JEFFERSON FEDERATION OF TEACHERS
HEALTH AND WELFARE FUND

SUMMARY PLAN DOCUMENT

EFFECTIVE JANUARY 1, 2016

FOR FURTHER INFORMATION
OR CLAIM FORMS
CALL, WRITE OR EMAIL:

JEFFERSON FEDERATION OF TEACHERS
HEALTH AND WELFARE FUND
2540 SEVERN AVENUE, SUITE 302
METAIRIE, LA 70002
Phone: 504-455-7261
Fax: 504-455-7267
Website: www.jfthw.org

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The Segal Company

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JEFFERSON FEDERATION OF TEACHERS
HEALTH AND WELFARE FUND

TO ALL ELIGIBLE PARTICIPANTS:

The Board of Trustees for the Jefferson Federation of Teachers Health and Welfare Fund is pleased to provide you with this booklet. The benefits consist of dental and vision insurance for all eligible Employees and Retirees of the Jefferson Parish Public School System, and are described in detail in the pages that follow and in the certificates of coverage and/or certificates of insurance issued by Guardian Insurance and Davis Vision.

There is no premium cost to eligible Employees; however, you must enroll in order to be eligible for coverage. If you wish to cover your Dependents, you will be charged a monthly premium for their coverage. Eligible Retirees must self-pay the monthly premium for themselves and their enrolled Dependents.

Here are some important tips on using your dental and vision insurance:

- You have access to a network of preferred dental and vision providers. Preferred providers give you a discount off their usual cost of services. Using preferred providers may result in a substantial savings to you.

- Because preferred providers (called In-Network Providers) are added to or removed from the network each month, it is wise to check with the provider to see if they are still participating in the network before you schedule an appointment.

- Notify the Fund Office of any address changes to ensure that you receive updated information. Inform the Fund Office of any changes in the status of your Eligible Dependents (for example, marriage, divorce, child reaches the age of 26 years).

- Important and helpful contact information is listed on the Quick Reference Chart located on the next page of this document.

We urge you to read this booklet carefully so as to familiarize yourself with the dental and vision insurance. Please keep the booklet in a convenient place for easy reference, along with the certificates of coverage. Your calls are always welcome at the Fund Office.

Sincerely,

Joe A. Potts, Jr., Chairman
Board of Trustees

QUICK REFERENCE CHART

Jefferson Federation of Teachers Health and Welfare Fund

Information Needed	Contact Information
Fund Office: • How to file dental and vision claims • Eligibility for benefits • Insurance information • COBRA information and premium payments • Extended Retiree coverage information and premium payments • To request a hard copy of this document or the Guardian certificate of coverage for dental insurance	**Jefferson Federation of Teachers Health & Welfare Fund:** 2540 Severn Avenue, Suite 302 Metairie, LA 70002 Phone: (504) 455-7261 Fax: (504) 455-7267 www.jfthw.org
Jefferson Parish School Board Insurance Office: • Open enrollment questions • Eligibility for benefits • Questions regarding payroll deductions • To request a hard copy of this document or the Guardian certificate of coverage for dental insurance	**Jefferson Parish School Board Administrative Office:** 501 Manhattan Blvd Harvey, Louisiana 70058 Phone: (504) 349-7600 www.jpschools.org
Dental Insurance: • Dental insurance ID cards • Dental network provider directory • Additions/deletions of network providers • Dental claims • Dental appeals	**Guardian Life Insurance of North America:** 7 Hanover Square New York, NY 10004 Or visit their website www.guardiananytime.com (you must register to access certain information) Phone: 1-800-541-7846
Vision Insurance: • Vision insurance ID cards • Vision network provider directory • Vision collection provider directory • Additions/deletions of network providers • Vision claims • Vision appeals	**Davis Vision:** 175 E. Houston Street San Antonio, TX 78205 Or visit their website www.davisvision.com (you must register to access certain information) Phone: 1-800-999-5431

DISCLAIMER – Full details of the coverage are provided in the Guardian and Davis Vision certificates and/or policies of insurance. If there is any discrepancy between the wording in this document and the certificates of coverage/insurance, the language in the certificates will govern. Although the Board of Trustees of the Jefferson Federation of Teachers Health and Welfare Fund and the Jefferson Parish School Board expect to continue dental and vision insurance for actives and retirees indefinitely, they reserve the right to change, modify or terminate these benefits in the future. Participation in these insurances does not create a contract between you, the Fund, and/or the JPSB.

ARTICLE I - DENTAL INSURANCE

SECTION 1 - GUARDIAN SCHEDULE OF BENEFITS

Your Dental Benefits	**PPO**	
Your Network Is	**DentalGuard Preferred**	
Calendar Year Deductible	**In-Network**	**Out- of-Network**
Per Individual Member	$50	$50
Charges covered for you (co-insurance)	**In-Network**	**Out-of-Network**
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$1,500	$1,500

A Covered Person may be eligible for a Rollover of a portion of his/her unused Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and II Services" in your certificate of coverage for details.

Lifetime Orthodontia Maximum	$1,000
Dependent Age Limit	26

Penalty for Late Entrants:

During the first 12 months that a late entrant is covered for dental insurance, Guardian will not pay for the following services: All Group II, Group III and Group IV Services.

Charges for the services Guardian does not cover under this provision are not considered to be covered charges, and therefore cannot be used to meet the dental insurance deductible.

Guardian does not apply a late entrant penalty to covered charges incurred for services needed solely due to an injury suffered by a Covered Person while insured by the dental insurance.

A late entrant is a person who: (a) becomes covered by this dental insurance more than 31 days after he/she is eligible; or (b) becomes covered again, after his/ her coverage lapsed because he/ she did not make required payments.

SECTION 2 - **DENTAL INSURANCE**

Dental benefits are fully insured and underwritten by the **Guardian Life Insurance Company of America**. The provisions governing eligibility, covered procedures, exclusions and defined terms, as well as COBRA continuation coverage, extended self-pay and claims procedures and appeals can be found in the **Guardian Life Insurance Company of North America's** certificate of coverage.

ARTICLE II – VISION INSURANCE

SECTION 1 - DAVIS VISION SCHEDULE OF BENEFITS

Benefit	In-Network		Out-of-Network	Benefit Frequency
	Visionworks	All Other Network Providers		
VISION EXAMINATION				
Comprehensive Eye Examination	$25 Co-Payment	$25 Co-Payment	Up to $32 Reimbursement	For each Covered Person Once every calendar year
Contact Lenses Evaluation, Fitting and Follow-Up In lieu of eyeglasses lenses				For each Covered Person Once every calendar year
EYEGLASSES				
Standard - Collection	Not Available	$25 Co-Payment	Not Covered	
Standard - Non-Collection	15% Discount	15% Discount	Not Covered	
Specialty - Non-Collection	15% Discount	15% Discount	Not Covered	
LOW VISION				
Comprehensive Evaluation	$300 Allowance per Evaluation	$300 Allowance per Evaluation	$300 Allowance per Evaluation	Once every 60 months for each Covered Person
Follow-up Visit	$100 Allowance per Follow-up Visit	$100 Allowance per Follow-up Visit	$100 Allowance per Follow-up Visit	Four visits every 60 months for each Covered Person
VISION MATERIALS				
Spectacle Lenses - per pair				For each Covered Person Once every calendar year
Single Vision	$25 Co-Payment	$25 Co-Payment	Up to $32 Reimbursement	
Bifocal	$25 Co-Payment	$25 Co-Payment	Up to $48 Reimbursement	
Trifocal	$25 Co-Payment	$25 Co-Payment	Up to $64 Reimbursement	
Lenticular	$25 Co-Payment	$25 Co-Payment	Up to $80 Reimbursement	

DAVIS VISION
SCHEDULE OF BENEFITS

Benefit	In-Network: Visionworks	In-Network: All Other Network Providers	Out-of-Network	Benefit Frequency
Frames				For each Covered Person Once every calendar year
Collection				
Fashion	Not Available	Included	Not Covered	
Designer	Not Available	Included	Not Covered	
Premier	Not Available	Included	Not Covered	
Non-Collection	$100 Allowance Additional discount of 20% on any overage	$50 Allowance Additional discount of 20% on any overage	Up to $50 Reimbursement	
Contact Lenses-- (only one option available per benefit frequency) In lieu of eyeglasses				For each Covered Person Once every calendar year
Collection Planned Replacement Disposable	Not Available	2 boxes 4 boxes	Not Covered	
Non-Collection	$115 Allowance Additional discount of 15% on any overage	$115 Allowance Additional discount of 15% on any overage	Up to $92 Reimbursement	
Visually Required Contact Lenses - with prior approval	Included	Included	Up to $225 Reimbursement	

DAVIS VISION
SCHEDULE OF BENEFITS

Benefit	In-Network		Out-of-Network	Benefit Frequency
	Visionworks	All Other Network Providers		
Lens Options - per pair				For each Covered Person Once every calendar year
Oversize Lenses	Included	Included	Not Covered	
Cataract Lenses	Included	Included	Not Covered	
Tint Solid or Gradient	Included	Included	Not Covered	
Ultraviolet (UV) Coating	$12 Co-Payment	$12 Co-Payment	Not Covered	
Scratch Resistant Coating	Included	Included	Not Covered	
Scratch Protection Plan (single vision)	$20 Co-Payment	$20 Co-Payment	Not Covered	
Scratch Protection Plan (multifocal)	$40 Co-Payment	$40 Co-Payment	Not Covered	
Polycarbonate Lenses	$30 Co-Payment	$30 Co-Payment	Not Covered	
Polycarbonate Lenses (For covered children, monocular patients, patients with prescriptions = -- +1-6.00 diopters)	Included	Included	Not Covered	
Standard Progressive Lenses (add on to Bifocal)	Included	Included	Not Covered	
Premium Progressive Lenses (add on to Bifocal)	Included	Included	Not Covered	
Ultra Progressive Lenses (add on to Bifocal)	$50 Co-Payment	$50 Co-Payment	Not Covered	
Plastic Photosensitive Lenses	$65 Co-Payment	$65 Co-Payment	Not Covered	
Polarized Lenses	$75 Co-Payment	$75 Co-Payment	Not Covered	
Standard Anti-Reflective (AR) Coating	$35 Co-Payment	$35 Co-Payment	Not Covered	
Premium Anti-Reflective (AR) Coating	$48 Co-Payment	$48 Co-Payment	Not Covered	
Ultra Anti-Reflective (AR) Coating	$60 Co-Payment	$60 Co-Payment	Not Covered	
High-Index Lenses	$55 Co-Payment	$55 Co-Payment	Not Covered	

DAVIS VISION
SCHEDULE OF BENEFITS

Benefit	In-Network		Out-of-Network	Benefit Frequency
	Visionworks	**All Other Network Providers**		
Low Vision Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	$600 Maximum Allowance per Aid $1,200 Lifetime Maximum Allowance for all Aids	
Laser Vision Correction Surgery				
Discount	Up to 25% or receive an additional 5% discount on any advertised specials	Up to 25% or receive an additional 5% discount on any advertised specials	Not Covered	

SECTION 2 - VISION INSURANCE

The vision benefits provided are fully insured and underwritten by HM Life Insurance Company, and offered by Davis Vision. Your vision benefits are described in the following section.

A. SCOPE OF VISION BENEFITS COVERAGE

The vision benefits available as described in this Section are designed to offset the expenses incurred by you and your covered Dependents for vision acuity examinations and prescribed eyewear.

You will not be paid a separate benefit, charged an additional Co-payment or incur any additional cost for any item listed as “Included” or “Included -- no Co-payment” in the Schedule of Benefits.

Vision benefits are payable only for eligible vision charges and are subject to the limitations described in this Section and the Schedule of Benefits.

B. ELIGIBLE VISION BENEFITS

1. Davis Vision Collection

In lieu of the frame Allowance, Covered Persons may choose to select any frame from the Davis Vision Collection. The Collection is available at most participating independent Provider offices and features three levels of frames.

In lieu of the non-Collection contact lens Allowance, you may be fitted with contact lenses from the Davis Vision Collection. Contact lenses from the Davis Vision Collection include the evaluation, fitting and follow-up care.

2. Examination

An exam or eye examination includes (but is not limited to):

- Case history -- chief complaint, eye and vision history, medical history
- Entrance distance acuities
- External ocular evaluation including slit lamp examination
- Internal ocular examination
- Tonometry
- Distance refraction -- objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields

- Assessment and plan
- Advising on matters pertaining to vision care
- Form completion -- school, motor vehicle, etc.
- Dilated Fundus Examination (DFE) (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systemic diseases) when professionally indicated.

3. Visually Required Contact Lenses

Visually Required contact lenses will only be covered when the treating Provider has determined that a Covered Person has a "chronic visual disturbance." For the purposes of this Section, chronic visual disturbance means a physiologic change in a Covered Person's vision either innate or acquired that inhibits the Covered Person's ability to achieve functional vision with spectacles such that a Visually Required contact lens is required to achieve the minimum functional vision needed to carry out normal daily activities. Chronic visual disturbance may include the following conditions: Keratoconus, Myopia, progressive or malignant, Hyperopia, Anisometropia, Aniseikonia, Aphakia, Aniridia or Irregular Astigmatism.

Visually Required contact lenses are available only if the treating Provider sends a completed request and supporting documentation showing a diagnosis of one of the foregoing conditions to Davis Vision before the lenses are initially ordered. The Visually Required contact lenses are subject to the maximum benefit Allowance per Frequency period. The Covered Person's benefit is paid in full up to the maximum Allowance during each Frequency period. Any amount due over the Allowance for such lenses during the Frequency period is the Covered Person's responsibility. Visually Required contact lenses are subject to prior approval. If advance approval for the initial Visually Required contact lenses is not obtained, the standard contact lens benefit may be applied if available. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Contact lens evaluation, fitting and follow-up care applies to standard daily wear, disposable, planned replacement, specialty and the Visually Necessary contact lens benefit.

4. Low Vision Program

Low vision is a significant loss of vision, but not total blindness. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the Covered Person's remaining useable vision.

A comprehensive low vision evaluation is performed in addition to an eye examination when the eye examination indicates a need for such an evaluation. This supplemental evaluation includes a history of functional difficulties that involves daily activities. The result of this evaluation may include prescription of various treatments options, including low vision aids, as well as assist the Covered Person with identifying other resources for vision and lifestyle rehabilitation.

The Low Vision Program is available both In and Out of Network and is subject to prior approval. A completed request must be sent to Davis Vision prior to the initial evaluation. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and follow-up visits up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. Any amount due over the Allowance above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids and the entire charge for such services or supplies will be the Covered Person's responsibility. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

5. Laser Correction Surgery

Laser vision correction is a surgical procedure to correct vision problems such as nearsightedness, farsightedness and astigmatism. Such procedures include Laser Epithelial Keratomileusis (LASEK), Laser in Situ Keratomileusis (LASIK), and Photorefractive Keratectomy (PRK).

Approval must be obtained prior to surgery. A completed request must be sent to Davis Vision prior to the initial evaluation. If the required approval is not obtained, the entire charge for the services will be the Covered Person’s responsibility.

Surgery must be performed within six months of the preoperative examination. If a Covered Person does not obtain the surgery within this time period, another pre-operative examination is necessary at the cost of the Covered Person.

6. Mail Order Replacement Contact Lens Program

Davis Vision’s mail order contact lens replacement service is powered by ABB Optical Group. By accessing www.davisvisioncontacts.com, you can easily order replacement contact lenses at a discount and have them shipped directly to your doorstep.

7. Eyeglass Warranty

Davis Vision provides a breakage warranty to repair or replace any Collection frame and/or lens(es) for a period of one year from the date of delivery. This warranty applies to eyeglasses (spectacle lenses, frames from the Davis Vision Collection and frames obtained from a national retail chain that is part of Davis Vision's Provider Network where the Davis Vision Collection is not displayed).

8. Costco

At Costco locations, a Covered Person will receive the full Allowance toward the location’s everyday low pricing. No additional discounts are available at Costco locations.

C. VISION BENEFIT EXCLUSIONS

Benefits will not be paid for, and the term “Covered Expenses” will not include the following:

1. Any Covered Expense not shown in the Schedule of Benefits or any expenses shown as “Not Available” or “Not Covered” in the Schedule of Benefits.

2. Eye examinations required by an Employer as a condition of employment.

3. Services or materials provided in connection with special procedures such as orthoptics and visual training (including but not limited to “Corneal Refractive Therapy” (CRT), or “orthokeratology”), or in connection with medical or surgical treatment (including laser vision correction) except as provided herein.

4. Materials which do not provide vision correction, except as provided herein.

5. Charges for the replacement of lost or stolen lenses or frames within the applicable Benefit Frequency period in the Schedule of Benefits.

6. Sickness or injury covered by a workers' compensation act or other similar legislation.

7. Charges incurred as a direct or indirect result or war (declared or undeclared).

8. Charges incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.

9. Services or supplies furnished to a Covered Person before the effective date of his/her Insurance under the Policy or after the date a Covered Person’s Insurance ends.

10. Any treatment rendered outside the United States or Canada.

11. Services rendered by practitioners who do not meet the definition of Provider.

12. Expenses covered by any other group insurance.

13. Expenses covered by a health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.

14. Any expenses covered by any union welfare plan or governmental program or a plan required by law.

15. Comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis Vision or its authorized representative.

16. Visually required contact lenses prescribed for a Covered Person for which prior approval was not obtained from Davis Vision or its authorized representative.

17. Laser vision correction for which prior approval was not obtained from Davis Vision or its authorized representative.

18. Refraction-only claims.

19. Glass Grey #3 sunglass lenses.

20. Glass lenses.

21. Blended segment lenses.

22. Intermediate vision lenses.

23. Photochromic glass lenses.

D. NETWORK PROVIDERS DO MAKE A DIFFERENCE

A Covered Person may use the Provider of his/her choice. There are two types of Providers - those that are part of the Network (In-Network Providers) and those that are not part of the Network (Out-of-Network Providers). The payment of benefits varies depending on the type of Provider chosen.

1. In-Network Providers

A Covered Person must contact an In-Network Provider before receiving services for a Covered Expense. The In-Network Provider will verify your eligibility for Covered Expenses with the Fund Office before the examination takes place. The Provider will submit all claims directly to Davis Vision.

When services or Materials are received from a Provider who is part of the Network, you are responsible for:

a) The Co-payment, if a cash payment is due the Provider; or

b) If an Allowance is provided - the difference between the Allowance and the Allowable Charge. Davis Vision will pay the dollar amount of the Allowance or

the Allowable Charge, if less. If the Allowable Charge is less than the Allowance, an In-Network Provider may bill you for the difference. Most In-Network Providers will offer an additional Discount to help with any overage; or

c) If only a Discount is provided - the difference between the Discount and the Allowable Charge. If the Allowable Charge is less than the Discount, Davis Vision will pay the Allowable Charge. If the Allowable Charge is less than the Discounted cost, an In-Network Provider may bill you for the difference.

2. Out-of-Network Providers

If you use an Out-of-Network Provider, you must first pay the billed charge and then submit your claim to Davis Vision for reimbursement.

Benefits for services or Materials received from a Provider outside of the Network are shown in terms of the dollar amount Davis Vision will pay you for that service or Material. If you use an Out-of-Network Provider, your total responsibility is the difference between the Reimbursement and the Provider's Actual Charge – Davis Vision will pay the dollar amount of the Reimbursement for that service or Material or the Provider's Actual Charge, if less. An Out-of-Network Provider may bill you for the difference.

SECTION 3 - DEFINITIONS

The following terms, whenever used in Article II, Vision Insurance, in this booklet as capitalized terms, will have the meanings set forth below.

A. **"Allowable Charge"** means the amount negotiated between an In-Network Provider and Davis Vision or its authorized representative as full payment for a Covered Expense shown in the Schedule of Benefits received or purchased by a Covered Person.

B. "**Allowance**" means a flat dollar amount payable under the vision insurance policy towards a Covered Expense from an In-Network Provider. Allowances are shown in the Schedule of Benefits. If the Provider's charge is less than the Allowance, Davis Vision will only pay up to the Provider's charge.

C. "**Class of Coverage**" means the types of coverages in which an Employee may enroll eligible dependent(s) in the vision insurance. The types are: spouse only, child or children only, and family.

D. "**COBRA**" means the continuation of coverage provisions added to the Public Health Service Act by the Consolidated Omnibus Budget Reconciliation Act of 1985.

E. "**Collection" or "Davis Vision Collection"** means Davis Vision's frame or contact lens collection shown in the Schedule of Benefits.

F. "**Co-Payment**" means the amount a Covered Person is required to pay to the Provider prior to an eye examination or towards the cost of Materials. The Co-Payments are shown in the Schedule of Benefits.

G. "**Covered Expense**" means the benefits listed in the Schedule of Benefits.

H. "**Covered Person**" refers to enrolled Employees, Retirees and their Dependents.

I. "**Dependent**" means:

1. An eligible Employee or Retiree's spouse (this does not include a former spouse who is legally separated, as applicable, or divorced from the Employee or Retiree);

2. Each child less than 26 years of age, for whom the Employee or Retiree or his/her spouse, is legally responsible, including:

   (a) Natural born children;
   (b) Adopted children, eligible from the date of placement for adoption;
   (c) Children covered under a Qualified Medical Child Support Order as defined by applicable federal and state laws.
   (d) Any child, if such children are in the legal custody of and residing with the Employee;

3. Each unmarried child age 26 or older with a mental or physical handicap, or developmental disability, who cannot support himself/herself, provided, the child remains unmarried and unable to support himself/herself.

   The child's developmental disability or physical handicap must have begun before the child reached the limiting age in order for his/her coverage to be continued. Proof of the child's disability must be furnished to the Fund Office within 31 days after coverage would otherwise terminate, and the insurance will continue for as long as your insurance coverage remains in effect and the child remains incapacitated. Additional proof may be required from time to time, but not more often than once a year.

4. An individual who is eligible as an Employee or Retiree cannot also be eligible as a Dependent.

5. For eligible Retirees, Dependent means the eligible Retiree's spouse or child as defined herein, provided the Dependent was covered for vision insurance on the Retiree's date of retirement.

J. **"Discount"** means the percentage that an In-Network Provider has agreed to reduce his/her charge by for the requested service, Materials or procedure. Discounts are shown in the Schedule of Benefits. Discounted vision services, Materials, supplies and treatments described in the Schedule of Benefits are not underwritten by Davis Vision.

K. "**Eligibility Date**" means the date you become eligible for vision insurance. It is the first day of the calendar month following your Waiting Period.

L. "**Employee**" means a full-time Employee of the Jefferson Parish School Board, and a regular full-time Employee of the Union or the Fund. For purposes of this insurance coverage only, "full-time" means the individual normally works a minimum of 20 hours per week. "Regular" means the individual's employment is permanent and consistent, rather than temporary or irregular. Employee shall also mean a duly elected member of the Jefferson Parish School Board, currently serving his/her term in office.

M. "**Employer**" means the School Board, the Union or the Fund.

N. "**Family and Medical Leave**" or "**FMLA Leave**" means a leave of absence, intermittent leave or leave on a reduced schedule for up to 12 work weeks in a 12-month period that is determined by the School Board to qualify under the Family and Medical Leave Act of 1993, in accordance with its FMLA policies and administrative procedures.

O. **"Frequency"** means the time period shown in the Schedule of Benefits during which you are eligible for the Covered Expenses shown in the Schedule of Benefits.

P. "**Fund**" or "**Trust Fund**" means the Jefferson Federation of Teachers Health and Welfare Fund and Trust.

Q. "**Grace Period**" is the thirty (30) calendar days following the commencement of a leave of absence without pay.

R. "**In-Network Provider**" means a Provider who has entered into a contract with Davis Vision or its authorized representative to provide eye examinations and/or Materials on an Allowable Charge basis. These Providers are part of Davis Vision's or its authorized representatives' network and will not bill you for more than:

1. The Co-Payment; or

2. Any difference between the Allowance and the amount he/she agreed to as total reimbursement (the Allowable Charge).

S. "**Leave Of Absence Without Pay**" is any leave from the Jefferson Parish Public School System ("JPPSS") which an Employee may take, during which he/she does not receive monetary compensation from either the JPPSS or its workers compensation carrier. Such leaves may include, but are not limited to, Alternative Maternity/Adoptive/Child Rearing/Leave of Absence Without Pay, Jury Duty/Court Appearance, Special Leave Without Pay, Public Service Leave, and Leaves for Federation Service.

T. **"Materials"** means frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Davis Vision policy of insurance.

U. "**Open Enrollment**" is the period of time designated by the Jefferson Parish Public School System, generally occurring in the fall of each year during which you may elect to enroll in dental and/or vision insurance.

V. "**Out-of-Network Provider**" means Providers of optometric services who have not entered into a contract with Davis Vision or its authorized representative to provide vision care services. An Out-of-Network Provider may bill you for the difference between the Reimbursement and his/her total charge (the Provider's Actual Charge).

W. "**Participant**" means any eligible current or former Employee or Dependent who is covered under the vision insurance.

X. "**Provider**" means a practitioner who is a legally qualified professional providing eye examination, refractive and/or post-refractive services and surgery within the scope of his/her license. This term includes an ophthalmologist, an optometrist, an optician or a surgeon recognized as such in accordance it the laws of the State in which the services are provided. There are two types of providers: In-Network Providers and Out-of-Network Providers.

Y. **"Provider's Actual Charge"** means the total amount charged by a Provider for a Covered Expense.

Z. "**Retiree**" means a former Employee who is covered under the vision insurance and who, upon retirement, immediately received retirement benefits from a Louisiana State Retirement System.

AA. "**School Board**" means the Jefferson Parish School Board.

BB. "**Self-Payment**" means contributions to the Fund by a Participant to pay for continued vision coverage under COBRA or the extended self-provisions herein for his/her or eligible Dependent(s), if applicable.

The amount of self-payment is determined annually by the Board of Trustees. Contact the Fund Office for the current self-payment amount.

CC. "**Trust Agreement**" means the agreement by which the Fund was established on May 9, 1983, and amended from time to time.

DD. "**Union**" means the Jefferson Federation of Teachers, Local 1559, AFT/LFT/AFL-CIO.

EE. **"Visually Required"** means a service, supply or treatment which is:

1. Ordered by a Provider;

2. Required for treatment of management of a medical condition or symptom;

3. Provided in accordance with approved and generally accepted medical and surgical practice.

FF. "**Waiting Period**" means the period beginning on the first day of your full-time employment or re-employment and ends on the last day of the calendar month after you have been employed full-time for 30 days.

SECTION 4 - ELIGIBILITY FOR VISION INSURANCE

A. EMPLOYEE ELIGIBILITY

1. New Employees. ***You must enroll for coverage during your Waiting Period in order to become eligible for vision insurance.*** The Waiting Period is the 30-day period beginning with your first day of full time employment with the Jefferson Parish School Board. If you enroll during your Waiting Period, once you satisfy the Waiting Period, you will become covered under the vision insurance on the first day of the calendar month following the Waiting Period (your "Eligibility Date"). If you do not enroll during your Waiting Period, you must wait until the next Open Enrollment to enroll.

2. Open Enrollment. If you enroll for coverage during Open Enrollment, you will be covered for vision insurance on January 1 following the date of your enrollment.

3. **Reinstatement of Eligibility.** If you terminate your employment but are re-employed, you can again become eligible for vision insurance on the first day of the calendar month after you satisfy a new Waiting Period.

4. **No Cost Employee Coverage.** The vision insurance is provided to you as an Employee without cost, as your coverage is funded by Employer contributions made to the Fund on your behalf.

B. DEPENDENT ELIGIBILITY

1. **Enrolling Dependents of New Employees.** You may enroll your Dependents for vision insurance during your Waiting Period. In order to enroll your Dependents, you must submit a completed enrollment form to the Fund Office and pay for the elected Class of Coverage. **If you enroll your Dependents before the end of your Waiting Period, they will also become covered on your Eligibility Date.** ***You may not enroll your Dependents for vision coverage after your Eligibility Date until the next Open Enrollment.***

2. **Enrolling Dependents during Open Enrollment.** In order to enroll your Dependents during Open Enrollment, you must complete the enrollment process for your Dependents and pay for the elected Class of Coverage.

3. **Newly Acquired Dependents.** If you acquire a new eligible Dependent by way of a life event (i.e., marriage, birth/adoption of a child), you must enroll the new eligible Dependent(s) within thirty one (31) days of the addition of such Dependent(s). Once timely enrolled, such Dependents shall become eligible for benefits on the date you acquired the new Dependent(s). Payroll Deductions for the Class of Coverage shall begin with the next regular paycheck following the date of enrollment.

4. **Paying For Dependent Coverage.** If you choose to enroll a Dependent for vision insurance, the cost will be deducted from your paycheck, beginning with the first paycheck issued after your Dependent's coverage begins.

If you do not timely enroll your newly acquired Dependent(s), you may not enroll them for vision insurance until next Open Enrollment.

C. FAMILY AND MEDICAL LEAVE ("FMLA Leave")

Generally, FMLA Leave is leave that is taken under certain circumstances that are critical to your family such as the birth of a child, the placement of a child with you for adoption or foster care, when you are needed to care for a child, a spouse or a parent with a serious health condition or when you are unable to perform your duties because of a serious health condition (see also the

definition of “FMLA Leave” under the Definitions). If you take FMLA Leave, your Employee only vision insurance will continue without cost; however, if you want to continue your Dependent’s coverage, you must continue to make contributions in the amount you were previously submitting for the Dependent coverage. The Administrative Manager will inform you of your rights if you should go on FMLA Leave.

D. QUALIFIED MILITARY SERVICE LEAVE

The federal law known as the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), provides you with certain rights to continue your coverage, including on a Self-Payment basis, in the event you take a leave of absence because of qualified military service. “Qualified military service” generally means voluntary or involuntary active duty, active duty training, inactive duty training or annual training in the United States Armed Forces or their reserve components or the National Guard. It is important that you contact the Administrative Manager as soon as possible after you learn that you will be leaving employment because of military service in order to determine your rights and obligations.

E. TERMINATION OF EMPLOYEE COVERAGE

Employee coverage will terminate on the earliest of the following to occur:

1. The date your status as an Employee ends because of death or termination of employment for any reason;

2. The date you go on a Leave of Absence Without Pay;

3. The first day of the month for which a required Self-Payment or contribution is not timely made to continue coverage;

4. The date the insurance policy is amended to terminate eligibility for the Employee class to which you belong;

5. The date the Fund terminates; or

6. The date the policy of insurance that insures your vision benefits terminates.

Upon termination of coverage, you and your Dependents can elect to continue coverage on a Self-Payment basis to the extent required under COBRA. The Administrative Manager will inform you of your rights at the time coverage terminates.

F. TERMINATION OF DEPENDENT COVERAGE

Your Dependent’s coverage will terminate on the earliest of the following to occur:

1. The date your Dependent no longer qualifies as a Dependent;

2. The date your coverage as an Employee terminates;

3. The first day of the month for which you fail to timely pay any contribution required to maintain your Dependent's coverage;

4. The date the Plan is amended to terminate coverage for all Dependents or for a classification of Dependents to which your Dependent belongs;

5. The date the Plan terminates; or

6. The date the policy of insurance terminates, or the Dependent's insurance portion of the Policy terminates.

Upon termination of your Dependent's coverage, your Dependent can elect to continue coverage on a Self-Payment basis to the extent required under COBRA. The Administrative Manager will inform your Dependent of his/her rights at the time his/her coverage terminates.

G. NOTIFICATION REQUIREMENTS

You must notify the Fund Office in the event your Dependent no longer qualifies as a Dependent for any reason, or when there is any error involving Dependent coverage, such as an error in Class of Coverage or in the amount being deducted from your paycheck to pay for Dependent coverage. For example, if you divorce your spouse, or your child turns 26, they would no longer be eligible for vision insurance. There is a maximum time period of ninety (90) days for any retroactive adjustment. Premiums are due through the end of the month in which the Fund Office receives written notification of the change.

SECTION 5 - SELF-PAY CONTINUATION COVERAGE (COBRA)

A. THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")

"COBRA" is a federal law that requires the Fund to offer you and other members of your family the option to continue your vision insurance[1] coverage, when it would otherwise end due to certain life events known as "qualifying events." This temporary continuation of health coverage required under COBRA is referred to as COBRA coverage.

The qualifying events are described below. After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is any Employee or Dependent spouse or child who will lose vision insurance coverage because of a qualifying

[1] Please refer to Guardian's Certificate of Insurance for information regarding your COBRA continuation of coverage rights for your dental insurance.

event, as well as any Dependent child who is born to or placed for adoption with a covered Employee during the period he/she is self-paying for COBRA coverage. Qualified beneficiaries who elect COBRA coverage must pay for it.

If a qualified beneficiary who is self-paying for COBRA coverage acquires a Dependent spouse or child who could be enrolled in vision insurance if the qualified beneficiary was an active Employee, the qualified beneficiary may add the Dependent to his/her coverage for the remainder of the COBRA coverage period.

In addition, if a qualified beneficiary with COBRA coverage has a Dependent (a) who is eligible but did not enroll in vision insurance at the time of the qualified beneficiary's initial enrollment because the Dependent had other coverage at that time, and (b) who lost the other coverage due to exhaustion of COBRA, loss of eligibility or termination of employer contributions (but not due to failure to pay timely a required premium or termination of coverage for cause), the qualified beneficiary may add that Dependent to his/her coverage, for the remainder of the COBRA period, within 30 days after termination of the Dependent's other coverage.

Please read this Section carefully, as it explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. For additional information about your rights and obligations under federal law, you should contact the Administrative Manager for the Fund, who administers COBRA coverage. The Administrative Manager can be reached at the following address and telephone number:

Administrative Manager
Jefferson Federation of Teachers Health and Welfare Fund
2540 Severn Avenue, Suite 302
Metairie, LA 70002
Phone (504) 455-7261 Fax (504) 455-7267

Whenever written notice is required to be given to the Administrative Manager under this Section, it will be effective only when mailed or hand delivered to the address listed above.

B. QUALIFYING EVENTS THAT TRIGGER THE RIGHT TO ELECT COBRA COVERAGE

If you are an Employee, you will become a qualified beneficiary if you lose your vision coverage because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

If you are a covered Dependent spouse of an Employee, you will become a qualified beneficiary if you lose your vision coverage because any of the following qualifying events happens:

1. The Employee dies;

2. The Employee's hours of employment are reduced;

3. The Employee's employment ends for any reason other than his/her gross misconduct;

4. The divorce or legal separation (if applicable) of you and the Employee.

If you are a covered Dependent child of an Employee, you will become a qualified beneficiary if you lose vision coverage because any of the following qualifying events happens:

1. The Employee dies;

2. The Employee's hours of employment are reduced;

3. The Employee's employment ends for any reason other than his/her gross misconduct;

4. You cease being eligible for coverage as a "Dependent child."

C. NOTICE REQUIREMENTS

COBRA coverage is offered to qualified beneficiaries only after the Administrative Manager has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment or death of the Employee, the Administrative Manager will notify you and your Dependents of your COBRA rights.

For the other qualifying events (divorce or legal separation, if applicable, of the Employee and Dependent spouse or a Dependent child ceasing to be eligible for coverage as a Dependent child), you must notify the Administrative Manager in writing, and for a divorce or legal separation provide a copy of the divorce or legal separation, within sixty (60) days after the qualifying event occurs. This notice must be mailed or hand delivered to the Administrative Manager at the address set forth in Section 1. If the Administrative Manager does not receive written notice of the qualifying event within this time period, the qualified beneficiary(ies) with respect to such event will not be eligible for COBRA coverage.

D. HOW TO ELECT COBRA COVERAGE

Once the Administrative Manager has been timely notified that a qualifying event has occurred, it will furnish the qualified beneficiary(ies) specific information on when and how to elect COBRA coverage, including the cost. Notice given to an Employee or Dependent spouse will be treated as notice to all affected Dependent children living with the Employee or Dependent spouse.

Each qualified beneficiary has 60 days after the later of (a) the date coverage would otherwise terminate by reason of the qualifying event, or (b) the date of notification of COBRA rights by the Administrative Manager, in which to notify the Administrative Manager in writing of the COBRA election and names of the qualified beneficiary(ies) for which it is elected. If COBRA coverage is waived during the election period, the qualified beneficiary may revoke the waiver and elect COBRA coverage at any time before the end of the 60-day election period; however, COBRA coverage may only be provided from the date of election and not retroactive to the loss of coverage.

E. LENGTH COBRA COVERAGE IS AVAILABLE

COBRA coverage is a temporary continuation of coverage. If elected and paid for in a timely manner, it will begin on the date coverage would otherwise have been lost.

For vision insurance coverage, COBRA coverage will be available (a) for up to a total of 36 months when the qualifying event is an Employee's death, divorce or legal separation, or a child's loss of eligibility status, or (b) for up to a total of 18 months when the qualifying event is an Employee's termination of employment or reduction in hours.

The following is a description of two ways in which an 18-month period of COBRA coverage for the vision insurance coverage can be extended.

1. 18-Month Disability Extension

If anyone in your family is determined by the Social Security Administration ("SSA") to be totally disabled and you notify the Administrative Manager in writing in a timely fashion, you and all other family members with COBRA coverage by reason of the same qualifying event may receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. In order to receive this disability extension, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage. Written notice of the request for a disability extension, a copy of the disability determination issued by SSA and the names of the qualified beneficiaries for whom an extension is requested, must all be given to the Administrative Manager within 60 days after issuance of the disability determination and before the end of the 18-month period of COBRA coverage.

If, prior to the end of the 29 month period of COBRA coverage, SSA determines that the individual is no longer totally disabled, the qualified beneficiary(ies) must send a copy of the determination to the Administrative Manager within 30 days after its issuance. The extended COBRA coverage for the disabled individual and all related qualified beneficiary(ies) will end on the last day of the month which includes the 30th day after a final determination by SSA that the individual is no longer disabled.

2. Second Qualifying Event Extension

If your Dependent spouse or child experiences another qualifying event while receiving 18 or 29 months of COBRA coverage, the affected Dependents can get additional months of COBRA coverage, up to a maximum of 36 months from the date COBRA coverage originally began due to the first qualifying event. For example, a second qualifying event would occur if the former Employee dies, or gets divorced or legally separated, or if a Dependent child ceases to be eligible as a Dependent child, as long as the event would have caused the Dependent spouse or child(ren) to lose vision insurance coverage had the first qualifying event not occurred. In all of these cases, the qualified beneficiary must notify the Administrative Manager in writing of the second qualifying event within 60 days after it occurs, in the same manner required had it been the first qualifying event, in order to qualify for the extension.

F. HOW THE COST OF COBRA COVERAGE IS DETERMINED AND WHEN PAYMENT IS DUE

COBRA coverage is available on a self-payment basis only. The amount of the required self-payment or "premium" is determined by the Trustees from time to time. The amount covers the cost of the coverage elected and may also include any additional amounts permitted by law. The initial premium is due within 45 days from the date of the initial election and must cover the cost of coverage from the date it would otherwise terminate through the date of the election. Each subsequent premium is due on the first business day of each month, subject to a 30-day grace period. The COBRA premium rates will remain constant for a 12-month period to the extent required by law, but otherwise will change as the cost of coverage changes.

If a premium is not paid timely, COBRA coverage will terminate and cannot be reinstated. Under a special rule, one untimely payment of a monthly COBRA premium will be excused and treated as timely, as long as it is received by the Administrative Manager within 60 days from the first business day of the month on which it is due (without regard to any grace period that normally applies.) Only one untimely payment will be excused under this special rule. COBRA coverage will not be provided until the required premium for that period of coverage is received by the Administrative Manager.

G. EVENTS THAT RESULT IN AN EARLIER TERMINATION OF COBRA COVERAGE

Generally, COBRA coverage will be available for the maximum periods described above in Section 5(E); however, it will end earlier on the first, if any, of the following dates to occur:

1. The first day of the month for which the COBRA premium is not paid timely (taking into account any grace periods and the one untimely payment rule);

2. The date the Fund terminates; or

3. The date the insurance policy under which the vision benefits are insured terminates.

H. COBRA COVERAGE IS OPTIONAL

COBRA coverage is optional for you and each qualified beneficiary. Further, each qualified beneficiary has an independent right to elect COBRA coverage. Even if you, as an Employee, do not elect COBRA coverage, each of your eligible Dependents may elect it.

I. KEEP FUND OFFICE INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Administrative Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrative Manager.

SECTION 6 - EXTENDED SELF-PAYMENT FOR RETIREES [2]

A. RETIREES ELIGIBLE FOR EXTENDED SELF PAYMENT

The following former Employees and their eligible Dependents, who self-pay for COBRA coverage for the entire COBRA period available to them are allowed to extend their vision insurance on a Self-Payment basis for a period immediately following exhaustion of their COBRA coverage:

1. Any Retiree who was an Employee immediately prior to retirement, and who was covered under the vision insurance, and who, upon retirement, immediately received retirement benefits from a Louisiana State Retirement System; or

2. Any Retiree who has continued coverage through COBRA immediately prior to retirement and who, upon retirement, received retirement benefits from a Louisiana State Retirement System; or

3. Any Dependent of a Retiree, provided the Dependent was covered under the vision insurance on the Retiree's date of retirement.

A Retiree who elects extended Self-Payment coverage may not enroll new Dependents during the period of extended coverage.

B. NOTIFICATION OF ELIGIBILITY AND COST

The Administrative Manager will notify eligible Retirees and Dependents, within 30 days from the date their COBRA coverage would otherwise terminate, of their option to continue coverage

[2] The Guardian Policy also allows for Extended Self-Pay for Retirees and Dependents.

under extended Self-Payment and the amount of the required Self-Payment. The cost of the extended coverage will be determined by the Trustees, and the Self-Payment is payable on a monthly basis, due on the first business day of the calendar month for which coverage is sought. Self-payment premiums are due on or before the 1st of each month for which coverage is intended. It is your responsibility to pay the required premiums on or before the due date. Payment, either by check or through your bank's online bill pay service, should be made to the JFT Health and Welfare Fund.

This Notice from the Fund Office is the only notification you will receive regarding the monthly premiums; you will not receive any billing statement, coupon booklet or other reminders from the Fund Office of premiums due.

Payments will be considered timely and coverage will be reinstated retroactively if payment is received within 30 days of the due date. If you fail to make the required timely premium payment, your coverage will terminate and will not be reinstated.

To maintain continuity of coverage, you are encouraged to pay the monthly premium by the 23rd of each month before the month in which you will be covered.

C. WHEN EXTENDED SELF PAYMENT ENDS

The extended vision insurance coverage will begin on the date COBRA coverage expires, and will terminate on the earliest of the following to occur:

1. The date the insurance policy is amended to discontinue the extended coverage rights for any class of participants to which you or your Dependents belong;

2. The date you are no longer a Retiree;

3. The first day of the month for which a required Self-Payment is not made timely (taking into account any applicable grace period);

4. The date the Fund terminates; or

5. The date the insurance policy that insures your vision benefits terminates.

This right to extended Self-Payment coverage is not a vested right and is not required by law. It may be discontinued or amended at any time by the Trustees or the Jefferson Parish School Board, and any such discontinuance or amendment will affect you and your Dependents regardless of whether you and your Dependents are receiving extended Self-Payment coverage at that time.

SECTION 7 - FILING AND PAYMENT OF VISION CLAIMS AND CLAIMS REVIEW PROCEDURE

A. NOTICE OF CLAIM

Written or authorized electronic/telephonic notice of a vision claim must be given to Davis Vision within 20 days after a Covered Expense is incurred or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Davis Vision at its Administrative Office. Notice should include the Policyholder's name and the Covered Person's name, address, Policy and Policy Number, and sent to the following address:

Davis Vision, Inc./HM Life Insurance Company
175 E. Houston Street
San Antonio, TX 78205

B. CLAIM FORMS

Davis Vision will send claim forms for filing proof of loss when it receives notice of a claim. If such forms are not provided within 15 days after it receives notice, the proof requirements will be met by submitting, within the time fixed in the Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

C. PROOF OF LOSS

Written or authorized electronic proof of loss satisfactory to Davis Vision must be given to Davis Vision at its Administrative Office within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which Davis Vision is liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

D. PAYMENT OF CLAIMS

Davis Vision will pay benefits not more than thirty days from the date upon which receipt of due written or authorized electronic proof of such loss.

All benefits will be paid in United States currency. All benefits payable under the Davis Vision Policy, unless otherwise stated, will be payable to the Covered Person, beneficiary or to his/her estate.

If Davis Vision is to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, Davis Vision may pay up to $1,000 to a relative by blood or marriage that it believes is equitably entitled. Any payment made by Davis Vision in good faith pursuant to this provision will fully discharge it to the extent of such payment and release it from all liability.

1. Right to Receive and Release Needed Information

Davis Vision has the right to obtain or give information needed to coordinate benefit payments with other plans. This can be from or to any other insurance company, organization or person, subject to the consent of the Covered Person. Any Covered Person claiming benefits must furnish Davis Vision with the necessary information needed to coordinate benefit payments.

2. Right to Make Payments

Davis Vision has the right to pay any other organization, as needed, to properly carry out this provision. Any such payments made in good faith are considered benefits paid under the Policy, and fully discharge its liability, to the extent of such payments.

3. Right to Recovery

Davis Vision has the right to retrieve any excess amounts that may have been paid out should they exceed the provisions of the Policy. This can be from the Covered Person for whom the payments were made. It can also be from any other insurance company or organization.

4. Review

If the claim is wholly or partly denied, the notice will include:

(a) Reasons for such denial;

(b) Reference to specific Certificate provisions, rules or guidelines on which the denial was based;

(c) A description of the additional information needed to support your claim;

(d) Information concerning your right to request that Davis Vision review its decision; and

(e) A description of Davis Vision's review procedures, time limits and notice of your right to bring civil action.

This request must be in writing and must be received by Davis Vision no more than 180 days after you receive notice of the claim decision. As part of this review, you may:

(a) Send written comments to Davis Vision;

(b) Review any non-privileged information relating to your claim; or

(c) Provide Davis Vision with other information or proof in support of your claim.

Davis Vision will review your claim promptly after receiving your request. It will advise you of the results of its review within 60 days after it receives your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Davis Vision's decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

5. Claimant Cooperation

Failure of a claimant to cooperate with Davis Vision in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

6. Administration

Davis Vision has the authority to review claims for the benefits provided by this Policy and for deciding appeals of denied claims. In this role, David Vision shall have the authority, in its discretion, to interpret the terms of the Policy, to decide questions of eligibility for coverage or benefits, and to make any related findings of fact. All decisions made by Davis Vision in this capacity shall be final and binding on Participants and beneficiaries to the full extent permitted by state and federal law.

Davis Vision will have no responsibility with respect to the administration of the benefit provided by this Policy except as described above. It is understood that its sole liability to the Policyholder and Covered Persons under the Policy shall be for the payment of benefits provided under this Policy. It may contract with another entity to perform this function on its behalf.

7. Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

8. Recovery of Overpayment

If benefits are overpaid, Davis Vision has the right to recover the amount overpaid by either of the following methods:

(a) A request for lump sum payment of the overpaid amount.

(b) A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, Davis Vision may recover the overpayment from the Covered Person's estate.

9. Limitation on Judicial Review

You, your Dependents and/or your beneficiary must first exhaust all of the claims filing and appeal procedures under the vision insurance policy, as set forth herein, before pursuing any action in court to recover benefits under the vision insurance.

ARTICLE III – FUND'S PRIVACY AND SECURITY STANDARDS FOR PROTECTION OF PROTECTED HEALTH INFORMATION

The Regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) Omnibus Rule regulate the uses and disclosures of your protected health information (PHI), including your electronic protected health information (E-PHI).

A. DEFINITIONS

The following terms, when used in this Article as capitalized terms, shall have the meanings indicated, and any other terms used in this Article that are not defined below shall be interpreted in a manner that is consistent with the requirements under the Privacy Standards and Security Standards:

1. "Electronic Protected Health Information" or "E-PHI" means "Protected Health Information" that is transmitted by or maintained in electronic media; it is limited to E-PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;

2. "HHS" means the Secretary of the United States Department of Health and Human Services;

3. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, and the privacy and security regulations promulgated by HHS under the authority of such Act, as amended from time to time;

4. "Information System" means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications and people;

5. "Plan" means the Jefferson Federation of Teachers Health and Welfare Plan.

6. "Plan Sponsor" means the Board of Trustees in their role as sponsor of the Plan;

7. "Privacy Standards" means the Standards for Privacy of Individually Identifiable Health Information set forth in the privacy regulations (45 CFR Part 160 and Part 164) promulgated by HHS under the authority of HIPAA, as amended from time to time;

8. "Protected Health Information" or "PHI" means individually identifiable health information that is created or received by the Plan in any form (oral, written or electronic), and relates to a Participant's past, present or future physical or mental health or condition; the provision of health care to a Participant; or the past, present or future payment for the provision of health care to a Participant;

9. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an Information System;

10. "Security Measures" means all of the administrative, physical and technical safeguards in an Information System; and

11. "Security Standards" means the security standards for the protection of Electronic Protected Health Information, as set forth in the security regulations (45 CFR Parts 160, 162 and 164) promulgated by HHS under the authority of HIPAA, as amended from time to time.

B. USES AND DISCLOSURES OF PHI BY PLAN

As a fully insured plan, the Plan's use and disclosure of PHI, including E-PHI will be limited to summary health information and information on enrollment and disenrollment.

1. Summary health information is information requested by the Plan Sponsor for the purpose of obtaining premium bids from health plans for providing health

insurance coverage under the Plan, or for modifying, amending or terminating the Plan.

2. Enrollment and disenrollment information includes the determination of eligibility, participation or coverage, the exchange of participant and dependent demographic and eligibility information with the Plan's insurers, and changes to existing participant and dependent information.

C. OTHER REQUIRED AND PERMITTED USES AND DISCLOSURES

The Plan shall allow Participants to inspect and copy their own PHI and shall provide Participants with an accounting of certain disclosures of PHI made by the Plan or its business associates to the extent required under the Privacy Standards. The Plan shall also disclose PHI whenever requested by HHS to investigate or determine the Plan's compliance with the Privacy Standards.

The Plan may use or disclose PHI, without the consent or authorization of the individual to whom it relates, in the following circumstances to the extent permitted or required under the Privacy Standards (45 CFR Section 164.512): (1) responding to disclosure requests in a judicial or administrative proceeding, such as a subpoena, discovery request or court order; (2) responding to public health authorities authorized to collect or receive information to help prevent or control disease, injury or disability, to report problems with products or to notify users of product recalls; (3) responding to public health, social service or protective service agencies to report child abuse, neglect or domestic violence; (4) responding to requests for medical information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs; (5) responding to a coroner, medical examiner or funeral director to identify a deceased person, determine the cause of death or assist them in carrying out their duties; (6) responding to a public health oversight agency for oversight activities authorized by law such as audits, investigations, inspections, licensure and disciplinary actions against providers; (7) responding to law enforcement officials in connection with law enforcement activities, such as investigating criminal conduct or victims of crime or in emergency situations; (8) responding to inquiries from correctional institutions or lawful officials having custody of an inmate, if necessary to protect the health of an inmate or other inmates and employees at the correctional institution; (9) responding to requests from health research agencies under certain circumstances; (10) when necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual; (11) responding when authorized by law in connection with military matters or matters of national security and intelligence; and (12) responding to organ procurement organizations for cadaveric organ, eye or tissue donation purposes.

D. USES AND DISCLOSURES REQUIRING AN OPPORTUNITY TO AGREE OR OBJECT

The Plan may disclose to a Participant's family member, relative, close personal friend or other person identified by the Participant, PHI that is directly related to their involvement with or payment for the Participant's health care. The Participant must either be present and consent,

or be informed in advance of the disclosure and be given an opportunity to object or not object to the disclosure; however, if the Plan is unable to do so because of the Participant's incapacity or emergency circumstances and the Plan decides that disclosure is in the Participant's best interest, the Plan may disclose to such person PHI that is directly related to the Participant's health care.

E. USES AND DISCLOSURES PURSUANT TO WRITTEN AUTHORIZATION

The Plan may use and disclose a Participant's PHI to the extent permitted by the Participant's HIPAA compliant written authorization.

F. PLAN SPONSOR'S SECURITY OBLIGATIONS FOR E-PHI

The Plan Sponsor agrees that if it creates, receives, maintains or transmits E-PHI on behalf of the Plan (other than enrollment/disenrollment information, summary health information and information disclosed pursuant to a HIPAA compliant written authorization, which are not subject to these restrictions), it will not use or disclose the E-PHI in a manner that is inconsistent with the Security Standards or HIPAA and to that end will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the E-PHI it creates, receives, maintains or transmits to or on behalf of the Plan as required by the Security Standards;

2. Ensure that the adequate separation between the Plan and Plan Sponsor, required under the Privacy Standards, is supported by reasonable and appropriate Security Measures;

3. Ensure that any agent, including a subcontractor, to whom it provides E-PHI agrees to implement reasonable and appropriate Security Measures to protect the E-PHI as required by the Security Standards; and

4. Report to the Plan any Security Incident involving E-PHI of which it becomes aware.

G. EFFECTIVE MECHANISM FOR RESOLVING NON-COMPLIANCE ISSUES

The Plan Sponsor shall establish and maintain at all times an effective mechanism for resolving any issues of non-compliance with the restrictions and limitations applicable to the disclosure and use of PHI as set forth in this Article, which may include any or all of the following as is determined to be appropriate based on the circumstances and severity of the non-compliance: verbal and/or written reprimands, counseling, retraining and discharge.

ARTICLE IV - GENERAL INFORMATION ABOUT THE FUND

The following is a list of certain general information that you may need to know.

1. NAME AND EFFECTIVE DATE

The "Jefferson Federation of Teachers Health and Welfare Fund" was initially adopted on May 9, 1983 and has been amended from time to time.

2. PLAN ADMINISTRATOR INFORMATION

The Administrator keeps the records for the Fund and is responsible for administration of the Fund. The Administrator will also answer any questions you may have about the Fund. The Fund is administered by a joint board of trustees consisting of an equal number of Trustees appointed by the Union and the School Board. The full board may designate a committee, comprised of less than the full board, to act on its behalf in Fund matters. The name, address, business telephone and fax numbers of the Administrator are:

Board of Trustees
Jefferson Federation of Teachers Health and Welfare Fund
2540 Severn Avenue, Suite 302
Metairie, Louisiana 70002
Telephone: (504) 455-7261
Fax: (504) 455-7267

3. PLAN ADMINISTRATIVE MANAGER

The Board of Trustees has appointed an Administrative Manager to assist in handling day-to-day administrative matters. The name, address, business telephone and fax numbers of the Administrative Manager are:

Mickey Graham, Administrative Manager
Jefferson Federation of Teachers Health and Welfare Fund
2540 Severn Avenue, Suite 302
Metairie, Louisiana 70002
Telephone: (504) 455-7261
Fax: (504) 455-7267

4. SERVICE OF LEGAL PROCESS

The name and address of the Fund's agent for service of legal process are:

Board of Trustees
Jefferson Federation of Teachers Health and Welfare Fund
2540 Severn Avenue, Suite 302
Metairie, Louisiana 70002

Agent for service of process for the Policy for vision insurance is HM Life Insurance, Co.

5. FUNDING MEDIUM

Dental and vision benefits are fully insured by insurance policies, which are purchased with assets of the Trust pursuant to provisions of the Trust Agreement, which assets are held for the purpose of providing benefits and defraying reasonable administrative expenses. Vision benefits are fully insured and underwritten by HM Life Insurance Co. Dental benefits are fully insured and underwritten by Guardian Life Insurance Company of America.

ARTICLE V – PARTICIPANT NOTIFICATION REQUIREMENTS

It is important that you and your Dependents notify the Administrative Manager whenever:

1. You change your name;

2. You change your home address;

3. You terminate your employment with the Employer or you are no longer an eligible Employee;

4. You are receiving Workers' Compensation benefits;

5. You enter qualified military service; or

6. Your Dependents no longer qualify as Eligible Dependents.