
**Jefferson County Department of
Education
Direct Reimbursement Plan**

Summary Plan Description

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This is the official Summary Plan Description for the **Jefferson County Department of Education Direct Reimbursement Plan** (the "Plan"). The Plan is a self-funded benefit plan that reimburses eligible employees and their eligible dependents for covered expenses. The Plan is available to the employees of **Jefferson County Department of Education** (the "Company"), and its affiliates that participate in the Plan ("Participating Companies"). It does not involve an insurance company. **Jefferson County Department of Education** is the Plan's Administrator and Direct Reimbursement Benefit Plans is the Plan's Claims Administrator.

If you elect to participate in the Plan, your pay will be reduced on a pre-tax basis by the amount required to pay for the type of coverage you elected. You may elect to cover only yourself or you may elect to cover yourself and one dependent or you may elect to cover yourself and all of your dependents. As you incur expenses, you may submit claims for reimbursement of these expenses. If your expenses are eligible for reimbursement under the terms of the Plan, you will receive a check for all or a portion of the reimbursable expenses (as payable under the Plan).

This Summary Plan Description will explain in more detail how the Plan works. However, if you have any questions concerning your benefits, ask your local Central Office representative. Other people (like your co-workers, your supervisor or even your dentist) are not authorized to answer your questions about the Plan.

Jefferson County Department of Education reserves the right to amend or terminate this Plan at any time. Nothing in this Summary Plan Description is intended to provide vested or nonchangeable benefits. Jefferson County Department of Education can also change the benefits or contributions under the Plan or any other aspect of the Plan at any time and for any reason. The changes will apply to all covered persons, unless otherwise specified by Jefferson County Department of Education. Generally, these amendments will not apply to expenses incurred prior to the date of enactment of the amendments.

Who Is Eligible?

All full-time employees, who have met the required waiting period and their eligible dependents, may participate in the Plan. You are a full-time employee if you routinely work at least 30 hours per week. Eligible dependents include your spouse to whom you are legally married and unmarried children under 19 years of age. Unmarried children between the ages of 19 and 24 may be included if they are full-time students. It is the employee's responsibility to provide proof of full-time student status.

An unmarried child with a mental or physical handicap or developmental disability, who can't support himself/herself may stay eligible for dependent coverage beyond the Plan's age limit if: (a) the condition started before he/she reached this Plan's age limit; (b) he/she became covered by this Plan before he/she reached the age limit and stayed continuously covered until he/she reached such limit; and (c) he/she depends on you for most of his/her support and maintenance. To do this, it is the employee's responsibility to send written proof that the child is handicapped and depends on you for most of his/her support and maintenance within 31 days from the date the child reaches the age limit. The employee may be asked for periodic proof that the child's condition continues. The child's coverage ends when yours does.

You can elect individual coverage (which only covers you), or you can elect individual + one dependent (which covers you and your eligible spouse or covers you and one eligible dependent child) or you can elect family coverage (which covers you and all of your eligible dependents). However, if you are divorced or separated from your spouse, you may be required under the terms of a "Qualified Medical Child Support Order" to provide coverage under the Plan to any of your children named in such order. A Qualified Medical Child Support Order is an order satisfying the requirements of ERISA and requiring a health (or dental) plan to recognize the child of a parent-employee as a plan participant.

What Must I Pay For Coverage?

The coverage under this Plan is contributory, meaning the employee pays all or a portion of the cost.

How Do I Enroll For Coverage?

If you want to cover yourself or your dependents under the Plan, you must:

- (1) apply for the coverage on the proper form; and
- (2) agree in writing to make the required contributions.

Prior to the first day of each Plan Year (**January 1 – December 31**) the Company will provide an annual enrollment period during which you may elect to be covered under the Plan or, if you are already covered, to change the type of coverage (for example, from individual to family coverage).

The coverage that you elect during the annual enrollment period will become effective on **January 1st** following the annual enrollment period. If you become employed during the Plan Year and you elect coverage during a period other than the open enrollment period, your coverage will be effective **the 1st day of the month following your hire date, provided the enrollment form has been received by Central Office.**

Can I Change My Election During The Year?

Your election to receive coverage under the Plan will remain in effect for the Plan Year (**January 1 – December 31**). If you are a new employee and elected coverage during a period other than the open enrollment period, your initial election will remain in effect from the date your election became effective until the following **December 31st**. If you do not complete a new election form for coverage during the next annual enrollment period, your election automatically will remain in effect for the next Plan Year.

You may change or revoke your election during the middle of a Plan Year only if you experience a "change in family status", and the change in coverage is on account of and consistent with the change in family status. Examples of changes in family status include: (1) your marriage, divorce or legal separation; (2) the birth or adoption of a child; (3) the death of a dependent; (4) a dependent who either becomes eligible for coverage or is no longer eligible; (5) a change in your spouse's employment; (6) a significant change in your or your spouse's health coverage attributable to your spouse's employment; (7) the receipt of a qualified medical child support order; (8) a "special enrollment period," as required under the Internal Revenue Code; or (9) any other event deemed a change in family status by the Plan Administrator, in accordance with applicable law.

What Happens If I Don't Enroll When I First Become Eligible?

If you (or your dependents) do not enroll in the Plan when you (or your dependents) first become eligible to participate in the Plan, you may enroll yourself (or your dependents) during the annual enrollment period for the next Plan Year or a later Plan Year. If you (or your dependents) do not enroll in the Plan when you (or your dependents) first become eligible to participate, you (or your dependents) will be referred to as a "late entrant". (Late entrants are subject to reduced benefits under the Plan, as described below.)

What Amount Of Expenses Does The Plan Pay If I Am A Late Entrant?

If you (or your dependents) are late entrants, the amount of expenses that will be reimbursed is reduced for the first Plan Year in which you (or your dependents) participate in the Plan. After the first Plan Year during which you (or your dependents) participate as late entrants, you (or your dependents) will be eligible for standard plan benefits, assuming you (or your dependents) continue to participate in the Plan. If you (or your dependents) subsequently drop coverage during an annual enrollment period and then re-enroll during a following annual enrollment period, the amount of expenses that will be reimbursed is again reduced for the first Plan Year in which you (or your dependents) resume participation in the Plan.

For each late entrant, the Plan will pay 50% of covered expenses incurred during the Plan Year. The maximum benefit per person for that Plan Year is \$500.00.

What Expenses Can I Get Reimbursed?

You will be reimbursed for all properly submitted expenses incurred by you or your covered dependents while you are covered under the Plan, except for those expenses discussed below that are not covered under the terms of the Plan. Covered expenses include treatment by any licensed provider.

Are There Any Expenses Not Covered?

You will not be reimbursed for the following expenses:

- Expenses incurred for injuries or conditions, which are payable through workers' compensation;
- Expenses incurred for services, which are covered by a governmental agency;
- Expenses incurred for services, which are covered by a company-sponsored medical plan;
- Expenses incurred for bleaching and/or expenses incurred for elective eye surgery, i.e., Radial Keratotomy.

What Amount Of Expenses Does The Plan Pay?

Each person covered by the Plan, other than a late entrant, is eligible to be reimbursed for the percentage of his or her expenses in the amount indicated below. The Plan Year in which the treatment was provided is the year used to determine the reimbursement.

The Plan will pay:

Option I – Dental Only

100% of the first \$125 of expenses, then

50% of the next \$1,750 of expenses

Maximum Annual Benefit of \$1,000 per Person

Orthodontia Included

Option II – Dental and Vision

100% of the first \$125 of expenses, then

50% of the next \$1,750 of expenses

Maximum Annual Benefit of \$1,000 per Person

Orthodontia Included

Includes a \$300 Annual maximum per person for Vision care (included in the \$1,000 annual maximum)

Vision covers frames, lenses, contacts and routine eye exams

Orthodontic Claims

Payment for orthodontic treatment is made in installments. The first payment (downpayment) is payable on the date your braces are placed. The downpayment may be up to a maximum of 25% of the estimated total treatment charge and will be processed according to your schedule of benefits. The balance of the estimated total treatment charge is prorated and paid on a monthly basis during the anticipated duration of the treatment. It is the responsibility of the employee to provide proof of continuation of treatment in order to receive reimbursement.

A one page "orthodontic questionnaire" must be completed by the orthodontist and submitted with the initial charges. This form is available from your Central Office Representative, or by calling Direct Reimbursement Benefit Plans.

Are There Any Deductibles?

No, there are no deductibles to satisfy before expenses are reimbursed under the Plan. This means that there will be no amount of expenses that you must pay before you are entitled to be reimbursed for your expenses.

How Do I File My Claim?

When you incur expenses you should obtain a written statement from your provider that describes the dates of service, the type of treatment and the charge. A request for claim payment should be made on claim forms that are obtained from the Central Office. Properly completed claim forms should be sent directly to the Claims Administrator (the address for the Claims Administrator is at the end of this Summary Plan Description) within a reasonable period following occurrence of the treatment or expense.

All claims for expenses must be submitted no later than 3 months after the end of the Plan Year in which the expenses were incurred. The Company reserves the right to verify all reimbursement requests. A fraudulent claim is grounds for termination of benefits and other disciplinary actions (including termination of employment) determined within the discretion of the Company.

What Do I Do If My Claims Are Denied?

If your claim is denied (all or in part), you will be informed of the reason(s) for denial, and you may initiate a review of the claim by contacting the Plan Administrator for further instructions. Under the review procedure, you or your duly authorized representative have the right to: (a) request the review by making written application to the Plan Administrator, no later than 60 days after the claim denial, (b) review pertinent Plan documents, and (c) submit issues and comments in writing in support of the claim. You will be notified in writing of the results of the claim review no later than 60 days following receipt of the properly completed request for review, unless it is necessary to seek additional information, in which case the determination will be made within 120 days.

When Does My Coverage End?

Your coverage, as well as that of your dependents, ends on the earliest of the following dates, subject to your right to elect COBRA coverage:

- The date this Plan terminates or is amended to exclude you or your dependents from the class of employees or dependents, as applicable, eligible for coverage;
- The date you are no longer in an eligible class of employees or, with respect to a dependent's coverage, the date the dependent is no longer an eligible dependent;
- The date your health insurance terminates due to loss of employment.
- The date of your death; or
- The date you withdraw from the Plan.

Any expenses that you incur during your period of coverage will be eligible for reimbursement, subject to the terms of the Plan.

What Are My Rights Under Cobra?

COBRA continuation of Plan benefits is available to those individuals who, for a variety of reasons, would normally lose coverage. Individuals who wish to continue coverage must elect to do so within certain time limits and must pay the entire cost of coverage plus an administrative charge on a regular timely basis.

Who Is Eligible For Cobra?

You and your dependents ("Qualified Beneficiaries") are eligible for COBRA continuation coverage if you and your dependents are actually covered under the Plan at the time of your "qualifying event," as described below. In addition, a child born to or adopted by an individual covered under COBRA is also considered a Qualified Beneficiary.

A "qualifying event" includes your termination of employment or reduction of hours of employment with the Company or a Participating Company. This excludes your discharge due to gross

misconduct. The Plan Administrator will determine what constitutes gross misconduct. Bankruptcy of the Company is also considered a qualifying event.

In addition to the above events, your spouse and dependent children are eligible for COBRA continuation coverage if they are actually covered under the Plan at the time of any of the following qualifying events:

- Your divorce or legal separation;
- Your death

In addition to the above events, your dependent children will be eligible for COBRA continuation coverage if they are actually covered under the Plan at the time they lose coverage under the Plan due to loss of dependent status.

What Notice Do I Have To Give For Cobra To Take Effect?

The Plan Administrator has no way of knowing when you are divorced or when a dependent child loses eligibility. Therefore, it is your responsibility and the responsibility of affected dependents to notify the Plan Administrator within 60 days of a divorce, legal separation or loss of a child's dependent status under the Plan. If this notice is not received within 60 days, the dependent will permanently lose eligibility for COBRA continuation coverage.

How Long Does Cobra Coverage Last?

COBRA continuation coverage may extend for 18 months in the case of your termination of employment or reduction of hours, and otherwise for 36 months, provided that a covered dependent lost coverage under the Plan as a result of the qualifying event. If coverage under the Plan continues beyond the occurrence of a qualifying event, the 18 or 36-month period will not begin until loss of coverage. The 18-month period may be extended if a second qualifying event causing loss of coverage (for example, death, divorce or legal separation) occurs during that period. Coverage will never last more than 36 months from the date of the original qualifying event (i.e., the date you terminated employment with a participating company or your hours were reduced). However, if you (the covered employee) separate from service or reduce your hours less than 18 months after the date you became entitled to Medicare, then the coverage for your dependents may be extended to a maximum of 36 months from the date you became entitled to benefits under Medicare.

What Are My Rights Under Cobra If I Am Disabled?

Qualified Beneficiaries deemed disabled for Social Security purposes (and their covered family members) can extend coverage up to 29 months if:

- The Qualified Beneficiary is determined, under the Social Security Act, to have been disabled within 60 days of the date COBRA coverage commenced for the Qualified Beneficiary;
- The determination of disability is made before the end of the initial 18-month continuation period; and
- A copy of the disability award is provided to the Plan Administrator within 60 days of the date of determination and before the end of the 18-month continuation period.

In the case of COBRA continuation coverage that is extended beyond the 18-month continuation period due to a Qualified Beneficiary's disability, COBRA continuation coverage will terminate on the first day of the month that begins more than 30 days after it is determined that the Qualified Beneficiary is no longer disabled, unless coverage is terminated earlier for any of the reasons described below for the termination of COBRA coverage.

Can Cobra Coverage Terminate Earlier Than Described Above?

Yes, although COBRA will generally continue for either the 18-, 29-, or 36-month period described above, it can be terminated earlier for any of the following reasons. If COBRA coverage terminates, it cannot be reinstated.

- The Qualified Beneficiary fails to pay the premium in a timely manner, defined initially as within 45 days of the date of the election and thereafter within 30 days of each due date;
- The Qualified Beneficiary becomes covered under another group plan (unless the Qualified Beneficiary is subject to pre-existing condition exclusions under that plan);
- The Qualified Beneficiary becomes entitled to Medicare benefits. However, your covered dependents may still continue their coverage if you become eligible for Medicare; or
- The Plan is terminated in its entirety and neither the Company nor its affiliates maintain any type of group plan.

How Do I Elect Cobra Coverage?

Qualified Beneficiaries will be notified in writing of their eligibility for COBRA continuation coverage and of the election procedures. In order to obtain COBRA continuation coverage, Qualified Beneficiaries must follow all instructions sent with the notice of eligibility. Generally, Qualified Beneficiaries will have 60 days from the date of notice to elect COBRA coverage. During this 60-day election period, the Qualified Beneficiaries must decide if they intend to continue their coverage by agreeing to pay the premiums on a monthly basis.

How Do I Pay For Cobra Coverage?

Payments for COBRA continuation coverage are payable monthly to the Plan Administrator and are due by the first of each month. COBRA continuation coverage will terminate if payments (other than the first payment) have not been received within 30 days of the first of each month. The first payment for COBRA continuation coverage is due within 45 days after you make your election to receive COBRA continuation coverage and the election is received by the Plan Administrator. If the payment is not made within the 45 days for the first payment, COBRA continuation coverage will terminate. The Plan Administrator is not required to send you payment reminders or overdue notices.

Information Required By The Employee Retirement Income Security Act Of 1974

Name Of Plan:

**Jefferson County Department of Education
Direct Reimbursement Plan**

Type Of Plan:

Welfare Benefit Plan

Plan Document:

This Summary Plan Description also constitutes the Plan document for **Jefferson County Department of Education Direct Reimbursement Plan**.

Plan Year:

January 1 – December 31

Plan Sponsor/Plan Administrator:

Jefferson County Department of Education is the principal employer that maintains the Plan and also is the Plan Administrator of the Plan.

The address of **Jefferson County Department of Education** is:

**PO Box 190
Dandridge, TN 37725**

The telephone number of Jefferson County Department of Education is:

865/397-3194

The Plan Administrator has the exclusive power and discretionary authority to interpret the Plan.

Agent For Receiving Service Of Legal Documents:

In the event of legal action involving the Plan, legal papers may be served upon **Jefferson County Department of Education**.

Claims Administrator:

Claims for benefits under the Plan will be processed by Direct Reimbursement Benefit Plans. The Claims Administrator's address is:

**Direct Reimbursement Benefit Plans
P.O. Box 71549
Newnan, GA 30271
770-683-1074**

Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan Administrator with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.

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

If you have any questions about your Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.