SCHEDULE OF DENTAL BENEFITS

CALENDAR YEAR DEDUCTIBLE	
TYPE I SERVICES	NONE
TYPE II & III SERVICES COMBINED	$25 PER PERSON $75 PER FAMILY
ORTHODONTIC SERVICES	NONE
BENEFIT PERCENTAGES	
TYPE I SERVICES	100% OF REASONABLE CHARGE
TYPE II SERVICES	80% OF REASONABLE CHARGE
TYPE III SERVICES	50% OF REASONABLE CHARGE
ORTHODONTIC SERVICES	50% OF REASONABLE CHARGE
MAXIMUM BENEFIT PAYABLE PER CALENDAR YEAR TYPE I, II & III SERVICES COMBINED	$750 PER PERSON
MAXIMUM LIFETIME BENEFIT FOR ORTHODONTIC SERVICES	$750 PER PERSON

DENTAL EXPENSE BENEFITS

Amount Payable
Benefits are payable for each type of service after the deductible for that type of service (if any) has been satisfied. Benefits are payable at the percentage rate applicable to the type of service. Both the deductible and percentage rates applicable for each type of service are specified in the Schedule of Dental Benefits.

Deductible
The deductible is the amount of covered dental expenses which must first be paid by the Covered Person before benefits for Type II & III Services are payable. The deductible applies only once each calendar year.

Family Deductible
If, in any calendar year, the members of a family incur charges toward their deductible equal to the family deductible amount specified in the Schedule of Benefits, no further deductible is required in connection with any other family member for the balance of that calendar year.

Three Month Carryover Deductible
Any dental expenses incurred during the last three (3) months of a calendar year which apply toward the deductible for that year will also be applied toward the deductible for the next calendar year.

Maximum Benefit
The maximum benefit payable for each person in any calendar year for Type I, II and III Services combined is specified in the Schedule of Dental Benefits. The maximum lifetime benefit payable for each person for Orthodontic Services is specified in the Schedule of Dental Benefits.

Pre-Determination of Benefits
If the charges for a proposed course of treatment are expected to exceed $200, each Covered Person can take advantage of a Pre-Determination of Benefits provision. Under this provision, the Covered Person files with Self-Funded Plans, Inc. a Dentist's diagnosis, proposed course of treatment, and expected charges. The Dentist may complete this information on a dental claim form. When a Pre-Determination of Benefits has been made, Self-Funded Plans, Inc. will inform the Covered Person, in advance of treatment, as to the estimated amount of any benefits payable under this Plan with respect to the proposed course of treatment.

Benefits for Temporary Work
Benefits for temporary dental service will be considered a part of the final dental service. Benefits paid for temporary service will be deducted from the benefits otherwise payable for the final service.

Alternate Treatment
If alternate services or supplies may be employed to treat a dental condition, Covered Dental Expenses will be limited to the Reasonable and Customary charge for those services or supplies which are customarily employed nationwide in the treatment of the Illness or Injury and are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the current total oral condition of the covered family member.

Covered Dental Expenses
Covered Dental Expenses are the Reasonable and Customary Charges of a Dentist which the Employee is required to pay for services and supplies listed below which are received by a covered family member in connection with a course of treatment; but only to the extent that the Plan determines that the services rendered and supplies furnished and the course of treatment are:

a. appropriate and meet professionally recognized national standards of quality; and
b. are necessary for the treatment of a non-occupational Illness or a non-occupational Injury and are customarily employed nationwide for the treatment of the dental condition;

taking into account the current total oral condition of the covered family member. The following is a complete list of those dental services which will be considered as Covered Dental Expenses; however, expenses that are incurred for the performance of any dental service not listed below will be considered a Covered Dental Expense only if the Plan Administrator agrees in writing to accept such expenses as Covered Dental Expenses. If the Plan Administrator so agrees, the benefits that are payable will be consistent with a payment for such similar Covered Dental Expenses that would provide the least costly professionally adequate treatment.

Type I Services
1. Routine oral examinations, but not more than two (2) examinations in any twelve (12) month period.
2. Prophylaxis, but not more than two (2) prophylaxis treatments in any twelve (12) month period.
3. Topical application of sodium or stannous fluoride; but not more than once in any twelve (12) month period.
4. Emergency pain treatments.
5. Space maintainers.
6. Diagnostic tests, x-rays and laboratory examinations.

Type II Services
1. Fillings (amalgam, acrylic, composite and silicate).
2. Endodontic treatment, including root canal therapy.
3. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
4. Repair or recementing of crowns, inlays, bridgework, or dentures; or relining of dentures.
5. Extractions.
6. Oral surgery (excluding any charges which are covered under the medical benefits plan).
7. General anesthetics administered in connection with oral surgery, only if Medically Necessary.
8. Injections of antibiotic drugs by the attending Dentist.

Type III Services
1. Inlays, onlays, gold fillings, and crowns.
2. Initial installation of fixed bridgework (including inlays and crowns to form abutments).
3. Initial installation of partial or full removable dentures.
4. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture or fixed bridgework, or addition of teeth to an existing partial denture, unless excluded herein.

Orthodontic Services
The term Orthodontic Procedure means the use of active appliances to move teeth, to correct faulty position of teeth (malposition), to correct abnormal bite (malocclusion), or to control harmful habits. An Orthodontic Treatment Plan means a Dentist's report, on a form approved by the Plan, that states the class of malocclusion or malposition; recommends and describes needed treatment by orthodontic procedures; estimates the duration of the treatment; estimates the total charge for the treatment; and includes cephalometric x-rays, study models and any other supporting evidence that the Plan may reasonably require. A charge is an Eligible Charge if all these conditions are met:

1. It is made for a service or supply furnished in connection with an orthodontic procedure and before the end of the estimated duration shown in the orthodontic treatment plan.
2. An active appliance for that orthodontic procedure is inserted while the person is covered for this benefit.
3. The orthodontic procedure is needed to correct one of these conditions:
    a. vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet) of at least four millimeters; or
    b. faulty alignment (either frontwards or backwards) of the upper and lower arches with each other by at least the width of one tooth section (one cusp); or
    c. cross-bite; or
    d. control harmful habits.

No benefit will be payable for any charges for an orthodontic procedure if an active appliance has been installed before the first day on which the person became covered for this benefit. Orthodontic benefits will be paid in equal installments every month. The Covered Person must be covered on the first day of each monthly period in order to receive payment for that period. The first monthly period will start on the date an active appliance is installed. The initial down payment will be payable at 20% of the total charge, payable at the coinsurance percentage. If orthodontic treatment is stopped for any reason before it is complete, the benefit will only pay for services and supplies actually received.

When Expenses Are Deemed to be Incurred
Expenses are deemed to be incurred as of the date dental care is performed, except as provided below:

1. Expenses for restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved, provided the person remains continuously covered during the course of treatment.
2. Expenses or charges for endodontic services shall be deemed incurred on the date the specific root canal procedure commenced, provided the person remains continuously covered during the course of treatment.

3. Expenses for fixed bridgework, crowns, inlays or restorations shall be deemed incurred on the first date of preparation of the tooth or teeth involved, provided the person remains continuously covered during the course of treatment.
4. Expenses for full or partial dentures shall be deemed incurred on the date the final impression is taken, provided the person remains continuously covered during the course of treatment.
5. Expenses for rebase of an existing partial or complete denture shall be deemed incurred on the first day of preparation of the rebase of such denture, provided the person remains continuously covered during the course of treatment.
6. Expenses or charges for orthodontia services shall be deemed incurred on the date the orthodontic procedure commenced, provided the person remains continuously covered during the course of treatment.

Dental Plan Limitations and Exclusions
Dental Expense Benefits do not cover expenses incurred for any of the following:

1. Charges for dental care which is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists, including charges for personalization or characterization of dentures.
2. Charges for treatment by other than a Dentist, except that cleaning or scaling of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist, if such treatment is rendered under the supervision and direction of the Dentist.
3. Charges for dental care which does not meet the standards of dental practice accepted by the American Dental Association.
4. Charges for the replacement of a lost or stolen prosthetic device.
5. Charges for sealants, for oral hygiene instructions or dietary instruction, for implantology and for plaque control program.
6. Charges for appliances or restorations, other than full dentures, whose primary purpose is to increase vertical dimension or stabilize periodontally involved teeth, or to restore the occlusion.
7. Charges for services or supplies which are furnished prior to the effective date of coverage. In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before the date coverage commenced, even though the prosthetic device or crown is not installed until after the date coverage commenced.
8. Charges for replacement of a crown, bridge or denture within five years following the date of its original installation unless such replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or the bridge or denture, while in the oral cavity, has been damaged beyond repair as a result of an injury received while the Covered Person is covered under the Employer's Plan.
9. Charges for dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law.
10. Charges for dental care which is furnished while a person is confined in a Hospital operated by the United States Government or any agency thereof (except in a foreign country), or dental care for which the person would not be required to pay if there were no benefits.
11. Charges which the person is not legally required to pay.
12. Charges which are in excess of the Reasonable and Customary Charge.
13. Charges for appointments not kept, or for the completion of claims forms.
14. Charges for adjustment or repair to a denture performed within six (6) months of the installation of the denture.
15. Charges for anesthesia, except when considered Medically Necessary and administered in connection with oral or dental surgery.
16. Charges for dental care not included in the list of defined eligible expenses.
17. Charges related to services or supplies of the type normally intended for sport or home use.
18. Charges for dental care resulting from any Injury sustained as a result of war, declared or undeclared.
19. Charges made by a Dentist or Dental Hygienist who normally lives in the Covered Person's home, or is a Close Relative.
20. Charges, if any, that are included as covered medical expenses.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

New Eligible Employees who begin employment within the first fifteen (15) days of the month and who are enrolled will be covered on the first day of the month following the date they began active, full-time employment. New Eligible Employees who begin employment after the 15th day of month and who are enrolled will be covered on the first day of the month following the first full month of employment.

Eligible Employees who return to work following a tour of active duty in a United States Military Reserve Unit will be covered on the date they return to work. Such Eligible Employees will continue to be covered under the Plan as if there had been no break in service.

Eligible Dependents who are enrolled will be covered on the same date as the Eligible Employee or the date such dependent is acquired (whichever is later). A newborn of an Eligible Employee will be covered from the moment of birth, provided the Eligible Employee already has dependent coverage; however, the newborn must be properly enrolled into the Plan as a new dependent within one (1) year following the date of birth. Claims submitted for a newborn will not be processed until the newborn is properly enrolled. If the Eligible Employee does not have dependent coverage at the time of the birth, the newborn must be properly enrolled into the Plan within thirty-one (31) days from the date of birth. A spouse will be considered an Eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a dependent of the Eligible Employee within thirty-one (31) days of the date of marriage. If a dependent is acquired other than at the time of his birth, due to a court order, decree, or marriage, that dependent will be considered an Eligible Dependent of the Eligible Employee from the date of such court order, decree, or marriage, provided this new dependent is properly enrolled as a dependent of the Eligible Employee within thirty-one (31) days of the court order, decree, or marriage. However, if a dependent child is acquired as a result of adoption, that child will be covered the day he is Placed with the adopting parents during the period before the adoption becomes final. For the purpose of this paragraph, the term "Placed" or "Placement" shall mean the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's Placement terminates upon the termination of such legal obligation.

If an Eligible Dependent (other than a newborn child) is confined to the Hospital on his effective date, his coverage shall not become effective until the day immediately following the termination of such confinement.

An Eligible Employee who wishes to enroll for employee or dependent coverage more than thirty-one (31) days after the Eligible Employee or Eligible Dependent is eligible for coverage may do so during the month of August of any year. An Eligible Employee who wishes to enroll for employee or dependent coverage more than thirty-one (31) days after the Eligible Employee or Eligible Dependent is eligible for coverage may not enroll for employee or dependent coverage at any other time during the year. If an Eligible Employee enrolls for employee or dependent coverage during the open enrollment period, such coverage will become effective on the next following October 1st.

However, an Eligible Employee may enroll for employee or dependent coverage after the Eligible Employee or Eligible Dependent is eligible for coverage due to a change in family status which results in loss of coverage, provided that proof of loss is submitted to the Employer within thirty-one (31) days. A change in family status for this purpose includes, but is not limited to:

the divorce of the Eligible Employee;
the disability of the Eligible Employee's spouse or ex-spouse;
the death of the Eligible Employee's spouse or ex-spouse;
the involuntary termination of employment of the Eligible Employee's spouse or ex-spouse;
or the involuntary reduction of the Eligible Employee's spouse's or ex-spouse's hours.

TERMINATION OF COVERAGE

The coverage of any Covered Person shall terminate on the earliest of the following dates:

1. The date of termination of the Plan;
2. The last day of the month following the month in which employment terminates, if during the school year, or until sick leave is exhausted;
3. The date following the last day of an Eligible Employee's contract period (which is September 30th of any year) if the contract is not renewed;
4. The date all coverage or certain benefits are terminated on a particular class by modification of the Plan;
5. The date the Employee fails to make any required contribution for coverage;
6. In the event of an authorized or unauthorized work stoppage by any group of St. Clairsville-Richland City School District Board of Education employees, the benefits provided under the Plan will cease upon commencement of such work stoppage or strike; or
7. With respect to an Eligible Dependent, the date coverage terminates for the Eligible Employee or the date such Dependent no longer meets the qualifications of an Eligible Dependent.

THE FAMILY AND MEDICAL LEAVE ACT OF 1993

In the event that the Employer approves a leave under The Family and Medical Leave Act of 1993 (FMLA) for an Eligible Employee, that Eligible Employee may receive up to 12 work weeks of continued benefits under this Plan while on such leave (provided that required contributions, if any, are made by or on behalf of that Eligible Employee). An Eligible Employee

returning from an approved leave under The Family and Medical Leave Act, who did not continue benefits under this Plan during such leave, will not be required to satisfy a new waiting period or provide proof of good health upon returning to Actively at Work status and meeting the definition of an Eligible Employee. In addition, such persons will continue to be covered under the Plan as if there had been no break in service. In the event that an Eligible Employee does not continue benefits under this Plan throughout an approved FMLA leave, the Continuation of Coverage Provision (COBRA) outlined in the Plan will apply to such Eligible Employee on the date that coverage under this Plan would cease. Continuation of Coverage (COBRA) may be offered a second time to such Eligible Employee in accordance with the following paragraph.

The Continuation of Coverage Provision (COBRA) outlined in the Plan will apply on the earliest of

1. The date that the Eligible Employee informs the Employer of his intent not to return from such leave; or
2. The date that the Eligible Employee does not return from such leave after the leave is over.

CONTINUATION OF COVERAGE PROVISION (COBRA)

Under certain circumstances (as outlined in this section), an Eligible Employee or Eligible Dependent may elect to continue certain benefits under this Plan, at the Covered Person's own expense, after that person is no longer eligible for coverage.
ELIGIBILITY FOR CONTINUATION. A person who is eligible for continuation coverage is called a "Qualified Beneficiary." The events making a person eligible for continuation coverage are called "Qualifying Events."
For a covered employee to become a Qualified Beneficiary, the employee must become ineligible for group coverage because of a Qualifying Event consisting of a termination of the employee's employment (other than because of gross misconduct) or because of a reduction in the number of hours worked.
For a covered spouse or covered child to become a Qualified Beneficiary, the spouse or child must become ineligible for group coverage because of one of the following Qualifying Events:

1. Death of the Eligible Employee;
2. Termination of the Eligible Employee's employment (other than because of the Employee's gross misconduct) or reduction in the number of hours of employment;
3. Divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse;
4. The Eligible Employee becoming entitled to Medicare; or
5. A dependent child ceasing to meet the definition of "Eligible Dependent."

Newborn children of the Eligible Employee and children placed for adoption with the Eligible Employee on or after the date of the Qualifying Event that are properly enrolled as Eligible Dependents will be considered Qualified Beneficiaries.
TYPE OF COVERAGE TO BE CONTINUED. A Qualified Beneficiary is entitled to the same coverage that is available to other similarly situated persons covered under this Plan who have not experienced a Qualifying Event. Proof of good health will not be required.
PERIOD OF CONTINUATION. A Qualified Beneficiary may elect to continue the group coverage beyond the Qualifying Event until the earliest of the following:

1. The end of:
   a. eighteen (18) months, in a case where the Qualifying Event was a termination of employment or a reduction in hours; or
   b. thirty-six (36) months, for other Qualifying Events;
2. The date on which the Employer ceases to provide any group health plan to any Eligible Employee;
3. The date on which coverage ceases under the Plan due to the Qualified Beneficiary's failure to make timely payment of any required premium;
4. The date on which the Qualified Beneficiary first becomes, after the date of election:
   a. Covered Person under any other group health plan. If the other group health plan contains an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for continuation coverage as long as the exclusion or limitation relating to the pre-existing condition has not been satisfied or deemed to have been satisfied; or
   b. entitled to benefits under Medicare.
5. In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter The Act) to have been disabled at any time during the first sixty (60) days of continuation coverage (if the Qualifying Event is termination of employment or reduction of hours), then continuation coverage may continue for up to twenty-nine (29) months with respect to all Qualified Beneficiaries as long as the Qualified Beneficiary notifies the Employer prior to the end of eighteen (18) months of continuation coverage that he was disabled at any time during the first sixty (60) days of continuation coverage. This notification must be made within sixty (60) days of being determined to be disabled under The Act. The Employer will charge the Qualified Beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this provision.

In the event that the Qualified Beneficiary is determined to be no longer disabled under The Act, the Qualified Beneficiary shall notify the Employer of this determination within 30 days.
If during extended coverage for disability (continuation of coverage months 19-29) a Qualified Beneficiary is determined to be no longer disabled under The Act, continuation coverage shall terminate the last day of the month following 30 days from the date of the final determination under The Act that the Qualified Beneficiary is no longer disabled.
PREMIUM FOR CONTINUATION. The Employer will determine the amount of premium which will be charged for continuation coverage. Premium may, at the election of the payer, be made in monthly installments. Without further notice from the Employer, the Covered Person must pay the monthly premium by the last day of the period before the period for which coverage is to be effective.
If election of continuation coverage is made after the Qualifying Event, payment must be made within forty-five (45) days of the date of election. No claim will be payable under this provision until the premium is received from, or on behalf of, the Covered Person.
ELECTION PERIOD. A Qualified Beneficiary may elect continuation coverage during the Election Period. The Election Period means the period which:

1. Begins not later than the date on which coverage terminates under the group plan because of the
2. Qualifying Event;
3. Is of at least sixty (60) days duration; and
4. Ends not earlier than sixty (60) days after the later of:
    a. the date coverage terminates under this Plan because of the Qualifying Event; or
    b. the date of the notice offering the election of continuation of coverage.

Multiple Qualifying Events. If during continuation coverage a Qualified Beneficiary experiences a second Qualifying Event and the original Qualifying Event was termination of the Eligible Employee's employment (other than for gross misconduct) or reduction in the number of hours of the Eligible Employee's employment, then that Qualified Beneficiary may be eligible to participate in continuation coverage for up to 36 months from the date of the original Qualifying Event. The "Notification of Qualifying Event" paragraph set forth below applies.
NOTIFICATION OF QUALIFYING EVENT. The Covered Person is responsible for notifying the Employer of the occurrence of the following Qualifying Events within sixty (60) days of the of the occurrence of such Qualifying Event: divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse, or a dependent child ceasing to be an Eligible Dependent.

DEFINITIONS OF KEY WORDS

ASSIGNMENT OF BENEFITS: Authorization by the Employee for the Plan Supervisor to pay benefits directly to the provider of the service.
CLOSE RELATIVE: The spouse, parent, brother, sister, or child of the Covered Person, or the spouse of the Covered Person's parent, brother, sister or child.
COVERED PERSON: The Employee or any person who is defined in this Plan as a Dependent of the Employee and is covered for benefits under this Plan.
DENTAL HYGIENIST: Someone who is currently licensed to practice dental hygiene and is acting under the supervision and direction of a Dentist.
DENTIST: A duly licensed dentist practicing within the scope of the dental profession and any other physician furnishing any dental services which such physician is licensed to perform.
ELIGIBLE DEPENDENTS: The Eligible Employee's spouse, unless divorced or legally separated, and all unmarried children and legally adopted children (including children Placed with the adopting parents during the period before the adoption becomes final) from birth to twenty-three (23) years of age, provided the children are not employed on a full-time basis and are dependent upon the Eligible Employee for financial support. For the purpose of this paragraph, the term "Placed" or "Placement" shall mean the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's Placement terminates upon the termination of such legal obligation.
Children will be considered as Eligible Dependents from age twenty-three (23) to twenty-five (25) if they are unmarried, Full-Time Students and are dependent upon the Eligible Employee or his spouse for financial support and maintenance.
A child who is physically or mentally incapable of self-support upon attaining the age of twenty-three (23) may be considered a dependent while remaining incapacitated, unmarried and continuously covered under the Plan. To continue a child under this provision, proof of incapacity may be required from time to time.
ELIGIBLE EMPLOYEES: All contracted Employees who work on a regular basis are eligible to be covered by the Plan, provided that they make the required contribution.
EMPLOYER: The Employer is St. Clairsville-Richland City Schools.
FULL-TIME STUDENT: A Dependent child who is enrolled in and regularly attending an accredited college or university for the minimum number of credit hours required by that college or university in order to maintain full-time student status.

PLAN ADMINISTRATOR: The Plan Administrator is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. The Plan Administrator is named in the General Information section of this plan document.
PLAN SPONSOR: The Plan Sponsor is the entity that sponsors this Plan. The Plan Sponsor is named in the General Information section of this plan document.
PLAN SUPERVISOR: The company providing services to the Employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it. The Plan Supervisor is Self-Funded Plans, Inc.
REASONABLE AND CUSTOMARY CHARGE: The Reasonable and Customary Charge for services is based on a relative value system for the types of services performed, taking into consideration the geographic areas where the services are performed, as well as the fees being charged within those geographic areas. **TOTAL DISABILITY**: In the case of an Employee, the inability to perform the duties of his regular occupation and the inability to perform any other work for compensation or profit. In the case of a Dependent, the inability to perform the normal duties of a person of the same sex and of comparable age.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent payment of benefits which exceed expenses. It applies when any person who is covered under this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always either pay its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. All benefits contained in the Plan Document are subject to this provision.

When any person is eligible for coverage under two or more plans, it is necessary to determine which plan is primary and which plan is secondary. The following rules are used to determine the primary carrier.

1. A plan which does not have a non-duplication of benefits or coordination of benefits provision will be the primary carrier.
2. If all the plans have Coordination of Benefits provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a dependent.
3. The primary plan is the plan that covers the person as an active, full-time employee, or that employee's dependent. The secondary plan is the plan that covers that person in a status other than as an active, full-time employee, or that employee's dependent.
4. If a person is covered as a dependent child under more than one plan:
   a. the plan of the parent whose birthday falls earlier in the year is the primary plan;
   b. if the father and mother have the same birthday, the plan covering the parent longer is the primary plan;
   c. if the other plan's provisions for coordination of benefits does not follow the rule of this plan (as stated in 4a & b), then the rules for coordination of benefits of the other plan shall determine the order of benefits;
   d. if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child will be determined by the specific terms of the Court decree. If the Court decree states which parent is responsible for the health care expenses of the child then that parent's plan shall be primary. If there is no Court decree or the Court decree is silent as to which parent is responsible for the health care expenses of the child, or if the Court decree is not being followed by the parent who is supposed to be providing coverage, then the plan that will pay primary benefits will be determined in the following order:
      (i) the plan of the parent with custody of the child;
      (ii) the plan of the spouse of the parent with custody of the child;
      (iii) the plan of the parent without custody of the child.
5. When the above rules do not establish an order of benefit determination, the benefits of a Plan which has covered the person for the longer period of time shall be determined before the benefits of a Plan which has covered the person the shorter period of time.
6. When this provision operates to reduce the total amount of benefits otherwise payable under this Plan as to a person for any Claim Determination Period, each benefit that would be payable in the absence of this Coordination of Benefits provision shall be reduced proportionately, and such reduced benefit shall be charged against any applicable benefit limit of this Plan.

This Plan will coordinate benefits with any of the following types of coverage:
1. Group, blanket, franchise or individual insurance coverage;

2. Hospital services payment plans, medical services prepayment plans, health maintenance organizations, or other group prepayment coverage;
3. Any coverage under labor-management trustee plans, union welfare plans, or employee organization plans, or employee benefit organization plans;
4. Any coverage provided by automobile "No Fault" legislation or any coverage provided by the Social Security Act or any other statute, including but not limited to Medicare;
5. Any employer-sponsored non-insured employee benefit plans;
6. Any coverage for students which is sponsored by, or provided through, a school or other educational institution.

SUBROGATION

In the event of any payment under the Plan, the Plan Administrator shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts or omissions of any person or entity, or which arise under any no-fault coverage, uninsured motorist coverage, underinsured motorist coverage or any other type of first party coverage (for the purposes of this provision, collectively referred to as "Other Coverage"). In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall release any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity, without the written approval of the Plan. In the event a Covered Person pursues a claim against a third party or Other Coverage, the Covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against a third party or Other Coverage, the Plan shall have the right to pursue, sue, compromise or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claims in the Covered Person's name. Each Covered Person hereby agrees to reimburse the Plan, for any benefits paid by the Plan, out of any monies recovered from any person, entity, or Other Coverage as the result of judgment, settlement or otherwise, regardless of how those monies are classified. In the event a Covered Person settles, recovers or is reimbursed by any third party or Other Coverage, the Covered Person shall hold any such monies in trust for the benefit of the Plan and reimburse the Plan for any benefits so paid hereunder on a first priority basis, regardless of whether or not the Covered Person has been made whole. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such monies from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights. The Plan will not pay or be responsible for, without the written consent of the Plan Administrator, any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage. For purposes of this provision, the term "Covered Person" will include anyone acting for, or on behalf of, a Covered Person when the Covered Person is referred to as taking an action.

MISCELLANEOUS PROVISIONS

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Whenever payments have been made by the Plan in an amount which exceeds the maximum amount of payment allowed under the Plan at that time, the Plan shall have the right to recover such payment irrespective of to whom it was paid, to the extent of such excess from among one or more of the following parties: any persons to whom or with respect to whom such payments were made, any insurance companies, or any other organizations or persons.

FACILITY OF PAYMENT

Whenever payments that should have been made under the Plan in accordance were made by another Plan, the Plan shall have the right, exercisable alone and at its sole discretion, to reimburse the other plan in the amount that would have been paid by this Plan. Such reimbursement shall be deemed payment for covered services and the Plan shall be fully discharged from liability.

RIGHTS OF RECOVERY
Whenever payments have been made by the Plan with respect to covered services in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Plan shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Plan shall determine: any persons to whom or with respect to whom such payments were made, any insurance companies, any other organizations or persons.

DISCRETIONARY AUTHORITY
The Plan Administrator shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matters arising under the Plan, based on the applicable facts and circumstances.

DECLARATORY JUDGMENT
In the event that a question of coverage is presented to a court of competent jurisdiction through a declaratory judgment, and the court rules that the Plan is responsible for providing coverage, then the Plan will cover the expense to the extent permitted by all other Plan provisions.

PLAN MODIFICATION AND AMENDMENT
The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion and the amendments or modifications which affect the Plan Members will be communicated to them.

PLAN TERMINATION
The Plan Sponsor may terminate the Plan at any time. Any termination of the Plan will be communicated to Plan Members.

ASSIGNMENT OF BENEFITS
In the event a Covered Person has executed an Assignment of Benefits, the Plan shall pay benefits directly to the provider of service. If the Plan receives notification from a provider that the provider has the Covered Person's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed.

PROOF OF CLAIMS
Written proof of claims must be furnished to the Plan by or on behalf of the Covered Person or the provider within twelve months (12) after the date such claims are incurred (a claim shall be considered incurred on the date the service is rendered or the supply is received). Proof of claims includes the following:

An itemized bill for the service or supply must be furnished to the Plan.
The Eligible Employee must complete one Employee's Statement per claimant per calendar year.
If the Plan Administrator or Plan Supervisor requests information from the Eligible Employee, the Eligible Employee must furnish such information as requested.
If the Plan Administrator or Plan Supervisor requests information from a provider and the provider does not furnish the requested information, the Eligible Employee will be required to obtain the requested information and furnish it to the Plan Administrator or Plan Supervisor.

All of the above requirements must be met within the twelve (12) month time period in order for the claim to be considered.

PAYMENT OF CLAIMS
All Plan benefits are payable to the Employee, or subject to any written direction of the Employee. All or a portion of any indemnities provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Employee's option and unless the Employee requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; however, if any such benefit remains unpaid at the death of the Covered Person or if the Covered Person is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, authorize the Plan Supervisor to pay such benefits to any one or more of the following relatives of the Covered Person: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Plan Administrator will not be required to see the application of the money so paid. If a claim is not paid in full, the Plan Supervisor will furnish notice to the Covered Person which will specify the reason or describe the additional information required to perfect the claim. Upon written request by the Covered Person within sixty days after notice is received, the Plan Administrator will review the claim in question and give a final written decision on the review within sixty days, or one hundred twenty days under special circumstances after such request is received.

ACTIONS
No action at law or in equity shall be brought to recover on the Plan prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within 3 years from the expiration of the time within which proof of loss is required by the Plan.

CONFORMITY OF LAW
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

CHANGE IN PLAN PROVISIONS
Any change in Plan provisions will apply only to expenses incurred on or after the effective date of the Plan change. If, on the effective date of a Plan change, a Covered Person is confined in a Hospital, the Plan provisions in force before the effective date of the change will continue in force until, in the case of the Eligible Employee, the Eligible Employee returns to work for one full day, or, in the case of an Eligible Dependent, the Eligible Dependent is released from the Hospital.

PLAN IS NOT A CONTRACT
The Plan shall not be deemed to constitute a contract between the Plan Sponsor and any Employee/member or to be a consideration for, or an inducement or condition of, the employment of an Employee/member. Nothing in the Plan shall be deemed to give an Employee/member the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Employee/member at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Sponsor with the bargaining representatives of any Employee/members.

BOOKLETS
The Plan Sponsor has issued herewith to each Covered Employee/Member under this Plan an individual booklet which summarizes the benefits to which the person may be entitled, to whom benefits may be payable, and the provisions of the Plan principally affecting the Employee and his dependents.

EXAMINATION
The Plan Administrator, at the Plan's expense, shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during the pendency of claim hereunder. If the Plan requires that the Covered Person be examined by a Physician of the Plan's choice, and the Covered Person does not comply with this request, the Plan has the right to deny benefits for the claim in question. The Plan Administrator also has the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

WORKERS' COMPENSATION NOT AFFECTED
This Plan is not in lieu of, and does not affect any requirement for coverage by Workers' Compensation Insurance.

HOW TO FILE A CLAIM

1. For dental claims, a dental claim form must be submitted. Complete Parts I and IV of the form and have your dentist complete Parts II, III and V of the dental claim form, then mail the completed form to the address printed on the form.
2. Proof of loss must be submitted to Self-Funded Plans, Inc. within 90 days after the date of loss. Self-Funded Plans, Inc. will accept proof of loss after this time only if you show that it was not reasonably possible to furnish proof within the required time, and proof was furnished as soon as was reasonably possible. Except in the absence of legal capacity, Self-Funded Plans, Inc. will not accept proof of loss more than one year from the time that proof is otherwise required.

HOW TO APPEAL A CLAIM

If your claim is denied in whole or in part, you will receive written notification delivered in the same fashion as reimbursement for a claim. A claim worksheet will be provided by the Plan Supervisor, showing the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for payment of a claim, the Plan Supervisor will request same. If a claim is denied in part or in full, you may appeal the decision. You or your authorized representative may examine pertinent documents (except for information in the file which the Physician does not wish made known to the claimant), and you may send a written letter of appeal outlining your position. The written appeal must be filed with the Plan Supervisor within 60 days after denial is received; however, it is suggested that it be filed promptly whenever possible. Upon receipt of the written appeal, the Plan Supervisor will furnish copies of all relevant documents to the Plan Administrator for review and final decision. A decision will be made within 60 days unless special circumstances require extension, in which

case such decision will be rendered no later than 120 days. A letter will be sent to you which references the pertinent Plan provisions supporting the decision. This decision will be final.

GENERAL INFORMATION

1. **NAME OF PLAN:**
   THE ST. CLAIRSVILLE-RICHLAND CITY SCHOOLS MEDICAL, DENTAL AND PRESCRIPTION DRUG BENEFITS PLAN
2. **NAME & ADDRESS OF PLAN SPONSOR:**
   St. Clairsville-Richland City Schools
   108 Woodrow Avenue
   St. Clairsville OH 43950

   OME-RESA
   Jefferson County Board of Education
   2023 Sunset Boulevard
   Steubenville OH 43952
3. **EFFECTIVE DATE OF PLAN**: January 1, 1994
4. **PLAN SPONSOR IDENTIFICATION NUMBER:** 34-1429524
5. **PLAN NUMBER:** 501
6. **ACCOUNT NUMBER**: 506-448
7. **TYPE OF PLAN:**
   This is a welfare plan providing dental benefits.
8. **TYPE OF ADMINISTRATION:**
   This is a self-insured plan.
9. **NAME, BUSINESS ADDRESS & TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR:**
   St. Clairsville-Richland City Schools
   108 Woodrow Avenue
   St. Clairsville OH 43950
   (740) 695-1624
10. **NAME OF THE DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS & ADDRESS AT WHICH PROCESS MAY BE SERVED ON SUCH AGENT:**
    Same as above
11. **THE SOURCES OF CONTRIBUTION TO THE PLAN:**
    Employees will contribute toward the cost of employee and dependent coverage.
12. **THE DATE OF THE END OF THE YEAR FOR THE PURPOSES OF MAINTAINING THE PLAN'S FISCAL RECORDS:**
    Plan year ending May 31st of each year.
13. **ELIGIBILITY REQUIREMENTS, TERMINATION PROVISIONS & DESCRIPTION OF THE CIRCUMSTANCES WHICH MAY RESULT IN DISQUALIFICATION, INELIGIBILITY, OR DENIAL OR LOSS OF ANY BENEFITS ARE DESCRIBED IN THIS SUMMARY PLAN DESCRIPTION.**
14. **CLAIMS:**
    The procedures to be followed in presenting claims for the benefits under this plan are described in this Summary Plan Description. If you have a claim which has been partially or wholly denied and you wish to question the claims decision, contact your Plan Administrator (named above) who will provide you with the reasons for the decision and the procedure to follow should you wish full review of your claim.
15. **EXAMINATION OF CLAIMANT:**
    The Plan Administrator, at the Plan's expense, shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during the pendency of claim hereunder. If the Plan requires that the Covered Person be examined by a Physician of the Plan's choice, and the Covered Person does not comply with this request, the Plan has the right to deny benefits for the claim in question. The Plan Administrator also has the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.