POINT ARENA SCHOOLS

MEMO

The District will pay up to $200.00 for an office visit which includes one complete eye exam (including eye refraction) per fiscal year (July – June). When the eye examination indicates the need for a correction to insure proper visual health and welfare, the District will now pay for the cost of the initial set of frames and lenses or, contact lenses, up to $500.00. The District will only pay for prescription sunglasses as long as they are within the $500 limit.

You are responsible for paying the provider and purchasing your frames and lenses. The District will reimburse you after you have submitted an itemized bill (also called "Super Bill") for your eye exam, a receipt from where you purchased your corrective wear (lenses, frames, contacts, sunglasses), and have submitted all your paperwork to the District Office for processing.
ddaleuski@pauhs.org.

GROUP VISION PLAN BENEFITS

Benefits of this plan are limited to the following:

DEDUCTIBLE
There will be no deductible to be met on any services or products provided under this plan.

ELIGIBILITY
A. Any individual (1) who is in full-time employment, (2) who received compensation from the Employer in the form of salary wages or commissions, (3) whose regular work week with the Employer is at least 20 hours, and (4) whose duties in such employment are performed at the Employer's usual place of business except salesman and others whose duties are of a kind and nature that require them to be performed away from such usual place of business. The date of eligibility shall be determined on the first day of the month following completion of one (1) month of continuous service in the employ of the Employer.

B. The date of eligibility for Dependent benefits is the latest to occur of the following; a) The effective date of any part of this agreement providing Dependent benefits, b) the date of eligibility of the subscriber, or c) the date the subscriber acquires a dependent. If a husband and wife are both eligible to be subscribers, their children may be eligible and may be enrolled as a dependent of both subscribers. The dependent will be effective with respect to a newborn child as of such child's date of birth, with respect to a minor child who is adopted by the employee as of the date that the child is placed in the custody of the employee for adoption.

C. Dependents are: a) a subscriber's spouse or domestic partner who is not legally separated from the subscriber; or b) a subscriber's unmarried child who is a biological, adopted, or foster child; a stepchild; a legal ward; or a child who is primarily dependent upon the subscriber for support and maintenance, is less than twenty-six (26) years of age, is not covered for benefits as a subscriber, and is not a member of the armed forces.

D. Benefits of an employee shall cease on the first to occur of the following dates: 1) the date the employee enters full time military services; and 2) the date the employee is retired (except a retiree under age 65), pensioned, leaves voluntarily or is dismissed from the employ of the Employer. Dependent benefits shall cease on the date of termination of employee benefits or the dependent ceases to qualify as a dependent.

COVERED SERVICES

A. A physician's prevailing or reasonable fee for the professional services of a physician; or the amount calculated under the applicable fee schedule for the professional services of a physician; or the reasonable charges of a licensed optometrist for one complete eye examination for refractive error in each fiscal year (July-June). Coverage will pay up to $200.00 for an eye examination.

B. When the eye examination indicates the need for a correction to insure proper visual health and welfare, coverage will pay for the cost of the initial set of frames and lenses up to **$**500.00 (***this would include prescription sunglasses***). Thereafter, in each Fiscal Year (July-June) the person will be entitled to one set of lenses required for any correction indicated by eye examination and one set of replacement frames, when the correction is such that a new set of frames is required up to **$**500.00. Contact lenses, if provided at the person's option, will be covered up to the total allowance for frames and lenses specified above.

EXCLUSIONS

A. Services and materials; (a) in connection with special procedures such as orthoptics and visual training, or (b) in connection with medical or surgical treatment.
B. Sunglasses or safety lenses.
C. Eye examinations required by an employer as a condition of employment.
D. Replacement of lenses or frames which have been lost, stolen or broken (unless two (2) contract years have passed).

RECORDS MAINTENANCE AND CONFIDENTIALITY

The District shall maintain adequate records of all transactions between itself, providers, Employer and covered individuals during the period this plan remains in force. The District will keep confidential all information and records it obtains in performing its function under this agreement and to comply with all laws now in effect or which may be hereinafter concerning confidentiality of such information or records to anyone other than specifically authorized persons.

The District will install and maintain internal control systems on claims processing, fraudulent claims, and claim quality review.

PAYMENT/TIME LIMIT FOR SUBMISSION OF CLAIM

The employee is responsible to provide payment to the provider who has rendered care to covered individual and/or their dependents, and for the purchase of their frames and lenses. The District will reimburse the employee after the employee, or the provider has submitted an itemized bill (also called a "super bill") for the eye examination. The District will also reimburse employee after the District has received an original receipt for the purchase of the employee's corrective wear (lenses, frames, contacts).

The District shall deny payment of any claim for services under this plan submitted more than one year after the date services were rendered.

COORDINATION OF BENEFITS

If an Eligible Person is entitled to coverage under more than one group vision program, including this Plan, then the benefits of this Plan shall be calculated so that if this Plan is primary, the Plan benefits will be paid. However, if this Plan is deemed secondary under the rules shown below, benefits will be paid up to the maximum under the Plan, but not to exceed the actual billed amount.

Determination of primary and secondary plans will follow the Department of Insurance COB Birthday Rule. The Birthday Rule stipulates that the plan of the Eligible Person whose birthday (month and day, not year) falls earlier in the calendar year will pay primary, and the plan of the other person covering the Eligible Dependent will be secondary payer.

In cases of dependent children of divorced or separated parents, the rule specifies that the plan of the parent with court-ordered financial responsibility for dependent child is the primary payer. If financial responsibility is not established, the plan of the parent with custody is the primary payer. If one plan has not adopted the Birthday Rule (such as an out of state plan) the rules of the plan without the Birthday Rule will determine which plan is primary.

CLAIMS APPEAL AND COMPLAINT PROCEDURES

The District shall notify each claimant who submits a claim, if such claim is denied, in whole or in part, stating the reason or reasons for the denial. Within sixty (60) days after receipt of such notice a claimant may make a written request for review of such denial, by addressing such request to the Superintendent stating the reason the claimant believes that the denial of the claim was in error and requesting any pertinent documents which the claimant wishes to review. The Superintendent will review the claim.

If the matter cannot be resolved by the Superintendent to the satisfaction of the claimant, it will be referred to the Board of Trustees who will have make the final determination.

A decision on a request for review shall be provided and communicated to the claimant in writing as soon as possible after a final decision is determined.

RETIREES

Vision coverage for retirees shall cease when the retiree becomes eligible for Medicare.

Dependents
The dependent of a retiree who is Medicare eligible shall be eligible to continue with the Vision Plan consistent with the benefits required under COBRA (Up to 36 months).

CONTINUATION OF GROUP COVERAGE

A. In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), a Person will be entitled to continue group coverage under this contract if he/she would lose coverage otherwise because of a Qualifying Event that occurs while the Contract holder is subject to the continuation of group coverage provisions of COBRA. The benefits under the group continuation coverage will be identical to the benefits that would be provided to the Person if the Qualifying Event had not occurred.

Qualifying Event

Qualifying Event is defined as any one of the following occurrences.

(1) With respect to the subscriber:
   a. the termination of employment (other than by reason of such Subscriber's gross misconduct); or
   b. the reduction of hours of employment to less than the number of hours required for eligibility

(2) With respect to the Dependent spouse and Dependent children:
   a. the death of the Subscriber; or
   b. the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or

c. the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
d. the divorce or legal separation of the Subscriber from the Dependent spouse; or the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
e. Dependent child's loss of Dependent status under this plan

(3) With respect to any of the above, such other Qualifying Event as may be added to Title X of C

Notification of Qualifying Event
The Member is responsible for notifying the Employer of divorce, legal separation, or a child's loss of Dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 days, provide written notice to the Member by
first class mail of the Member's right to continue group coverage under this Plan. The Member must then notify the COBRA administrator within 60 days of the later of (1) the date of the notice of the Member's right to continue group coverage or (2) the date coverage terminates due to the Qualifying Event.

If the Member does not notify the COBRA administrator within 60 days, the Member's coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

Duration And Extension Of Continuation Of Group Coverage.
In no event will continuation of group coverage under COBRA be extended for more than 18 or 36 months, depending on the Qualifying Event, from the date the Qualifying Event has occurred which originally entitled the Member to continue group coverage under this Plan.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Participant elects to enroll.

Effective Date of the Continuation of Coverage
The continuation of coverage will begin on the date the Member's coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as dues are timely paid.