

Your Summary Plan Description

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Please note this is just a summary of your plan. For additional details please see the Plan Contract for each benefit. Thank you.

PROGRAM OVERVIEW

Your State of Delaware Benefits

The State of Delaware provides you with the opportunity to elect medical coverage (including Medco prescription coverage) and enroll in health care and dependent care flexible spending accounts, group life insurance, blood bank and supplemental benefits. For complete information on the State Benefit Plans available to you, refer to the Open Enrollment Booklet or the State's website at www.ben.omb.delaware.gov. You can also link to the State's Benefits Website through your District's Benefits Website at www.schooldistrictbenefits.com/colonial.

Your School District Benefits

Please review the following chart, which lists the plans offered by the School District and the vendors that provide these benefits:

Plan	Carrier
Dental	MetLife
Vision Care	Vision Benefits of America
Life and AD&D Insurance	Reliance Standard

Eligibility

Eligibility Under Your State of Delaware Plans

You are eligible for coverage under the State plans if you are a(n):

- **Permanent full-time employee** (regularly scheduled to work 30 or more hours per week or 130 or more hours per month)
- **Elected or appointed official**
- **Permanent part-time employee** (regularly scheduled to work less than 130 hours per month)
- **Pensioner** receiving or eligible to receive a pension from the State

Eligibility Under Your School District Plans

Full-time and part-time employees are eligible for coverage under the plans based on negotiated contract.

- For **dental and vision care benefits**, you are eligible on the first of the month on or after your date of hire.
- For life and accidental death and dismemberment (AD&D), you are eligible on your date of hire. If you are absent from work because of an illness or injury on the day your insurance becomes effective, coverage will not begin until the day you return to work.

Dependent Coverage

Dependent Coverage Under Your School District Plan

Dental and Vision coverage for eligible dependents ends as follows:

- December 31st of the year in which he or she reaches age 21.
- If a full-time student, coverage will end on the earlier of the following:
 - (1) the end of the month in which dependent child is no longer a full-time student, or
 - (2) the end of the month in which the dependent child attains age 24.
- The last day of the month in which the child marries.

It is the employee's responsibility to notify the Benefits Office, within 30 days, when the dependent is no longer eligible for coverage for any of the above reasons.

Enrollment

To elect coverage you must complete an enrollment form within 30 days of the date you are first eligible.

If you do not enroll within 30 days, you may need to submit evidence of good health to elect life and accidental death and dismemberment coverage during a later enrollment period.

Changing Your Benefits (Life Events)

Once you have made your benefit selections no changes will be permitted unless you experience a life event including but not limited to one of the following:

- You experience a change in employment status
- You experience a change in marital status
- You have a child, or adopt a child
- Your dependent changes his/her status
- Your spouse experiences a change in employment status resulting in loss in coverage or your spouse's benefits are terminated

If you experience one of these life events, you will have 30 days to make changes to your benefits. If you fail to contact the Employee Benefits Office within 30 days of the event, you will have to wait until the next open enrollment period.

Your Flex Credits Benefit/Benefits Costs

As a School District Employee you receive two local flex credits:

- The first flex credit (OptnFlexCr) may be used for the State's medical plan cost only
- The second flex credit (ProgFlexCr) may be used for **District** benefits: dental, vision care, and life and AD&D coverage

The second flex credit may also be used for any excess health plan costs not covered by the first flex credit.

The amount of your flex credits are in accordance with the current negotiated contract or are based on special Board action.

For all employees, when you select your benefits, if the cost of your benefits exceeds your flex credits, you will have to pay the excess through your payroll deductions.

For employees whose spouse is also employed by the School District, when you select your benefits, you are limited to your own flex credit benefits amounts. Because the cost for family dental is the most expensive benefit you should consider having one spouse elect employee coverage and the other spouse elect employee and children coverage.

YOUR SCHOOL DISTRICT BENEFITS

Your School District Dental Plan

Routine professional dental care is an important part of your family's health care. The School District's Dental Plan offers two choices of dental coverage through MetLife. Both cover a variety of preventive, basic and major services.

These choices allow you to choose a plan that best meets your family's needs. The plan options differ in the level of coverage they provide and the amount you pay for each option. Your choices include:

- Plan A: High Option
- Plan B: Moderate Option

Plan A: High Option

Plan A offers the highest level of dental coverage. This plan stresses preventive care to help you and your family avoid serious dental problems. The plan pays 100% of the covered cost (reasonable and customary charges) of preventive and basic services. It also pays 80% of the covered cost (reasonable and customary charges) of major services and orthodontia care. The maximum benefit you can receive under this plan each year is \$2,000 per person. Orthodontia care carries a separate \$2,000 per person lifetime maximum.

Plan A also includes a Preferred Provider Organization (PPO) feature, which gives you the option of receiving care from PPO participating dental care providers and paying less out-of-pocket.

Participating dentists agree to charge negotiated rates. These rates are typically lower than the rates charged by non-participating dentists. This means that when you visit a participating dentist, your out-of-pocket costs may be less. Remember, when you visit a non-participating dentist, you are responsible for a percentage of the reasonable and customary charges. In addition, you pay any amount above the reasonable and customary limit. Here's an example of how you might save money using a participating dentist compared to a non-participating dentist.

HERE'S AN EXAMPLE

Let's assume you need a major procedure that's covered at 80%:

	Participating Dentist	Non-participating Dentist
Provider's Regular Fee	\$600	\$600
Negotiated Fee	\$375	N/A
Reasonable & Customary Limit	N/A	\$500
Plan Pays	80% of \$375 = \$300	80% of \$500= \$400
You Pay	20% of \$375 = \$75	\$200 (\$600-\$400 = \$200)
Savings obtained by using a participating provider: \$125		

NOTE: This chart is for illustrative purposes only.

To locate a participating provider in your area, visit www.metlife.com/dental or call 1-800-942-0854 to request a provider directory.

Plan Option A Benefit Summary:

Coverage Type:	In-Network	Out-of-Network
Type A - Preventive	100% of PDP Fee*	100% of R&C Fee**
Type B - Basic Restorative	100% of PDP Fee*	100% of R&C Fee**
Type C - Major Restorative	80% of PDP Fee*	80% of R&C Fee**
Type D - Orthodontia	80% of PDP Fee*	80% of R&C Fee**
Deductible***		
Individual	None	None
Family	None	None
Annual Maximum Benefit:		
Per Person	\$2,000	\$2,000
Orthodontia Lifetime Maximum:		
Per Person	\$2,000	\$2,000

- * PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full.
- ** Reasonable & Customary charges are based on the research of a dentist's usual, actual & community average charge as determined by MetLife.

Plan B: Moderate Option

Plan B offers a moderate level of dental coverage. This plan stresses preventive care to help you and your family avoid serious dental problems. The plan pays 100% of the covered cost (reasonable and customary charges) of preventive services. It also pays 80% of the covered cost (reasonable and customary charges) of basic restorative services, and 50% of major services and orthodontia care. A deductible of \$25 per person and \$50 per family must be met before the plan pays any benefits. If your actual charges exceed the amount payable under the plan, you pay the difference. The maximum benefit you can receive under this plan each year is \$1,500 per person in-network, or \$1,000 out of network. Orthodontia carries a separate \$1,500 lifetime maximum in-network.

Plan B also includes a Preferred Provider Organization (PPO) feature, which gives you the option of receiving care from PPO participating dental care providers and paying less out-of-pocket.

Participating dentists agree to charge negotiated rates. These rates are typically lower than the rates charged by non-participating dentists. This means that when you visit a participating dentist, your out-of-pocket costs may be less. Here's an example of how you might save money using a participating dentist compared to a non-participating dentist.

HERE'S AN EXAMPLE

Let's assume you need a major procedure that's covered at 50%:

	Participating Dentist	Non-participating Dentist
Provider's Regular Fee	\$600	\$600
Negotiated Fee	\$375	N/A
Reasonable & Customary Limit	N/A	\$500
Plan Pays	50% of \$375 = \$187.50	50% of \$500= \$250
You Pay	50% of \$375 = \$187.50	\$350 (\$600-\$250 = \$350)
Savings obtained by using a participating provider: \$162.50		

NOTE: This chart is for illustrative purposes only.

To locate a participating provider in your area, visit www.metlife.com/dental or call 1-800-942-0854 to request a provider directory.

Plan Option B Benefit Summary:

Coverage Type:	In-Network	Out-of-Network
Type A - Preventive	100% of PDP Fee*	100% of R&C Fee**
Type B - Basic Restorative	80% of PDP Fee*	80% of R&C Fee**
Type C - Major Restorative	50% of PDP Fee*	50% of R&C Fee**
Type D - Orthodontia	50% of PDP Fee*	50% of R&C Fee**
Deductible***	In-Network	Out-of-Network
Individual	\$25	\$25
Family	\$50	\$50
Annual Maximum Benefit:	In-Network	Out-of-Network
Per Person	\$1,500	\$1,000
Orthodontia Lifetime Maximum:	In-Network	Out-of-Network
Per Person	\$1,500	\$1,000

- * PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full.
- ** Reasonable & Customary charges are based on the research of a dentist's usual, actual & community average charge as determined by MetLife.
- *** Applies only to Type B & C Services.

What is Covered

The plans pay for many of the preventive, basic and major services you and your family receive. The following services are covered under both plans.

Type A - Preventive	How Many/How Often:
Prophylaxis (cleanings)	Two per calendar year.
Oral Examinations	Two exams per calendar year.
Topical Fluoride Applications	One fluoride treatment per calendar year for dependent children up to 18th birthday.
X-rays	Full mouth X-rays: one every 36 months. Bitewing X-rays: two sets per calendar year.
Sealants	One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday.

Type B - Basic Restorative	How Many/How Often:
Fillings	When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Simple Extractions	
Crown, Denture, and Bridge Repair	
Oral Surgery	
Endodontics	
General Anesthesia	
Periodontics	
Space Maintainers	

Type C - Major Restorative	How Many/How Often:
Dental Implants	Initial placement to replace one or more natural teeth, which are lost while covered by the Plan.
Bridges and Dentures	Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. Dentures and bridgework replacement: one every 5 years. Replacement of an existing temporary full denture if the

	temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Crowns/Inlays/Onlays	Replacement: once every 5 years.

Type D - Orthodontia	
<ul style="list-style-type: none"> • Adult and dependent orthodontia covered. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • Benefit for initial placement of the appliance will be made representing 20% of the total benefit. • Orthodontic benefits end at cancellation of coverage. 	

What is Not Covered

It is important to understand what your plan covers and how much of your benefits it will pay. Advance claim review helps you understand what your copayment will be and any other cost for which you may be responsible.

The following is a list of exclusions and limitations under your dental plan. Please refer to the actual plan documents or contact MetLife at 1-800-942-0854 for more details on limitations and exclusions:

- Services that are not considered reasonable and customary
- Services not performed by a dentist, with the exception of licensed dental hygienists and routine x-rays
- Services performed by or for the government unless payment of the charge is required by law
- Services that would have been covered by the government, except for Medicaid
- Replacement or modification of dentures, bridges, crowns, or gold restoration within five years of installation
- Dentures or bridges that replace natural teeth when the teeth were missing before you were covered. This does not apply if the denture or bridge also replaces a natural tooth that was removed while you are covered and was not an abutment to a partial denture or bridge installed in the last five years.
- Appliances, services, or supplies ordered while you were not covered
- Cosmetic services including crown facing or the facing of artificial teeth behind the second bicuspid, except for certain eligible expenses. Eligible expenses include cosmetic services needed as a result of accidental injuries suffered while you are covered.
- Appliances, restorations, or procedures needed to alter vertical dimensions, restore biting, or correct attrition or abrasion
- Replacement of lost or stolen dental appliances

- Injuries or diseases covered by workers' compensation or other occupational laws
- Charges for treatment that is deemed not medically necessary
- Any charge above the copayment percentage based on reasonable and customary charges. Where benefits are based on a schedule, the dental plans do not pay any amount that exceeds the scheduled benefits.

Orthodontia

Orthodontia benefits for you and your eligible family members are covered both plans. These plans provide benefits for the following:

- Services or supplies provided for an orthodontia procedure during the term of treatment
- Active appliances inserted while covered under the plan
- Services that correct overbites, overjets, faulty alignment, or crossbites
- Services your dentist submitted for pre-approval with the insurance company and were approved

When Coverage Ends

Your coverage generally ends on the earliest of the:

- Last day of the month in which your employment ends
- Date you are no longer eligible for benefits
- Last day of the period for which you have made the required contributions
- Date coverage is cancelled

Coverage for your family generally ends when your coverage ends or when a dependent is no longer eligible.

Continuation of Coverage

In certain circumstances, you may continue dental coverage for yourself and your family when your coverage ends.

Coordination of Benefits

If you have dental coverage through your spouse's employer or another source, and have coverage through the School District's plan, a provision known as Coordination of Benefits may reduce your benefit under the School District's plan so your combined benefits will not be more than the expense recognized by both plans. It is important that you understand the Coordination of Benefits guidelines that determine which of your plans pay benefits first.

Appealing a Claim

For dental benefits, if your claim is denied in whole or part, you will be notified in writing. The notification will include the reasons for the denial and any additional

information required if you want to appeal. Learn when and how to appeal your claim on page 29.

Glossary

The following explanations will help you understand how the dental plans work.

Annual Benefit Maximum. For each plan year, each plan pays a maximum dollar amount toward your covered dental expenses. Once your dental benefits reach this dollar maximum, you are not eligible for dental benefits until the beginning of the next plan year.

Copayment. After the plan pays a percentage of the reasonable and customary fee for dental services the remaining cost is your copayment. For example, if the plan pays 80% of a basic or major service, the remaining 20% is your copayment. Keep in mind the actual charges may be greater than what the insurance company defines as a reasonable and customary charge. If so, you are responsible for payment of any amounts over the reasonable and customary limits.

Deductible. This is the amount that you and your family must pay for covered basic and major services before the plan will pay any benefits under Plans B and C.

Dentist. For the purposes of these plans a dentist must be licensed and acting within the scope of his/her profession. Any other doctor or professional providing dental services must also operate within the scope of services he/she is licensed to perform.

Participating Dentist. A dentist who is a member of the MetLife network. Keep in mind you receive a higher level of benefits by coordinating your care through a dentist who is in the network. To obtain a directory of participating dentist, call MetLife at 1-800-942-0854.

Reasonable and Customary (R&C). The plans only pay for charges that are within reasonable and customary limits. This is an amount generally charged for similar services within your geographic area. If the fee is higher than the reasonable and customary charge, you are responsible for the remaining percentage of the charge (your copayment), as well as the charges above the reasonable and customary limit.

Your School District Vision Plan

The Vision Care Plan is administered by Vision Benefits of America (VBA). If you enroll in the plan, you may choose to receive care from a VBA-participating provider and receive a higher level of benefits, including 100% coverage for a vision exam and lenses. Alternatively, you may choose to receive care from a non-participating provider and have treatment reimbursed at a reduced level.

How the Vision Care Plan Works

Each time you or a covered spouse or dependent needs vision care, you must verify that you are eligible for services. You can either contact VBA's Customer Service Dept. at 800-432-4966 or visit VBA's website at www.visionbenefits.com. You can request a benefit form be mailed to your home address or, if your VBA doctor will accept an electronic authorization, you can ask them to obtain one on your behalf. To find out which doctors accept the electronic authorizations, call VBA or log on to their website. You must present the mailed form to your provider on your first visit.

What is Covered

Whether or not you choose a VBA-participating provider, vision care benefits includes a vision exam, standard lenses and a pair of frames once every 12 months. You and your covered spouse and dependents are eligible for the following benefits:

Benefit	Frequency	VBA Participating Provider	Non-Participating Provider
Vision Exam	Once every 12 months	Covered 100%	\$35 Maximum Reimbursement
Clear Standard Lenses			
Single Vision	Once every 12 months	Covered 100%	\$40 Maximum Reimbursement
Bifocal		Covered 100%	\$50 Maximum Reimbursement
Blended "No Line" Bifocals		Covered 100%	\$50 Maximum Reimbursement
Trifocal		Covered 100%	\$75 Maximum Reimbursement
Lenticular		Covered 100%	\$100 Maximum Reimbursement
Progressive Multifocal		Covered 100%	\$75 Maximum Reimbursement

Polycarbonate Lenses		Covered 100%	Not covered
Tints/UV Protective/ Scratch Resistant Coatings		Covered 100%	Not covered
A/R coatings		Covered 100%	Not covered
Photocromic Lenses		Covered 100%	Not covered
Frames	Once every 12 months	Covered 100% up to \$75 wholesale allowance (approximately \$160 to \$200 retail)	\$60 Maximum Reimbursement

NOTE: When you use a VBA provider, you must present a VBA benefit form on your first visit.

*The UCR (usual, customary and reasonable) fee is charged by other providers in a specific geographic area.

Contact Lenses Selected in lieu of glasses

Contacts and a contact lens exam are reimbursed up to a combined maximum of \$190.

Contacts - Medically Required

VBA will pay 100% of the UCR fee* if you use a VBA-participating provider and \$250 if you use a non-participating provider.

Additional Vision Care Benefits

The following options are supplementary cosmetic benefits available through the Vision Care Plan for an additional cost. All fees for additional benefits are set by VBA.

- Rimless frames
- Lamination of a lens or lenses
- Contact lenses or frames in excess of what is covered by the plan

Call VBA's Customer Service Department at 1-800-432-4966 or visit the VBA Web site for information about these benefits.

What is Not Covered

Your vision care benefit does not cover the following:

- Orthoptics or vision training
- Two pair of glasses in lieu of bifocals
- Services or materials provided as a result of any Workers' Compensation Law (or similar legislation)

- Replacement of lost or broken lenses or frames provided under this plan other than the normal intervals when services are otherwise available
- Non-prescription lenses
- Medical or surgical treatment of the eyes
- Any eye examination, or corrective eyewear, required by an employer as a condition of employment
- Glasses and contact lenses during the same eligibility period (once in 12 months)
- High index lenses

If you use a VBA-participating provider, but do not provide the VBA benefit form on your first visit, your vision care services may not be covered under VBA's higher level of benefits for using network providers. In this instance, the VBA-participating provider may elect to charge his or her UCR fees.*

* The UCR (usual, customary and reasonable) fee is charged by other providers in a specific geographic area.

When Coverage Ends

Your coverage generally ends on the earliest of the:

- Date your employment ends
- Date you are no longer eligible for benefits
- Last day of the period for which you have made the required contributions
- Date coverage is cancelled

Coverage for your family generally ends when your coverage ends.

Continuation of Coverage

In certain circumstances, you may continue vision coverage for yourself and your family when your coverage ends.

Appealing a Claim

For vision coverage benefits, if your claim is denied in whole or part, you will be notified in writing. The notification will include the reasons for the denial and any additional information required if you want to appeal. Learn when and how to appeal your claim on page 29.

Your School District Life and AD&D Insurance Plan

The Life and Accidental Death and Dismemberment (AD&D) Insurance Plan provides valuable benefits for you and your family if you become seriously injured or die while you are insured.

Recognizing that benefit needs can change, the School District has included several options in your life and accident insurance coverage to protect your family from financial hardship. One option offers you the ability to continue your coverage if you become totally disabled. You may also elect to receive part of your life insurance coverage while you are still living if you become terminally ill. In addition, under certain conditions, you may convert your life insurance to an individual policy if you leave the School District.

Life Insurance Benefits

A life insurance benefit is paid to your beneficiary in the event you die while you are insured. Your life insurance benefit depends on your age and is equal to the amount shown on the following table up to a maximum of \$350,000.

Age	Benefit*
Up to age 65	Two times your annual earnings
Age 65-69	One times your annual earnings
Age 70-74	Half of your annual earnings
Age 75+	\$5,000

*The amount of your life insurance benefit is rounded up to the next \$500.

In all cases, the minimum benefit your beneficiary will receive is \$5,000, unless you have collected under the accelerated death benefit and only the balance is paid to the beneficiary.

Accidental Death and Dismemberment (AD&D) Benefits

AD&D coverage pays the benefits to your beneficiary for the loss of your life or to you for the loss of your sight, hand, foot, hearing or speech as the result of an accident. AD&D benefits are in addition to your life insurance through the School District. Benefits are paid only if you are insured at the time of the loss, the loss is within 90 days of the accident that caused it, and the loss is directly from the accident and from no other cause

The following table shows the AD&D benefit amounts for each specific type of loss:

Type of Loss	Amount of Benefit*	Benefit Recipient
Life	100% of your life insurance benefit	Your beneficiary
Both hands, both feet, or sight in both eyes	100% of your life insurance benefit	You
Both hearing and speech	100% of your life insurance benefit	You
Hearing or speech	50% of your life insurance benefit	You
One hand, one foot, or sight in one eye	50% of your life insurance benefit	You
Thumb and index finger of the same hand	25% of your life insurance benefit	You

*The maximum AD&D benefit payable for all losses resulting from a single accident is the full amount of your life insurance benefit depending on your age at the time of loss.

WHAT IS NOT COVERED BY AD&D INSURANCE

This coverage is for losses caused by accidents. No benefits are payable for a loss caused or contributed to by:

- (1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or
- (2) caused by suicide, or intentionally self-inflicted injuries; or
- (3) caused by or resulting from war or any act of war, declared or undeclared; or
- (4) caused by an accident that occurs while in the armed forces of any country, except as shown under the Reserve- National Guard Benefit (any premium paid to us for any period not covered by this Policy while the Insured is in such service will be returned pro rata); or
- (5) caused by or resulting from riding in, getting into or out of any aircraft, unless:
 - (a) the Insured Person is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
 - (b) the aircraft is not owned, leased or operated by or on behalf of you, the Insured Person or any other employer of the Insured Person, unless a specific written agreement has been obtained from us; or
- (6) sustained during the Insured Person's commission or attempted commission of an assault or felony.

Beneficiaries/Payment of Benefits

When you enroll for coverage, you will be asked to complete a form naming your beneficiary. You may name any person(s), trust, estate, or charity as your beneficiary. The beneficiary you elect for life insurance will be the same beneficiary for death

benefits under your AD&D coverage. It is important to keep your beneficiary designation up to date.

You have the right to change your beneficiary at any time by making a written request (appropriate forms are available on the website and from your Employee Benefits Office). It is important to notify the School District's Employee Benefits Office promptly of any beneficiary change.

If you choose more than one person as your beneficiary and do not specify how you would like your insurance to be shared among the beneficiaries, they will share equally.

If you do not choose a beneficiary, if you have not named a beneficiary, or the named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you: (1) your legal spouse; (2) your surviving children (including legally adopted children), in equal shares; (3) your surviving parents, in equal shares; (4) your surviving siblings, in equal shares; or, if none of the above, (5) your estate.

PAYMENT OF YOUR BENEFITS TO YOUR BENEFICIARY

As soon as the School District is notified of your death, your beneficiary will be contacted about the benefits available and what forms are needed to process the claim. At this time, your beneficiary may decide if the benefit will be paid to them in installments or in a lump sum. A claim must be filed within 90 days after the end of the calendar year of your death. If a claim is already pending, contact the School District's Employee Benefits Office for an explanation of the claim procedure.

We will not be liable for any payment we have made in good faith. If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary.

If You Become Disabled

The Amount of Insurance during a period of Total Disability for one year will be extended if:

- you become totally disabled prior to age 70;
- the Total Disability begins while you are insured;
- the Total Disability begins while the Policy is in force;
- the Total Disability lasts for at least 6 months;
- the premium continues to be paid; and

- Proof of Total Disability is received within one (1) year from the date it began.

After proof of Total Disability is approved, you are not required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned. You must submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one year periods. You may be required to be examined by an approved Physician approved. You will not need to be examined more than once a year after the insurance has been extended two full years.

The Amount of Insurance extended will be limited to the amount of basic group life coverage on your life that was in force at the time that Total Disability began excluding any additional benefits. This amount will reduce or cease at any time if you had not been totally disabled. The Amount of Insurance extended for you will cease on the earliest of:

- the date you no longer meet the definition of Total Disability; or
- the date you refuse to be examined; or
- the date you fail to furnish the required proof of Total Disability.

If you qualify for benefits in accordance with the Waiver of Premium in Event of Total Disability provision because you have been diagnosed by a Physician as totally disabled due to the following Condition(s) or Procedure(s), as later defined;

- Life Threatening Cancer; or
- Heart Attack (Myocardial Infarction); or
- Kidney (Renal) Failure; or
- Receipt of Major Organ Transplant; or
- Stroke.

You will receive an additional, one time, lump sum benefit in an amount equal to 10% of the death benefit under the basic life portion of the policy up to a maximum of \$100,000. This lump sum benefit applies only to the first Condition or Procedure to occur among those hereinafter defined which qualifies you for waiver of premium benefits. No further lump sum benefits will be payable under this provision during the same or any subsequent periods of Total Disability, or as a result of the occurrence of any other Condition or Procedure.

If You Become Terminally Ill

If you become terminally ill, you may elect to receive 75% of your life insurance benefit while you are still living. By electing to receive a part of the benefit in advance, you

forfeit that portion of the benefit amount that would have been paid to your beneficiary after your death. It is important to note that if, while you are receiving this benefit, your age changes to make you eligible for another age group, your benefit amount will be reduced accordingly. Your benefit will be paid to you in one lump sum.

You are eligible to receive a portion of your benefit if:

- You provide a written request
- You are under age 75
- You have been covered for at least 60 days
- You voluntarily elect to receive this benefit.
- Your assignee or irrevocable beneficiary must submit their signed acknowledgment and agreement for payment of this benefit.

NOTE: You are not eligible for this benefit if you are required to use this option to meet creditor claims, such as bankruptcy; or if you are required by a government agency to apply, receive, or keep government benefits.

If You Leave the School District

If you leave the School District, your life insurance and AD&D benefits stop. You may convert all or part of your life insurance and AD&D benefits to an individual policy during the 31 days following the date your employment ends. You will not need a medical exam or evidence of insurability to convert your coverage but you will need to complete a written application. If you die within the 31 days after your employment ends, your life insurance benefit through the School District will be paid to your beneficiary. The benefit is equal to the same amount you would be entitled to if you had not left the School District.

The premium for the individual policy will be based on your age at the time you convert and for an amount that does not exceed your coverage in effect before your employment ended. Special conversion rules apply if coverage is terminated for all participants in your class. You must pay the first premium by the 31st day after your employment ends.

The life insurance converted policy's Principal Sum will be an amount not over what you had at your time of termination. The AD&D converted policy's Principal Sum will be the lower of: the Amount of Principal Sum applicable under the Policy or \$350,000.

When you retire, you can convert all or part of your life insurance to an individual policy just as you could have had you left the School District for any reason.

WORK AND FAMILY LIFE CHANGES

As your life changes, your benefits status and needs may change. This section can help you when you experience a major life change. It highlights your benefits status, options and issues to consider if you marry, have or adopt a child, retire, etc.

Typical changes are listed below:

- You are hired
- You get married or have/adopt a child
- You become disabled
- You retire
- You die while employed
- You end employment

You Are Hired

The chart below illustrates what happens to your benefits **when you are hired** (and scheduled to work 10 or more hours a week):

Plan	Eligibility	Coverage Available	Benefits Include
Dental	You are eligible on the first of the month on or after your hire date	For you, your spouse, and your dependent children Coverage for Eligible dependents ends as follows: <ul style="list-style-type: none"> • December 31st of the year in which he or she reaches age 21. • If a full-time student, coverage will end on the earlier of the following: <ol style="list-style-type: none"> (1) the end of the month in which dependent child is no longer a full-time student, or (2) the end of the month in which the dependent child attains age 24. • The last day of the month in which the child marries. 	Three dental plan choices. All include preventive, basic, and some major services. Two include orthodontia.

Vision Care	You are eligible on the first of the month on or after your hire date	Same as Dental- see above.	Vision care benefits through VBA.
Life and Accidental Death & Dismemberment	You are eligible on your date of hire.	For you	Life Insurance. Up to two times your annual earnings to a maximum of \$350,000, depending on your age. AD&D. Up to 100% of your life benefit, depending on your injury.

You Get Married Or Have/Adopt A Child

Plan	
Dental and Vision Care	You have up to 30 days to add a dependent. Otherwise, you must wait until the next open enrollment period
Life and Accidental Death & Dismemberment	You may want to change your beneficiary designation.

You Become Disabled

Plan	
Dental and Vision Care	You can continue coverage for up to 18 months by paying the full cost plus 2%.
Life and Accidental Death & Dismemberment	Your life insurance coverage may continue at no cost to you after you have been disabled for nine months, provided you are under age 70. AD&D coverage is discontinued.

You End Employment or Retire

Plan	
Dental and Vision Care	You can continue coverage for up to 18 months by paying the full cost plus 2%.
Life and Accidental Death & Dismemberment	Your life and AD&D benefits end. Life insurance benefits may be converted to an individual policy, contact the Benefits Office within 30 days of the date you end employment.

Other Important Information About State of Delaware Plans

For other important information about the plans offered by the State of Delaware, please visit the Delaware Statewide Benefits Office web site at

<http://www.ben.omb.delaware.gov/>

OTHER IMPORTANT INFORMATION ABOUT YOUR SCHOOL DISTRICT PLANS

This section contains information about important matters pertinent to certain benefit plans offered by the School District. You should read this section carefully. The information may be needed for filing claims and other inquiries about your benefits.

In this section you'll find information about:

- Continuation of Coverage (COBRA)
- Coordination of Benefits
- Appealing a Claim
- Plan Funding

Continuation of Coverage (COBRA)

Continuation of coverage is available to you and your covered family members if coverage under the School District's dental, vision, or prescription drug plans ends because of one of the qualifying events described below. To continue coverage, you or your covered family members must apply and pay for continuation of coverage before the deadline for payment.

If you have any questions about COBRA or its application, please contact the School District's Employee Benefits Office, 318 E Basin Road, New Castle, DE 19720, (302) 323-2732. All notices described below should be addressed to the School District's

Employee Benefits Office. Also, if you have changed your marital status, or you or your spouse have changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the plan, you must notify the Employee Benefits Office as soon as you become aware of the event.

COBRA Eligibility

You and your covered spouse and dependents (referred to as qualified beneficiaries under COBRA) may purchase continued coverage for up to 18 months if you lose coverage under the plan due to:

- Termination of your employment (for reasons other than misconduct) **or**
- A reduction of your work hours

PREEXISTING CONDITION LIMITATION

Once you have elected COBRA, if you or your covered spouse or dependent become covered under another group plan and are affected by a preexisting condition limitation under that plan, COBRA coverage may continue until you have satisfied the preexisting condition limitations under your new plan (at which point your COBRA coverage may be terminated).

IN CASE OF DISABILITY

You and your covered spouse and dependents may be eligible for a total of 29 months of continued coverage if you or a covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at the time of your termination of employment or within 60 days of the qualifying event. This 11 month extension is available to all family members who are qualified beneficiaries due to termination or reduction on hours of employment, including those who are not disabled. You must notify the School District's Employee Benefits Office in writing that you or a covered family member is disabled within the initial 18 –month coverage period and within 60 days of Social Security's disability determination. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must have last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide the written determination of disability from the Social Security Administration to the Employee Benefits Office within 60 days of the latest of:

- The date of the disability determination by the Social Security Administration,
- The date of the qualifying event, or
- The benefit determination date.

You will be required to pay up to 150% of the group rate during the 11-month extension. Your verbal notice is not binding until confirmed in writing and until a copy of the determination from the Social Security Administration is provided to the Employee Benefits Office.

If during continued coverage, the Social Security Administration determines that you or the family member is no longer disabled, you or your family member must in for the School District's Employee Benefits Office of the redetermination within 30 days of the date is made. If another qualifying event occurs within the 29-month continuation period, then the maximum continued coverage period is 36 months after termination of employment or reduction in hours.

Continued Coverage for Dependents

Your covered spouse and dependents may purchase continued coverage under the School District's plan for 36 months, if they lose coverage as a result of your:

- Death,
- Divorce or legal separation,
- Entitlement to Medicare, or
- Dependent child ceasing to be a dependent as defined by the plan.

If you become entitled to Medicare while you are an active associate and you later experience a qualifying event (e.g. terminate your employment), your dependents may be eligible for continued coverage until the later of:

- 36 months from the date you first became covered by Medicare, or
- The maximum coverage period for the qualifying event (18 months in the case of termination of employment).

SEPARATE ELECTIONS

You and your covered spouse and dependents can elect COBRA coverage independently. For example, a spouse or dependent child may elect continuation coverage even if you do not elect continuation coverage.

NEWBORN AND ADOPTED CHILDREN

If you give birth or adopt a child while you are on COBRA continuation coverage, you may enroll your new child for COBRA coverage immediately. Your newborn or adopted child will be a "qualified beneficiary". This means that the child will have independent election rights and multiple qualifying event rights.

Multiple Qualifying Events

Should your spouse or dependents experience more than one qualifying event, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event. For example, if you terminate employment, you and your spouse or dependents may be eligible for 18 months of continued coverage. If during this 18 month period, your spouse or dependent child

ceases to be a dependent under the plan (a second qualifying event), your spouse or child may be eligible for an additional period of continued coverage. This additional period may not exceed a total of 36 months from the date of your termination (the first qualifying event).

How to Get Continued Coverage

Both you and the School District have responsibilities if qualifying events occur that make you or your covered dependents eligible for continued coverage.

You or your covered dependents must notify the School District's Employee Benefits Office in writing within 60 days of the date of the qualifying event or the date coverage ceased under the plan, whichever is later, when one of these events occurs:

- You become divorced or legally separated, or
- Your dependent child is no longer considered and eligible dependent as defined by the plan.

This notice must include the name of the employee, the name of the qualified beneficiaries entitled to COBRA, and the date of the event giving rise to COBRA entitlement. This 60-day period is different from the 30-day period you have to notify the School District when you have experienced a life event in order to change your coverage status. If notification is not provided during this 60-day period, any covered dependent who loses coverage will not be permitted to elect COBRA coverage.

The School District will notify you or your covered dependents of the right to elect continued coverage should the following events occur:

- Termination of employment,
- Reduction in work hours, or
- Your death

ELECTION PERIOD

You and your covered dependents will have a 60-day period in which to elect continued coverage, beginning on the later of :

- The date your coverage terminates by reason of the qualifying event, or
- The date you or your covered dependents are sent notification of the right to elect continued coverage.

TYPE OF COVERAGE

If you choose continued coverage, you will have the same coverage that you had the day before your qualifying event. You will not be asked to furnish evidence of good health.

Cost of Continued Coverage

You and your covered dependents may be required to pay up to 102% of the full group cost for your continued coverage. You will be asked to pay for coverage in monthly installments, and you must make your first payment no later than 45 days after the date you elected continued coverage. Subsequent payments will be due on the first of each month, with a 30-day grace period. If the cost of benefits changes in the future for active employees, these changes will also affect continued coverage under COBRA on an annual basis. You will be notified in advance of any changes in the cost of coverage.

Termination of Continued Coverage

Your right to purchase continued group coverage may end before the expiration of the 18, 29 or 36 month coverage period if:

- You or your covered dependents fail to make the required payment on time,
- The School District terminates the plan for all employees,
- You or your spouse becomes entitled to Medicare after the date COBRA is elected,
- You or your covered dependents become covered under another group health plan after the date COBRA is elected (Your continued coverage with the School District will not be terminated if you or a covered dependent has a preexisting condition that is not covered under the other plan due to a preexisting condition limitation clause.), or
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that you or a covered spouse or dependent are no longer disabled.

NOTE: Coverage under COBRA will be provided as required by law. If the law changes, your rights will also change.

Coordination of Benefits

For Dental Coverage

If you have dental coverage through your spouse's employer or another source, and have coverage through the School District's plan, a provision known as Coordination of Benefits may reduce your benefits under the School District's plan. This is to ensure that your combined benefits will not be more than the expenses recognized by both plans. Your benefits from the other plan will be taken into account when your benefits through

the School District are determined. Coordination of benefits does not apply to any individual policy you have.

Other sources that provide dental benefits include the following:

- Government plan except Medicaid
- Any group coverage (whether insured or not)
- Motor vehicle no-fault coverage

The following guidelines determine which plan pays benefits first:

- The plan covering you as an active employee if the School District pays first
- For dependent children, the plan of the parent whose birthday comes first in the calendar year pays first unless the parents are legally divorced or separated
- If the parents are legally divorced or separated, the benefits for the child are determined as follows (except when a court decrees otherwise):
 - First, the plan of the parent with legal custody pays
 - Then, the plan of the spouse of the parent with legal custody pays
 - Finally, the plan of the parent without legal custody pays
- If you are receiving continuation coverage under the School District's plan, and you are also covered under another plan, the other plan pays first
- If the other plan does not agree with the School District's plan on the order of benefit payment, the rule of the other plan will prevail
- If none of the above apply, the plan that has covered the individual for the longest time pays first

If the claims administrator determines that payments exceed the coordination of benefits provision, the administrator has the right to recover the overpayment from the other insurance company, the other plan sponsor, or you.

Appealing a Claim

For dental, vision care, life insurance and AD&D and long term disability benefits, if your claim is denied in whole or part, you will be notified in writing. The notification will include the reasons for the denial and any additional information required if you want to appeal.

You are entitled to appeal a claim that is denied. To appeal a claim, write to the insurance company within 60 days of the date you receive the denial notice and state the reasons why you believe your claim should not have been denied. Include any additional documentation that supports your claim. You ay also submit questions comments you think are appropriate, and you may review relevant documents. Generally, you will receive a written decision on your appeal within 60 days of the date your insurance company receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days following the receipt of your request.