PUTNAM COUNTY BOARD OF EDUCATION
DENTAL AND OPTICAL PLAN

Summary Plan Description

July 2021 Edition

Putnam County Board of Education Dental and Vision Program

TABLE OF CONTENTS

PUTNAM COUNTY BOARD OF EDUCATION DENTAL AND OPTICAL PLAN
ADMINISTRATIVE INFORMATION

This booklet is a "Summary Plan Description" as defined by the Employee Retirement Security Act of 1974.

The Plan is administered by American Benefit Corporation.

NAME OF PLAN

Putnam County Board of Education Dental and Optical Plan

NAME AND ADDRESS OF EMPLOYER:

Putnam County Public Schools
77 Courthouse Drive
Winfield, WV 25213

EMPLOYER IDENTIFICATION NUMBER

55-6000387

PLAN NUMBER

0003

TYPE OF PLAN

Dental and Optical Expense Plan

PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS

Chris Campbell
Putnam County Schools
77 Courthouse Drive
Winfield, WV 25213
(304) 586-0500

CLAIMS ADMINISTRATOR:

American Benefit Corporation
3150 US Route 60
Ona WV 25545
(800) 778-6118

Claims Submission

Putnam County Board of Education
3150 US Route 60
Ona WV 25545

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator.

CONTRIBUTIONS

The entire cost of the Plan is paid for by the Putnam County Board of Education.

PLAN YEAR

The Plan's fiscal records are kept on a plan year which is the twelve month period beginning each July 1 and ending on the following June 30. Deductibles and annual maximums commence each July 1 and end on June 30.

GENERAL PROVISIONS

Administration of Plan

The Plan is administered by the Plan Administrator who has full and complete authority, responsibility, discretion and control over the Plan.

Type of Administration

The Plan is administered directly by the Plan Administrator with claims processing provided contractually by the Third Party Administrator.

Funding

The Plan is funded by contribution amounts sufficient to pay the costs of the Plan.

Plan Benefits

The Plan provides Dental and Optical Care Expense Benefits.

How to File a Claim

Claims are submitted by provider of services directly to the Third Party Administrator for payment. If a provider required you to pay for services at the time rendered you can obtain a claim form from the Payroll Department for proper submission to the Third Party Administrator.

Written proof of claim must be submitted to the Plan's Third Party Administrator within three hundred sixty-five (365) days after the date services were rendered. Failure to submit written proof of claim within that time will neither invalidate nor reduce any claim; however, you must furnish written proof that the claim could not have been submitted within three hundred sixty-five (365) days from the date services were rendered in order for benefits to be provided.

Plan's Right of Recovery of Monies Paid in Error

The Plan reserves the right to recover any monies paid in error to or on behalf of Covered Employees or Covered Dependents, or to providers.

Until regulations are issued by the appropriate federal agencies, the Plan will use good faith efforts to define and interpret the term 'essential benefits' in a reasonable and consistent manner to comply with the restrictions against lifetime and annual limits under the federal health care reform law (Patient Protection and Affordable Care Act of 2010).

RIGHTS AND PROTECTIONS UNDER ERISA

As a Participant in the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U. S. Department of Labor, such as annual reports and plan descriptions.
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report.
4. Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as the result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan pm the rules regarding your COBRA rights.

In addition to creating rights for plan Participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Employee Benefit Plan. These persons are referred to as 'fiduciaries' in the law. Fiduciaries must act solely in the interest of the plan Participants and they must exercise prudence in the performance of their plan duties. No one, including your employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and consider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan which you are entitled to receive, and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution

Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration. The publication hotline number is 1-800-998-7542.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), your eligibility may be continued provided your employer makes the required contribution on your behalf. Eligibility may be up to twelve (12) weeks during the twelve (12) month period, for any of the following reasons:

To care for your child after the birth or placement of a child with you for adoption or foster care, so long as such leave is completed within twelve (12) months after the birth or placement of the child;

To care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or

For your own serious health condition.

In the event you and your spouse are both covered as Eligible Employees, the continued coverage may not exceed a combined total of twelve (12) weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of twelve (12) weeks.

Conditions:

You are eligible to continue your coverage under FMLA if you have worked for your employer for at least one (1) year; have worked at least 1,250 hours over the previous twelve (12) months for such employer; your employer employs at least fifty (50) Employees within seventy-five (75) miles of your work site and your employer continues to pay your required contributions.

If, on the day your eligibility is to begin, you are already on an FMLA leave, you will be considered actively at work. Benefits for you and any eligible Dependents (if applicable) will be in accordance with the terms of the Plan as set forth herein.

You and your Eligible Dependents (if applicable) are subject to conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

FMLA continuation ends on the earliest of the day you return to work, the day you notify your employer that you are not returning to work, the day your coverage would otherwise end under the Plan or the day coverage has been continued for twelve (12) weeks.

UNIFORM SERVICES ACT

Continuation Coverage for Participants on Leave with the Uniform Services

Pursuant to 38 U.S.C. 4301 et seq., the Plan shall provide continuing coverage for members on military leave from work due to required service for one of the uniformed services. "Military Leave" means any service in the uniformed services including the performance of duty on a voluntary or involuntary basis with all types of military training or service. Specifically, this includes services, performed under competent authority, in the nature of active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a time necessary for a person to be absent form employment for an examination to determine the fitness of the person to perform any of these duties.

"Uniformed Services" refer to the US armed services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive day training, and the commissioned core of the public health service). Moreover, the President is authorized to expand the categories of covered services through the exercise of emergency war powers.

This continuation of coverage is similar to "Continuation Coverage" provided by the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA) except as follows:

Continuation coverage is to last for eighteen (18) months beginning on the first day missed because of uniformed service.

Charges to Employee – for up to thirty-one (31) days missed service, the employer may not charge the Employee any more than the Employee's regular rate paid for participating in the Plan; after thirty-one (31) days missed, the employer may charge the Employee up to one hundred two percent (102%) of the full premium of the Plan as derived under COBRA.

A Plan member who returns to work is covered on the same terms and conditions as other members who have not been on military leave in that no waiting time or pre-existing condition requirement may be applied to the member on uniformed services leave in addition to any such requirement as existed when one first became a member.

The Plan reserves the right to exclude coverage for any injury that is determined by the Secretary of Veterans Affairs to have been incurred or aggravated by the Participant's military service.

BENEFIT REVIEW PROCEDURES

Initial Claim Determination:

<u>Definitions</u>

1. Urgent claims are requests for eligibility status or for medical care or treatment of an emergency nature, which could seriously jeopardize the life or health of the claimant or would subject the claimant to severe pain.

2. A pre-service claim is a request for eligibility status or for benefits for which a Plan requires pre-approval, such as pre-admission certification for a hospital admission or a predetermination of benefits for major dental care.

3. A post-service claim is a request for a benefit following the claimant's receipt of services.

Time Limits

1. A decision with respect to an urgent care claim will be made within seventy-two (72) hours. If the claim is not complete, the Plan will so notify you of the additional information required within twenty-four (24) hours.

2. A decision on pre-service claim will be made within fifteen (15) days. The Plan will advise of a defective or incomplete filing of pre-service claim within five (5) days of receipt. The Plan may take an additional fifteen (15) days, if it is determined an extension is necessary due to matters beyond the control of the Plan and you are advised of the need for the extension.

3. A decision on a post-service claim will be made within thirty (30) days. The plan will advise of a defective or incomplete filing of a post-service claim within thirty (30) days of receipt. You will have forty-five (45) days to provide the required information. The Plan may take an additional fifteen (15) days, if it is necessary due to matters beyond the control of the Plan and you are advised of the need for the extension.

Concurrent Care Decisions

1. If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by the Plan of such course of treatment before the end of the period or number of treatments previously agreed to will be considered a denial. The Plan will notify you of this action in advance of the application of the reduction or termination and advise of the appeal rights to permit a review prior to the date the benefit is reduced or terminated.

2. A decision on the previously agreed to course of treatment for an urgent care claim will be acted upon as soon as possible. The Plan will advise of a defective or incomplete filing of pre-service claim within twenty-four (24) hours, provided the claim is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Claim Denial Procedures

If your claim is denied or partially denied, you will be notified in writing and provided an opportunity for a review. The written notice of denial will provide:

1. The specific reason(s) for the denial;
2. The specific Plan provision on which the determination is based;
3. A description of additional information or information necessary for the Participant to perfect the claim and an explanation of why this additional information is necessary;
4. A statement that the specific rule, guideline, protocol or other criterion relied upon in making the determination, if applicable, will be provided at no cost upon request;

5. A statement advising that an explanation of the scientific or clinical judgment relied upon and the names of the individuals from whom opinion(s) were secured, if a determination is based upon medical necessity or experimental treatment, or similar exclusion or limit, will be provided at no cost; and
6. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement regarding the Participant's right to bring a civil action under section 502(a) of ERISA.

Claim Review Procedures

If the Participant's claim has either been denied or partially denied and he is not satisfied with the decision, he may appeal the decision and request a review of the claim. The matter shall be referred to the Claims Review Board. The appeal:

1. Must be in writing and can be made by the Participant or the Participant's duly authorized representative;
2. Should be mailed or delivered to the Plan address shown in the Summary Plan Description;
3. Should state the reasons the Participant believes the initial determination was incorrect;
4. Should include any written comments, documents, records and other information relating to the claim for benefits; and
5. Must be submitted within one hundred and eighty (180) days of the date the Participant received the notice of denial or partial denial.

You will be provided access to and copies of all documents, records and other information relevant to your claim at a reasonable charge.

1. A decision on review of an urgent care claim will be made within seventy-two (72) hours after receipt of the Participant's request for review.
2. A decision on review of a pre-service claim will be made within thirty (30) days of receipt of the Participant's request for review.
3. A decision on review of a post-service claim will be made by the Claim Review Board within thirty (30) days following receipt of the request for review and the Participant will be notified of the decision within five (5) days of the decision.

THE DECISION OF THE CLAIMS REVIEW BOARD ON REVIEW WILL BE MADE IN GOOD FAITH AND WILL BE FINAL AND BINDING ON ALL ISSUES. THE PARTICIPANT OR THE PARTICIPANT'S DULY AUTHORIZED REPRESENTATIVE WILL BE REQUIRED TO EXHAUST THE ENTIRE CLAIM REVIEW PROCEDURE BEFORE INSTITUTING ANY OTHER FORM OF ACTION.

Statute of Limitations

After you have received the final written decision of the Claims Review you will have a period of one hundred and eighty days (180) after the date of the written decision to commence on Legal action for a Court of appropriate jurisdiction to review the decision of the Claims Review Board. If you fail to commence such an action you will be barred from further review.

ELIGIBILITY

Employees Eligible Under The Plan

To be eligible for coverage under the Plan, an individual must be an Employee in a regularly scheduled position working a minimum of seventeen and a half (17.5) hours per week.

If you and your spouse are both covered under this Plan, your children may only be covered as dependents of you or your spouse.

Dependents Eligible Under The Plan

Dependents that are eligible include:

- your legal spouse;
- your biological children, adopted children and/or stepchildren under age 26;
- children or stepchildren over age 26 who live with you, have been continuously covered by the Plan since before age 26, and who are incapacitated and cannot support themselves due to a physical or mental disability which began before age 26 if coverage was extended as a "qualifying child" or "qualifying relative". For newly hired employees in their initial enrollment period in the Plan it is not necessary that the dependent be covered before age 26.

Disabled Child

Your dependent child may be covered after reaching age 26 if he or she is incapable of self-support because of mental or physical disability. To be eligible:

- The disabling condition must have begun before age 26 if coverage was extended as a "qualifying child" or "qualifying relative"; and
- The child must be incapable of self-sustaining employment and chiefly dependent on you for support and maintenance.

To continue this coverage, contact the Administration Office for an application. You will be asked to provide documentation when the child reaches age 26 and periodically thereafter.

Qualified Medical Child Support Order (QMCSO)

If the employee and his or her spouse divorce, and the employee is not the custodial parent for the dependent child(ren), the employee may continue to provide medical benefits for the child(ren) through the Plan. If the non-custodial parent is ordered by the court to provide Dental and Vision coverage for the child(ren), the custodial parent may submit claims for the court-ordered child(ren), and benefits may be paid directly to the custodial parent. The custodial parent will receive Explanations of Benefits (EOBs) as a result of the (QMCSO) as claims are processed. Contact the Administration Office for more information.

WHEN DOES COVERAGE BEGIN

Employee Coverage

Coverage for you begins on the first day of the calendar month following the day on which you:

1. become an Employee;
2. begin working for Putnam County Board of Education; and
3. complete and submit an enrollment form to the Payroll Department.

Dependent Coverage

Dependent coverage begins on the first day of the calendar month on which:

1. Coverage begins for you; and
2. You complete and submit an enrollment form to the Payroll Department.

Continuation of Coverage Upon Retirement

In order for you to qualify for continuation of benefits, you must retire under Board guidelines; you have completed the last 15 full consecutive years of employment in a regularly scheduled position working a minimum of seventeen and a half (17.5) hours per week at Putnam County Schools.

WHEN DOES COVERAGE END

Employee Coverage

Your coverage ends on the earlier of:

1. sixty (60) days after the last day of the month in which you were physically present on the job;
2. the date you are no longer in a class of Employees eligible to be covered by the Plan;
3. the last day of the month through which the required contribution, if any, is paid for the purchase of your coverage; or
4. the date the Plan is terminated.

Dependent Coverage

Dependent coverage ends the earliest of:

1. the date your coverage ends;
2. when the Dependent is no longer an Eligible Dependent; or
3. the last day of the month through which the required contribution, if any, is paid for the purchase of Dependent coverage.

Retiree Coverage

Retiree coverage ends the earlier of:

1. the date retiree coverage is deleted from the Plan; or
2. the date the Plan is terminated.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

DENTAL AND VISION BENEFITS CONTINUANCE PROVISIONS

You may elect to continue certain benefits provided by the Plan in the event your coverage, or that of your dependents, would otherwise terminate. The length of the time for which the benefits elected may be continued is based upon the qualifying event which would have caused the loss of benefit eligibility.

Continuation of Group Dental and Vision Benefits

1. You may elect to continue Dental and Vision benefits for yourself and your eligible dependents for as long as eighteen (18) months from the day your eligibility ends because:
   (a) your employment terminates (other than due to gross misconduct); or
   (b) you do not earn sufficient credited service to qualify for benefits.

2. You may elect to continue benefits for an additional eleven (11) month period beyond the basic eighteen (18) months provided for in 1. above if you are awarded Social Security Disability Benefits as the result of a disability which commenced prior to the qualifying event or within sixty (60) days of the commencement of the COBRA continuance. Proof of the total disability must be provided to the Administration Office prior to the end of the basic eighteen (18) month period.

3. Your eligible spouse and/or any eligible dependent child may elect to continue Dental and Vision benefits for as long as thirty-six (36) months from the day eligibility ends because;
   (a) you die;
   (b) you become entitled to Medicare benefits and elect that coverage as primary;
   (c) you and your spouse are legally separated or divorced; or
   (d) a child is no longer an eligible dependent.

When the qualifying event is the end of employment or reduction of the participant's hours of employment and the participant became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered participant becomes entitled to Medicare eight (8) months before the date on which his eligibility lapses, COBRA continuation coverage for this spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months).

You are responsible for notifying the Administration Office in writing when Dental and Vision benefits end in accordance with 3(b), 3(c), or 3(d) above. This notice must be received by the Administration Office within sixty (60) days after the divorce, legal separation, or dependent's loss of eligibility. You will need to provide a copy of any court order, birth certificate, or other information the Plan may deem relevant. Additionally, if you are already receiving COBRA continuation coverage, you must notify the Administration Office in writing, of any qualifying event that may extend your COBRA eligibility period.

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six

(36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B or both), gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Upon recognition of the occurrence of a qualifying event, the Administration Office will send you and your spouse a notice describing your rights to purchase continued benefits. (The notice will be sent to a former dependent if the qualifying event resulted in the loss of dependent eligibility.) You or your dependents have sixty (60) days to return the written application for COBRA continuation coverage. This sixty (60) day period begins the latter of:

(a) the date benefits would otherwise end (the last day of the Benefit Month) or
(b) the date the notice is received. (If the notice is sent after the last day of the Benefit Month.)

The required contribution for purchase of the continued coverage must be paid to the Plan within forty-five (45) days from the date the COBRA continuation is elected. The notice of your rights to COBRA will provide the costs associated with the options available. This initial payment must include the current month's premium plus any premium due for the months which have elapsed since the end of the last benefit period for which you or your dependents were eligible. Subsequent payments are due monthly on the first day of the month. A thirty (30) day grace period is granted for payment of the amount due.

The COBRA continuance will end at the earliest of the following to occur:

(a) the day the Plan ceases to provide any group health plan;
(b) the day premium is due and unpaid;
(c) the day the covered person, after the date of the COBRA election, first becomes covered under another group plan that does not contain a pre-existing conditions limitation or such limitation is not applicable to the covered person in the absence of a pre-existing condition; (A plan's pre-existing conditions limitation period will be reduced by each month that you or your family had continuous health coverage (including COBRA) with no break in coverage greater than sixty-three (63) days. When coverage ends you will receive a certification of the duration of your coverage. This provision applies individually to each COBRA beneficiary.)
(d) the day a person covered under COBRA again becomes covered under the Plan;
(e) the day a covered person is entitled to benefits under Medicare; or
(f) the day Dental and Vision benefits have been continued for the period of time provided in 1. and 2. above.

Notes:

1. Continued coverage begins after the expiration of previously earned eligibility. You cannot purchase double coverage for the same period of time.
2. You or your Dependents are not permitted to continue COBRA if you and/or they become eligible for other group coverage on or after the date the COBRA coverage becomes effective.
3. In the event more than one continuation provision applies, the periods of continued coverage will run concurrently.
4. The continuation of eligibility through self-contribution will be counted to reduce the maximum eighteen (18) month continuation period described above.
5. Any period of continued eligibility for a surviving spouse of a deceased participant provided by the Plan will be applied to reduce the period of continuation mandated under this provision.
6. It is the responsibility of the covered employee or covered dependent to pay the premium when due.

DEFINITIONS

Benefit Period is the period of time during which a covered employee or covered dependent may receive benefits during a Plan year. It begins on the date on which accumulated covered dental charges exceed the deductible. It ends on the date coverage terminates or on June 30 of the calendar year in which it begins, whichever is earlier.

Covered Dependent is an Eligible Dependent for whom a Covered Employee has properly elected dental/vision coverage under the Plan.

Covered Employee is an Employee who has properly elected dental/vision coverage under the Plan.

Deductible
There shall be a deductible for an amount of eligible dental expenses for which benefits are payable in any one Plan Year (July 1 through June 30).

Dentist is an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be a dentist when he performs any of the dental services described in the Dental Schedule of Benefits, and is operating within the scope of his license.

Dependent is an individual who is a Dependent of a Covered Employee.

Eligible Dependent is a Dependent who is eligible under the Plan as set forth in the section entitled "Dependents Eligible Under the Plan".

Employee is an individual who is employed by Putnam County Board of Education.

Ophthalmologist is an individual duly licensed to practice ophthalmology in the state where the vision care is rendered, and is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be an ophthalmologist when he performs any of the vision services described in the Vision Schedule of Benefits, and is operating within the scope of his license.

Optometrist is an individual duly licensed to practice optometry in the state where the vision care is rendered, and is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be an optometrist when he performs any of the vision services described in the Vision Schedule of Benefits, and is operating within the scope of his license.

Plan means the Putnam County Board of Education.

Physician is a practitioner of the healing arts who is duly licensed in the state where practicing to prescribe and administer drugs or to perform surgery and who is providing treatment within the scope and limitations of that license.

Retiree is an individual that is retired from Putnam County Schools.

Third Party Administrator is the entity which, through a contract with Putnam County Board of Education, provides various services to the Plan, including, but not limited to, payment of claims submitted by or on behalf of Covered Employees and Covered Dependents.

USUAL, CUSTOMARY AND REASONABLE CHARGE

Usual Charge means the amount most consistently charged by a Physician or other provider to patients for a given service.

Customary Charge means a charge which falls within the range of Usual Charges for a given or similar service billed by most Physicians or other providers with similar training, experience, certification, qualification, accreditation, and/or experience within a given geographic area.

Reasonable Charge means a charge which meets the Usual and Customary criteria, or which the Plan determines is reasonable in the light of the circumstances.

COORDINATION WITH OTHER HEALTH BENEFITS

All Dental and Vision Benefits provisions are subject to the COORDINATION OF BENEFITS provisions.

If an Employee or an Eligible Dependent is entitled to benefits under any other plan or would have been eligible except for their failure to enroll (as defined below) that will pay part or all of the expense incurred, the amount of benefits payable under the Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. In no event will the amount paid by this plan exceed the amount which would have been paid if there were no other plan involved.

The term "Plan" includes any plan providing benefits or services for or by reason of Dental and Vision treatment for which benefits or services are provided: (a) group, blanket or franchise insurance coverage, (b) group Blue Cross, Blue Shield and any other pre-payment coverage provided on a group basis, (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, Employee benefits organization plans or any other Employee benefits organization plans or any other arrangement of benefits for individuals of a group and (d) any coverage under governmental programs or any coverage required or provided by any statute.

The rules for determining which plan is the primary carrier plan are as follows:

1. A plan without a non-duplication clause always pays first.

2. The plan covering the patient as Employee (rather than as Dependent) pays first.

3. The plan covering a child as a Dependent of the parent whose birthday occurs first during the calendar year pays first. In the case of divorced parents, the following line of benefit determination is applied:

    a. A Dependent of the (natural) parent if the mother has custody;
    b. A Dependent of the step-parent if the natural parent has custody;
    c. A Dependent of the (natural) parent.

If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a Dependent child.

4. Except insofar as three (3) may apply first, when a participant is covered as an Employee under two (2) plans, or as a dependent under two (2) plans, the plan under which the patient has been covered the longer time pays first. In determining the length of time the individual has been covered under a given plan, we will consider

two (2) successive plans covering a given group to be one continuous plan so long as the claimant concerned was eligible for coverage within twenty-four (24) hours after the prior plan terminated.

WHEN IN ACCORDANCE WITH THE ABOVE RULES, IT IS DETEMINED THIS PLAN HAS SECONDARY RESPONSIBILITY, ONLY THOSE COVERED CHARGES FOR WHICH THE PARTICIPANT IS RESPONSIBLE IN ABSENCE OF COVEREAGE UNDER THIS PLAN WILL BE CONSIDERED.

DENTAL SCHEDULE OF BENEFITS

Eligible Charges

All charges will be based on Usual, Reasonable and Customary Charges.

TYPE	DEDUCTIBLE FISCAL YEAR	PAYMENT FACTOR	MAXIMUM FISCAL YEAR
1	$0	100%	$1,500* Fiscal Year
2	$25	90%	
3		60%	
4	$50	50%	$1,750 Lifetime

*The fiscal year maximum does not apply to dependents under the age of 19.

Covered Dental Expenses

Covered dental expense include the following items that are incurred by a Covered Employee or Covered Dependent for any dental service provided for in the "Schedule of Benefits", if said dental service is performed by or under the direction of a Dentist, is essential for the necessary care of the teeth, and begins while the Covered Employee or Covered Dependent has the dental benefits coverage provided by this Plan:

Type I Expenses (Preventive Dental Services)

Procedures Include:
Preventive, Diagnostic, Emergency, Palliative
Services and some Corrective Surgical Procedures

1. Oral Examinations
   a. Initial examinations, diagnosis and charting and recall examinations will be paid for no more frequently than twice in a Fiscal year.
   b. Tooth space maintainers (initial appliance only and for children under age sixteen (16)).
   c. X-ray and x-ray interpretations:
      Complete series of x-rays or panographic x-rays, limited to one during any thirty-six (36) month period.
      Sets of bitewing x-rays will be paid for no more frequently than twice in any fiscal year period.
   d. Prophylaxis will be paid for no more frequently than twice in a Fiscal year.
   e. Sealants for dependents under age fourteen (14), one application, once in thirty-six (36) months.
   f. Fluoride once in a Fiscal year for children under age eighteen (18).

Type II Dental Expenses (Basic Dental Services)

a. Fillings.
b. Cyst or tumor removal.
c. Oral surgery and related general anesthesia.
d. Extractions.
e. Treatment of periodontal and other diseases of the gums and other tissues of the mouth.
f. Endodontic treatment, including root canal therapy.

g. Preformed stainless steel crowns and repairs to preformed stainless steel crowns.
h. Repair of bridges or dentures or crowns.
i. Rebase or reline of an existing partial or complete denture.
j. Emergency or specific examinations or consultations.
k. Implants.
l. Impactions after Medical Plan considers charges first.
m. Nitrous Oxide.
n. Post and Core/Build-Up.
o. Recement and Crown Lengthening.
p. Bone Grafts.

Type III Dental Expenses (Major Dental Services)

a. Inlays, gold fillings, crowns and initial installation of fixed bridgework.
b. Initial installation of removable dentures.
c. Replacement of a removable denture of fixed bridgework or the addition of teeth to such a denture or bridgework, provided the Plan receives proof that the denture or bridgework being replaced is at least five (5) years old and cannot be made serviceable by a dentist.
d. Abutments.

Type IV Dental Expenses (Orthodontic Services for Eligible Dependent Children)

a. Interceptive, interventive or preventive orthodontic services other than space maintainers which are eligible under Type I.
b. Fixed appliances (Includes diagnostic procedures, formal full-banded treatment and retention).
    i. Permanent dentition
    ii. Mixed dentition
    iii. Deciduous dentition
c. Removable appliances (includes diagnostic procedures, removable appliance therapy, and retention)
    i. Permanent dentition
    ii. Mixed dentition
    iii. Deciduous dentition

To be covered, orthodontic treatment must be needed for one of the following conditions:

1. Overbite or over jet of at least four (4) millimeters; or
2. Upper and lower arches in either a protrusive or retrusive relation of at least one cusp; or
3. Cross-bite; or
4. An arch length differences of more than four millimeters in either the upper or lower arch; or
5. Bi-maxillary protrusion of ten (10) or more millimeters.

PRETREATMENT REVIEW

Pretreatment review is a system designed to give you and your Dentist a better understanding of the covered expense payable under this Plan before services are provided. When charges for a proposed dental service or a series of dental services are expected to exceed two hundred dollars ($200), your Dentist must submit a claim form to the Third Party Administrator (TPA) showing the proposed treatment plan and fees. The TPA will then use this pretreatment review to determine the benefits which will be payable for each dental service according to the terms of this Plan and notify your Dentist accordingly.

The TPA's approval of the treatment plan does not guarantee benefits will be paid if the services submitted for pretreatment review are performed after the date coverage for the Covered Employee or Covered Dependent terminates.

ORTHODONTIC TREATMENT

Course of Orthodontic Treatment means the period which begins when the first orthodontic appliance is installed and ends when the last orthodontic appliance is removed, provided that successive courses of orthodontic treatment shall be considered as one course of orthodontic treatment unless the succeeding course begins more than two (2) years after the end of the preceding course.

Member must be covered under the Plan when the first orthodontic appliance is installed in order to be eligible for benefits.

United Concordia Dental Network PPO

United Concordia Dental Network participating dental providers have agreed to accept a discounted fee. You will not be billed for this discount. You always have the freedom to choose any dentist you want; however, you will likely save money with a United Concordia Dental Network dentist or dental provider because the allowed amounts are typically lower than what the dental providers usually charge. United Concordia Dental Network participating providers may be found online at www.unitedconcordia.com. Dental providers may be nominated by contacting United Concordia Dental Network at 800-332-0366 or following the Nomination Guide on the website.

4-MOST/STRATOSE Dental Network PPO

Stratose Dental Network (formerly known as 4-MOST) participating dental providers have agreed to accept a discounted fee. You will not be billed for this discount. You always have the freedom to choose any dentist you want; however, you will likely save money with a Stratose Dental Network dentist or dental provider because the allowed amounts are typically lower than what the dental providers usually charge. Stratose Dental Network participating providers may be found online at www.stratose.com. Dental providers may be nominated by contacting Stratose Dental Network at 888-258-6477 or by completing the nomination form found on the web site.

DENTAL LIMITATIONS

Expenses due to the following are not Covered Dental Expenses:

1. Any part of expense for which no benefit is payable under any other Personal or Dependent Insurance provisions solely because of a Deductible amount requirement or the application of a Coinsurance Factor.
2. Treatment by other than a dentist or doctor except the scaling or cleaning of teeth by a licensed dental hygienist performed under the supervision and direction of a Dentist or doctor.
3. Treatment which is cosmetic in nature, including charges for personalization or characterization of dentures.
4. For facings on crowns/pontics posterior to the second bicuspid.
5. Prosthetic devices (including bridges and crowns) and the fitting of such devices if (a) they were ordered while the Covered Employee or Covered Dependent was not eligible under this Plan, or if (b) they are finally installed or delivered more than ninety (90) days after termination of the individual's termination date.
6. Replacement of any prosthetic device (including bridges and crowns) within five (5) years of the last replacement, or for duplication of any appliance to be used as a spare, or for the replacement of any lost or stolen prosthetic device.
7. Adjustment of prosthetic appliance within six (6) months of initial installation and not included in the cost of such appliance.
8. Dentures, crowns, inlays, onlays, bridgework and other appliances or services intended to increase vertical dimension or restore occlusion.
9. Occlusal equilibration, except to the extent necessary to treat periodontal disease.
10. Restorative crowns, inlays, onlays, or gold fillings except for the restoration of teeth which, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.
11. Charges for dental care not included as covered dental procedures.
12. Charges for Dental care which does not meet the standards of dental practice accepted by the American Dental Association.
13. Expense related to services or supplies of the type normally intended for sport home use.
14. Charges for periodontal splinting.
15. For education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene, or dental plaque control.
16. Charges for appliances or restorations to increase the vertical dimension or restore occlusion; or splinting.
17. Charges for dental care to correct congenital or developmental malformation.
18. Charges for the treatment of or the tempormandibular joint.
19. Charges for replacement of an appliance or prosthetic device, crown, cast restoration or a fixed bridge within five years of the date it was last placed. This exclusion will not apply if replacement is needed due to an accidental injury received while insured.
20. Charges for drugs administered by the attending Dental Practitioner.
21. Services received or supplies purchased outside the United States or Canada, unless the insured person is a resident of the United States or Canada and the charges are incurred while traveling on business or extended vacation.
22. Replacement of bridges or dentures lost, misplaced or stolen.
23. Services covered by the Medical Plan would be covered by the Dental Plan unless for impactions.
24. Desensitizing Medicament.

VISION SCHEDULE OF BENEFITS

For the following items benefits will be paid up to the maximum amount as shown below:

BENEFIT	MAXIMUM
EXAMINATIONS	$100 per Fiscal year
FRAMES	$125 once every Fiscal year
LENSES, PAIR	
SINGLE VISION	$75 once every Fiscal year
BIFOCAL	$90 once every Fiscal year
TRIFOCAL	$100 once every Fiscal year
LENTICULAR	$125 once every Fiscal year
CONTACT LENSES-IN PLACE OF LENSES a. Where visual acuity is not correctable to 20/70 in the better eye except by the use of contact lenses. b. As a requirement following cataract surgery. c. When such person is being treated for a condition such as Keratoconus or Anisometropia, and contact lenses are customarily prescribed as part of the treatment. d. If otherwise prescribed for this Employee or Dependent.	$225 once every Fiscal year

Please Note: For dependents under the age of 19, benefits will be paid up to 100% of the scheduled amount plus 10% of the additional covered cost.

Covered Vision Expenses

Covered vision expenses include the following items that are incurred by a Covered Employee or Covered Dependent for any vision service provided for in the "Schedule of Benefits", if said vision service is performed by or under the direction of an Optometrist or Ophthalmologist, is essential for the necessary vision care, and begins while the Covered Employee or Covered Dependent has the vision benefits coverage provided by this Plan:

1. Eye examinations by a licensed ophthalmologist or optometrist; or
2. Frames purchased in conjunction with such newly prescribed lenses.

VISION LIMITATIONS

Expenses due to the following are not Covered Vision Expenses:

1. Examination, lenses or frames, received in or from an institution owned or operated by the federal government where there is no obligation to pay in the absence of insurance.
2. More than one purchase of frames in any Fiscal year.
3. Sunglasses.
4. Routine yearly examination required by an employer in connection with your, or your dependent's occupation.
5. Repair to frames.

GENERAL LIMITATIONS AND EXCLUSIONS

No payment will be made under this Plan for expense incurred in connection with:

1. Care or treatment given by or in any facility owned or operated by the federal government unless the Covered Employee or Covered Dependent would be required to pay such charges in the absence of coverage.
2. Disease for which you or your Covered Dependent are entitled to benefits under any Workers' Compensation Law or Act, or accidental injury arising out of or in the course of employment.
3. Charges which are in excess of the Usual, Customary and Reasonable Charge based upon the general level of charges made by others rendering similar service in the same geographic area for services of lie severity;
4. Bodily injury sustained or sickness contracted while on duty with any armed forces of any country or international organization;
5. Services rendered by a member of the patient's immediate family or any one residing with the patient;
6. Treatment or services related to injuries sustained while committing a felony;
7. Treatment or services for an intentionally self-inflicted injury;
8. Treatment or services which are experimental or investigative in nature;
9. Treatment or services incurred after the date of termination of the person's coverage, except as provided herein;
10. Telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
11. Services covered by the Medical Plan will not be covered by the Vision Plan.

PUTNAM COUNTY BOARD OF EDUCATION

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information.

Protected health information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact: Chris Campbell, Putnam County Board of Education, 77 Courthouse Drive, Winfield, West Virginia 25213, (304) 586-0500.

EFFECTIVE DATE

This Notice of Privacy Practices became effective on April 14, 2003.

OUR RESPONSIBILITES

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the contract holder for your member contract.

We maintain confidential information and have procedures for accessing and storing confidential records. We restrict internal access to your confidential information to employees who need that information to provide your benefits. We train those individuals on policies and procedures designed to protect your privacy. Our Privacy Officer monitors how we follow those policies and procedures and educates our organization on this important topic.

Primary Uses and Disclosures of Protected Health Information

The following is a description of how we are most likely to use and/or disclose your protected health information.

1. Payment and Health Care Operations

We have the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

2. Payment

We may use or disclose your protected health information to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your protected health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the services provided to you. We may also use and disclose your protected health information to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your protected health information to adjudicate your claims. Also, we may disclose your protected health information to other health care providers or entities that need your protected health information to obtain or provide payment for your treatment.

3. Treatment.

We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

4. Health Care Operations

We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. Please note that we will not use any of your genetic information when performing underwriting activities. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

5. Disclosures to Plan Sponsors

Putnam County Board of Education Dental and Optical Plan is the Plan sponsor. We may disclose your protected health information to the Plan sponsor. The Plan sponsor is not permitted to use protected health information for any purpose other than the administration of the Plan. The Plan sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plan, it will restrict access to

your protected health information to those individuals whose job it is to administer the Plan and it will not use protected health information for any employment-related actions or decisions. The Plan may also disclose enrollment information to the Plan sponsor. The Plan may also disclose summary health information to the Plan sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan.

6. Disclosures to Business Associates

We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

7. Disclosures to Family Members or Others

Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

8. Other Uses and Disclosures

The law allows us to disclose protected health information without your prior authorization in the following circumstances:

- **Required by law.** We may use and disclose your protected health information to comply with the law.

- **Public health activities.** We will disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.

- **Reports about victims of abuse, neglect or domestic violence.** We will disclose your protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree.

- **To health oversight agencies.** We will provide protected health information as requested to government agencies that have the authority to audit or investigate our operations.

- **Lawsuits and disputes.** If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested.

- **Law enforcement.** We may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime

if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).

- **Coroners, medical examiners and funeral directors.** We may disclose protected health information to facilitate the duties of these individuals.

- **Immunization Records.** We may disclose immunization records to schools where state law allows for such disclosures.

- **Organ procurement.** We may disclose protected health information to facilitate organ donation and transplantation.

- **Medical research**. We may disclose protected health information for medical research projects, subject to strict legal restrictions.

- **Serious threat to health or safety.** We may disclose your protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.

- **Special government functions.** We may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.

- **Workers' compensation or similar programs.** We may disclose your protected health information when necessary to comply with worker's compensation laws.

9. Plan Sponsor

We may disclose your protected health information to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

USES AND DISCLOSURES WITH YOUR WRITTEN AUTHORIZATION

We will not use or disclose your protected health information for any purpose other than the purposes described in this Notice without your written authorization. For example, we will not (1) supply protected health information to another company for its marketing purposes (unless it is for certain limited Health Care Operations), (2) sell your protected health information (unless under strict legal restrictions), (3) your protected health information for marketing purposes, (4) disclose your psychotherapy notes or (5) provide your protected health information to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions we already have taken.

YOUR INDIVIDUAL RIGHTS

You have the following rights:

Right to inspect and copy your protected health information. Except for limited circumstances, you may review and copy your protected health information. Your request must be

addressed to the Privacy Officer. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance.

Right to correct or update your protected health information. If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Privacy Officer. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person who created the information is no longer available to make the amendment;

- Is not part of the protected health information we keep about you;

- Is not part of the protected health information that you would be allowed to see or copy; or

- Is determined by us to be accurate and complete.

If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your protected health information.

Right to obtain a list of the disclosures. You have the right to get a list of protected health information disclosures, which is also referred to as an accounting. You must make a written request to the Privacy Officer to obtain this information.

The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, disclosures to law enforcement personnel or disclosures made before April 14, 2003. The list we provide will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Right to choose how we communicate with you. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Right to request additional restrictions on health information. You may request restrictions on our use and disclosure of your protected health information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket, unless otherwise required by law

Right to be notified of a breach. You have the right to be notified if there is a breach of your unsecured protected health information, as defined under the HIPAA Privacy Rules.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, put your complaint in writing and address it to the Privacy Officer: Chris Campbell, Putnam County Board of Education, 77 Courthouse Drive, Winfield, West Virginia 25213, (304) 586-0500. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

FUTURE CHANGES TO OUR PRACTICES AND THIS NOTICE

We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the Privacy Officer.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

(PPACA)

This group health plan believes this plan is a 'grandfathered health plan' under the PPACA. As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits in benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the address or telephone number provided in Administrative Section.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the address or telephone number shown above.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.