do not have to show that you are insurable. However, under the law, you are responsible for all premiums for continuation coverage. Your first payment for continuation coverage is due within 45 days after you provide notice of electing coverage (this is the date your election notice is postmarked, if mailed, or the date your election notice is received by the Plan Administrator, if hand-delivered). This payment must include the amount necessary to cover all months that have ended between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, you will have a grace period of 30 days to pay the premiums. If you do not pay the applicable premiums, in good funds, when due, your continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

F. Length Of Continuation Coverage

If you choose continuation coverage, the Participating District will provide the same coverage as is available to similarly situated employees or dependents under the Plan.

18-Month Continuation Period. In the case of a loss of coverage due to end of employment (other than for gross misconduct) or a reduction of hours of employment, coverage generally may be continued only for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to an employee's death, divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the Plan, or, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment (other than for gross misconduct) or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the enrolled employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

G. Extending The Length Of Cobra Coverage

If you elect COBRA, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from an enrolled employee's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the enrolled employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

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

You must provide the Plan Administrator a copy of the Social Security Administration's determination within the 18-month period and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the enrolled employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premiums.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event: An extension of coverage will be available to Spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the enrolled employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of an enrolled employee, divorce or legal separation from the enrolled employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when an enrolled employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.).

This extension due to a second qualifying event is available only if you notify the Plan Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. If this notice is not provided to the Plan Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon Law for an employee's Spouse or Registered or Unregistered Domestic Partner age 55 and older who loses coverage due to the employee's death, or due to legal separation or dissolution of marriage or registered domestic partnership, or termination of an unregistered domestic partnership. See page 35 for details.

H. Newborn Or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the enrolled employee, the child is considered a qualified beneficiary. The employee may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The employee or a family member must notify the Participating District within 31 days of the birth or placement to obtain continuation coverage. If the employee or family member fails to notify the Participating District in a timely fashion, the child will not be eligible for continuation coverage.

I. Special Enrollment And Open Enrollment

Under continuation coverage, qualified beneficiaries have the same rights afforded similarly-situated plan participants who are not enrolled in COBRA. A qualified beneficiary may add newborns, new Spouses, Registered Domestic Partners, or Unregistered Domestic Partners, and adopted children (or children placed for adoption) as covered dependents in accordance with the Plan's eligibility and enrollment rules, including HIPAA special enrollment. If non-COBRA participants can change plans at open enrollment, COBRA participants may also change plans at open enrollment.

J. When Continuation Coverage Ends

This notice shows the maximum period of COBRA coverage available to the qualified beneficiaries. COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premiums are not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the Participating District ceases to provide any group health plan for its employees; or
- during a disability extension period (the disability extension is explained above), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

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

When COBRA continuation coverage ends, you and/or your enrolled dependents *may* be eligible to enroll in an individual Portability Plan provided by ODS.

If you have any questions about COBRA, please contact the Plan Administrator. Please notify the Plan Administrator if you or your Spouse have changed addresses.

K. Trade Act Of 2002

This COBRA provision applies only to employees who have lost their jobs or had a reduction in hours as a result of import competition or shifts of production to other countries.

Second Election Period for Certain Trade-Displaced Individuals. Certain enrolled employees who did not elect COBRA coverage are entitled to elect COBRA coverage during a special second election period. Enrolled employees who are eligible to make a COBRA election during this special second election period (Trade Adjustment Assistance (TAA) Eligible Employees) must satisfy each of the following requirements:

- They must be receiving a trade readjustment allowance under the Trade Act of 1974 (or be eligible for such an allowance once unemployment compensation is exhausted) or receiving alternative trade adjustment assistance under the Trade Act of 1974;
- They must have lost group health plan coverage due to a termination of employment or reduction of hours that resulted in eligibility for a trade readjustment allowance or alternative trade adjustment assistance; and
- They did not elect COBRA during the regular COBRA election period available to them as a result of their termination of employment or reduction of hours.

The special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which a TAA Eligible Employee began receiving a trade readjustment allowance (or would have become eligible for such an allowance but for the requirement to exhaust unemployment compensation) or began receiving alternative trade adjustment assistance, but only if the election is made within six months after the initial loss of group health plan coverage that occurred in connection with the TAA Eligible Employee's termination of employment.

Duration of COBRA Coverage Elected During the Special Second Election Period. COBRA coverage elected during the special second election period is not retroactive. Coverage commences on the day that the special second election period began, and the maximum COBRA coverage period will terminate on the same day that it would have terminated if COBRA coverage had been elected during the regular 60-day election period.

COBRA Tax Credit. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance coverage, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

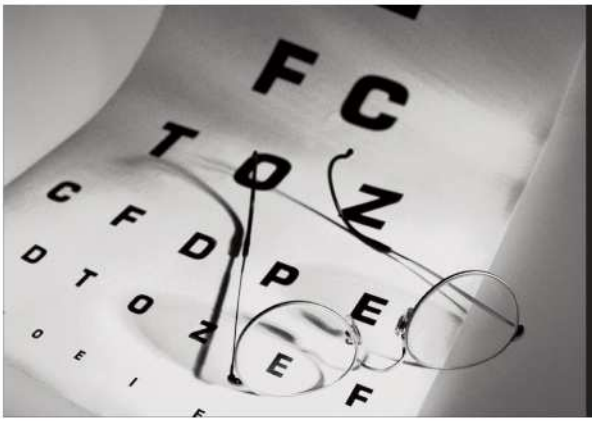
Coverage will terminate if an employee is called to active duty by any of the armed forces of the United States of America. However, if an employee requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the employee pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If an employee does not elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the group if released under honorable conditions, but only if he or she returns to active employment:

- On the first full business day following completion of his or her military service for a leave of 30 days or less;
- Within 14 days of completing military service for a leave of 31 to 180 days; or
- Within 90 days of completing military service for a leave of more than 180 days.

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the VA to be service connected will be allowed.

When coverage under this Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the employee had not taken military leave and coverage had been continuous under this Plan. There will be no additional eligibility-waiting period and the pre-existing condition limitation will be credited as if the employee had been continuously covered under this Plan from the original effective date. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. For complete information regarding rights under the Uniformed Services Employment and Reemployment Rights Act, contact the Participating District.



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