EMPLOYEE BENEFIT PLAN DOCUMENT

The Plano Independent School District (the "District"), through its Risk Pool, has approved the Plano I.S.D. Employee Benefit Plan (the "Plan") as a benefit to its eligible Employees. All Employees should read this Plan document carefully.

The benefits hereinafter described are available to eligible Employees of the District during the continuance of the Plan, but such benefits are subject to modification or termination at any time with respect to expenses or treatments (including those already in process) not yet incurred.

The District also reserves the right to charge Employees for employee or Dependent coverage and to change such charges at any time. The District will inform the Employee of such charges, or changes herein, prior to their effective date.

Eligible Employees may choose from the health plan options available under TRS-ActiveCare, two dental plans, and four vision plans. This Plan document describes the benefit available under the Employee Assistance Program (EAP) and the eligibility, change of coverage, and termination of coverage rules for the Dental and Vision Plans. **This Plan document does not describe any of the terms of TRS-ActiveCare or any of the benefits available under the Dental and Vision Plans. For a summary of the terms of the health options available under TRS-ActiveCare, see the TRS-ActiveCare Enrollment Guide and Benefits Booklet. For the benefit terms of the Dental and Vision Plans, see the separate dental and vision insurance contracts.**

The EAP, Dental, and Vision Plans are intended to be "excepted benefits" that are exempt from most requirements of the Patient Protection and Affordable Care Act ("PPACA"). To the extent the EAP is not an excepted benefit, it is intended to be a "grandfathered health plan" under the PPACA. As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted, and a grandfathered health plan is not subject to all of the coverage mandates and requirements of the PPACA. If you have any questions or complaints regarding the Plan or its status as a grandfathered health plan, you may contact the Plano ISD Benefits and Risk Management Department (contact information above). You may also contact the U.S. Department of Health and Human Services and www.healthreform.gov.

As a governmental plan, the Plan may opt out of and has opted out of compliance with the Newborns and Mothers Health Protection Act (NMHPA). However, the Plan has been voluntarily amended to comply with some, but not all, of the applicable requirements of the law.

The Plan is to take effect as of 12:01 A.M., central standard time, on September 1, 2024, at Plano, Texas.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
EMPLOYEE ASSISTANCE PROGRAM

The EAP should be the first step in accessing mental health and substance abuse related disorders services. The EAP maintains patient confidentiality as specified in applicable state and federal laws. The EAP is a professional assessment and counseling service provided as a benefit to Employees and their Dependents and serves as an outside source for Employees and Dependents to call upon for consultation in dealing with issues of mental health, substance abuse related disorders, and personal concerns.

For each problem, an established number of visits per plan year to an EAP professional are provided free of charge for every Employee and his or her Dependents. If the EAP counselor finds that the Employee or Dependent requires specialized or longer-term care than the EAP is intended to provide, an effort will be made to expedite a referral to a mental health/substance abuse professional.

Additional information regarding the EAP is provided in the separate EAP brochure, the provisions of which (as amended from time to time) are incorporated into this Plan.

SCHEDULE OF BENEFITS
DENTAL PLAN

THE DENTAL PLAN OPTIONS ARE PROVIDED UNDER A SEPARATE INSURANCE POLICY.

THE ELIGIBILITY, TERMINATION, AND CHANGE OF COVERAGE SECTIONS OF THIS PLAN DOCUMENT APPLY TO THE DENTAL PLAN OPTIONS; HOWEVER, NO OTHER SECTIONS OF THIS PLAN DOCUMENT GOVERN.

PLAN PAYS

FOR DESCRIPTIONS OF COVERED EXPENSES, PLEASE REFER TO THE APPLICABLE DENTAL PLAN INSURANCE CONTRACT.

SCHEDULE OF BENEFITS
VISION PLAN

THE VISION PLAN OPTIONS ARE PROVIDED UNDER A SEPARATE INSURANCE POLICY.

THE ELIGIBILITY, TERMINATION, AND CHANGE OF COVERAGE SECTIONS OF THIS PLAN DOCUMENT APPLY TO THE VISION PLAN OPTIONS; HOWEVER, NO OTHER SECTIONS OF THIS PLAN DOCUMENT GOVERN.

PLAN PAYS

FOR DESCRIPTIONS OF COVERED EXPENSES, PLEASE REFER TO THE VISION PLAN BROCHURE.

II. DEFINITIONS

The following definitions shall apply for purposes of the Plan. These definitions shall not be construed to provide coverage under any benefit unless specifically provided.

A. GENERAL DEFINITIONS

1. Change in Status means an event which permits a mid-year change in an Employee's election to participate in the Plan or a level of coverage under the Plan, as determined under the Employer's Flexible Benefits Plan.

2. Contract Administrator means the person(s) or firm(s) retained by the Risk Pool (including, if applicable designated staff of the Employer or Risk Pool) for the processing of all or a portion of the claims and payment of benefits, administration, accounting, reporting, and other services contracted for by the Risk Pool.

3. Employer means the Plano Independent School District.

4. Plan means the Plano Independent School District Employee Health Benefit Plan as described herein and as amended from time to time.

5. Plan Sponsor means the Risk Pool.

6. Plan Year means the 12-month period from September 1 to the next following August 31.

7. Risk Pool is a legal entity established to provide health and accident coverage for the eligible employees of the Plano Independent School District and the eligible Dependents of such employees.

8. Special enrollment event means an event that allows the Employee and/or the Employee's eligible Dependents for medical, dental, and/or vision coverage during the year if the Employee or one of the Employee's eligible Dependents loses other coverage due to certain circumstances as determined under the Employer's Flexible Benefits Plan.

B. PARTICIPANT DEFINITIONS

1. Employee: a person in a permanent status and regularly scheduled to work at least 25 hours per week. An Employee is not considered to be in permanent status if the Employee is classified by the Employer as a substitute, adult temp, student worker, volunteer, contractor, or other classification that does not have permanent status under the Employer's personnel policies. If an individual is on approved leave status under the Employer's leave policies and was in permanent status immediately prior to or coincident with beginning the leave status, he or she will be deemed to have the same permanent status and to be scheduled to work the same number of hours as prior to or coincident with the beginning of such approved leave status. If an individual is not in the semi-monthly pay group (as established by the Employer) and is an Employee as of the last scheduled work day before his summer break, the individual will be deemed to be an Employee while continuing to receive regular pay through the summer break. If an individual is in the semi-monthly pay group (as established by the Employer) and is an Employee as of the last scheduled work day before his summer break, the individual will be deemed to be an Employee through August 31 of that calendar year. Claims incurred during the summer break by such an Employee in the semi-monthly pay group (or by a Covered Dependent of such an Employee) may be pended until the Employee returns to active, covered employment after the end of the summer break. Deemed Employee status shall end on the date an Employee is involuntarily terminated.

2. Dependent:

    a. The legal spouse of a Covered Employee as defined for purposes of the Internal Revenue Code of 1986, as amended.

b. An eligible child of a Covered Employee. The term child shall include a natural child, legally-adopted child, foster child, stepchild, or grandchild. A child to be acquired by adoption is considered an eligible child from the moment the Covered Employee becomes a party in a suit to adopt the child.

An eligible child may be covered from birth to the end of the calendar month in which he/she reaches age 26.

An eligible child may be covered past age 26 provided the child is primarily supported by the Covered Employee and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of these criteria must be submitted to the Contract Administrator within 31 days after the child's 26th birthday. During the next two years, the Contract Administrator may, from time to time, require proof of the continuation of such criteria. After that, the Contract Administrator may require proof no more than once a year.

c. Excluded as dependents are:

i. any person(s) legally separated or divorced from a Covered Person; or

ii. any person(s) on active military duty for any country, except to the extent required by applicable law; or

iii. any person(s) who fails to meet any of the eligibility criteria.

3. Actively at work - An Employee will be considered actively at work with the Employer on a day which is one of the Employer's scheduled work days if he is performing in the customary manner all of the regular duties of his employment with the Employer on that day, either at one of the Employer's business establishments or at some location to which the Employer's business requires him to travel. An Employee will be considered actively at work on a day which is not one of the Employer's scheduled work days if he was performing in the customary manner all of the regular duties of his employment on the preceding scheduled work day.

An Employee will be considered actively at work on any day when absent from work due to a health factor or when on approved leave status under the Family Medical Leave Act, temporary disability, or any other Employer leave policies.

4. COBRA participant is an individual who was covered under the Plan as an active Employee or Dependent and who was affected by a qualifying event when coverage would normally end, but elected continuation of coverage in accordance with the provisions of COBRA and the terms of the Plan.

5. Contribution means the amount payable by the Employer, the amount payable by the Employee or the amount payable by the Employer/Employee jointly for participation in the benefits of the Plan.

6. Covered Dependent is a Dependent who is eligible for coverage and who has enrolled in the Plan.

7. Covered Employee is an Employee who is eligible for coverage and who has enrolled in the Plan.

8. Covered Person is a Covered Employee or Covered Dependent.

9. Enroll is to make written application for coverage on the prescribed forms. Enrollment is not completed until such forms are received by the Employer and any required contribution has been made.

III. ELIGIBILITY AND CHANGE OF COVERAGE

A. INITIAL ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

1. Covered Employees

An eligible Employee may become a Covered Employee provided the Employee is actively at work on the date of eligibility.

The date of eligibility for a newly eligible Employee is the first day of the month following the attainment of "Employee" status. For purposes of the Employee Assistance Program only, the date of eligibility is the date of employment or re-employment as an Employee.

2. Covered Dependents

An eligible dependent may become a Covered Dependent in the EAP, Dental, or Vision Plan benefits simultaneously with the related Employee becoming a Covered Employee.

If both spouses are eligible Employees, one may be a Covered Dependent of the other. No person will be eligible for coverage under this Plan simultaneously as both a Covered Employee and a Covered Dependent or as a Covered Dependent of more than one Employee.

3. Enrollment

The Employee and/or Dependents' coverage is effective on the date of eligibility provided that enrollment is made and received by the benefits and risk management department of the Employer on or before the date of eligibility.

B. ANNUAL ENROLLMENT

Employees may make coverage changes effective as of the first day of each Plan Year, provided an enrollment change form has been completed and returned to the benefits and risk management department of the Employer in advance of such date and in accordance with guidelines established by the Employer.

C. NEWBORN OR NEWLY ADOPTED CHILDREN

A Covered Employee's newborn children are covered at birth in the same Plan options as the Employee if the Covered Employee enrolls the child within thirty-one (31) days after the date of birth. A child who is adopted or placed for adoption will be covered as of the date of adoption or placement for adoption if the Covered Employee enrolls the child within thirty-one (31) days after the adoption or placement for adoption. For purposes of the dental plan only, newborn and adopted children will automatically be covered only for thirty-one (31) days from the date of birth or the date of adoption or placement for adoption. Newborn and adopted children who are not enrolled within these timeframes may not become covered, or continue coverage under the dental plan, until the plan year when coverage is requested during the annual enrollment period. However, a child may be enrolled during the year to the extent required by a Qualified Medical Child Support Order (QMCSO) under the Omnibus Budget Reconciliation Act of 1993. A child who does not qualify as an eligible Dependent cannot be enrolled under the Plan.

A claim for maternity or newborn expenses is not considered as enrollment for coverage of a newborn child.

If additional Dependents are born, adopted or otherwise become Dependents while the Employee is covering Dependent(s) under the Plan and such additional Dependent coverage does not require an increase in the Employee's contribution, such Dependent will not become covered until completion of an enrollment form for such Dependent and until the effective date.

D. CHANGE IN STATUS AND SPECIAL ENROLLMENT

These rules do not apply to the EAP. EAP coverage is automatic for eligible Employees and Dependents and does not require an enrollment election or the payment of any premium by the Employee/Dependent.

An Employee may add or terminate coverage under a dental plan or vision plan, or change the number of Dependents covered by a particular dental or vision option, during the plan year only as a result of a Change in Status or special enrollment event. An application for such change must be made within thirty-one (31) days after the Change in Status or special enrollment event. Otherwise, the change cannot be made until the next annual enrollment period as determined by the Employer. Election changes due to a Change in Status are permitted only to the extent the election change is permitted under the Flexible Benefit Plan. Changes to benefit selections may only be made as a result of a Change in Status event or special enrollment event and must correspond with such event.

Any change made to an Employee's coverage due to change in status or special enrollment event will be effective the first of the month following the change in status or special enrollment event except in the case of newborn or newly-adopted children (as explained herein).

A special enrollment event occurs if the Employee and/or the Employee's eligible Dependents (1) are eligible for coverage under the Plan but chose to decline coverage because the Employee and/or the Employee's eligible Dependents have other medical coverage and (2) subsequently lose that other medical coverage. The Employee and/or the Employee's eligible Dependents may enroll in the Plan as a result of a special enrollment event if either of the following conditions is satisfied: (i) when the Employee declined enrollment in the Plan for the Employee or the Employee's eligible Dependent, the Employee or the Employee's eligible Dependent had COBRA continuation coverage under another plan and that COBRA continuation coverage has since been exhausted, or (ii) when the Employee declined enrollment in the Plan for the Employee or the Employee's eligible Dependent, the Employee or the Employee's eligible Dependent had coverage other than COBRA continuation coverage and either the other coverage has terminated as a result of a loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment. Loss of eligibility does not include a loss of coverage due to a failure to timely pay premiums or the termination of coverage for cause (such as a termination of coverage for making a fraudulent claim).

If a person becomes an eligible Dependent through marriage, birth, adoption, or placement for adoption, the new Dependent may be enrolled in the Plan after the occurrence of such event, subject to the deadlines for enrolling after a Change in Status or special enrollment event. If the Employee is eligible for enrollment but not enrolled, he/she must also enroll to enroll the new Dependent. In the case of the birth, adoption, or placement for adoption of a child, the Employee's legal spouse may also be enrolled as a Dependent during such period if such spouse is otherwise eligible for coverage but not already enrolled.

IV. TERMINATION AND CONTINUATION OF COVERAGE

A. TERMINATION OF COVERAGE

The coverage of any Employee or Dependent under any benefit shall automatically cease on the earliest to occur of:

1. The last day of the month in which the Employee's actively at work status ceases; or

2. The last day of the month in which the Employee ceases to be in a class of Employees eligible for the coverage; or

3. The last day of the month immediately preceding the first month for which an Employee fails to make all or part of any required contribution for coverage within thirty (30) days after the date such contribution was due; or

4. The last day of the month in which the Employee dies; or

5. The date the Plan is discontinued with respect to the Employer; or

6. The date the Plan is discontinued with respect to the class of Employees to which such Employee belongs; or

7. The last day of the month in which the Covered Person ceases to be eligible as defined herein; or

8. Except to the extent required by applicable law, the date the Covered Person becomes an active member of the Armed Forces of any country or state or international organization or becomes a member of any civilian force auxiliary to any military force; or

9. The date the Employee elects to waive or terminate coverage for the Employee and/or the Employee's Covered Dependents in connection with a Change in Status or leave under the Family Medical Leave Act; or

10. The date the Plan is amended to terminate coverage.

Subsections (1) and (2) above are subject to the requirements of Texas Education Code Section 22.004(k)-(l) for the TRS-ActiveCare medical options only. Therefore, for the employee assistance program, dental plan, and vision plan, if an Employee voluntarily resigns his or her employment with the Employer effective after the last day of the instructional year, the Employee may remain covered by the Plan until the last day of the month in which he or she receives his or her final paycheck for regular pay (excluding pay for vacation or other leave).

If coverage terminates retroactively (for example, due to a failure to pay all of the required contribution for coverage for a month), any partial contribution paid for such coverage shall be refunded to the Employee, and the Employee and any other recipient or holder of any benefits paid with respect to periods after the retroactive termination date shall be jointly and severally liable to repay such benefits to the Plan. The Plan has a right to recover such benefits from the person or agency who received or holds such benefit, and may offset such amount from any other benefits otherwise payable under the Plan. Such excess amount is subject to a constructive trust in favor of the Plan. The person receiving or holding plan benefits must produce any instruments or papers necessary to ensure the Plan's right of recovery.

The Employer reserves the right to terminate the Plan or change any of its benefits or required contributions at any time.

B. COBRA CONTINUATION OF COVERAGE

COBRA continuation coverage will be made available to eligible qualified beneficiaries as required by the amendments to Title XXII of the Public Health Services Act adopted pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) and by mandatory provisions of the American Rescue Plan Act of 2021. Under no circumstances will benefits during the continuation of coverage period be greater than those benefits provided prior to such continuation of coverage period. Continuation of coverage under COBRA will not apply if the Employer ceases to maintain any group health plan for any employee.

During the annual enrollment period determined by the Employer, COBRA participants may exercise the same rights as active Employees in making changes in their coverage.

The Plan does not provide for continuation coverage except as required by law. Therefore, the following provisions will be construed and applied to provide continuation coverage only to the minimum extent required by law.

1. Eligibility for COBRA Continuation Coverage. COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a "qualifying event." Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

    a. A Covered Employee will become a qualified beneficiary if he or she will lose coverage under the Plan because either one of the following qualifying events happens:
        1. his or her hours of employment are reduced, or
        2. his or her employment ends for any reason other than his or her gross misconduct.

        For purposes of determining the date of the qualifying event, an individual who is deemed to be an Employee during the summer break shall be considered to terminate employment or to experience a reduction in hours of employment (as applicable) when such deemed Employee status ends. Deemed Employee status shall end on the date an Employee is involuntarily terminated.

    b. A Covered Spouse will become a qualified beneficiary if he or she will lose coverage under the Plan because any of the following qualifying events happens:
        1. his or her spouse dies;
        2. his or her spouse's hours of employment are reduced;
        3. his or her spouse's employment ends for any reason other than his or her gross misconduct;
        4. his or her spouse becomes enrolled in Medicare (Part A, Part B, or both); or
        5. he or she becomes divorced or legally separated from his or her spouse.

    c. Covered Dependent Children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:
        1. the parent-employee dies;
        2. the parent-employee's hours of employment are reduced;
        3. the parent-employee's employment ends for any reason other than his or her gross misconduct;
        4. the parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
        5. the parents become divorced or legally separated; or
        6. the child stops being eligible for coverage under the Plan as a "Dependent child" as defined in the Plan Document.

    The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plano ISD benefits and risk management department has been 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 HR department will notify the benefits and risk management department of the qualifying event within 30 days following the date coverage will end.

For the other qualifying events {divorce or legal separation of the employee and spouse, a Dependent child's losing eligibility for coverage as a Dependent child, or enrollment of the employee in Medicare (Part A, Part B, or both)}, a Covered Person is required to notify the benefits and risk management department within 60 days after the qualifying event occurs. The notice must specify the type and date of the qualifying event; the name and social security number of the covered Employee; the names, dates of birth, and social security numbers of affected qualified beneficiaries; and such other information as is required by the benefits and risk management department. This initial notice to the benefits and risk management department may be done in writing, in person, or by telephone, and may be provided by a Covered Employee or Covered Dependent. The benefits and risk management department will provide a form for the Covered Employee's signature and will inform him or her of the documentation required to process the qualifying event. **If the required notice is not provided to the benefits and risk management department within in the 60-day period described above, COBRA continuation coverage will not be available**. Special notice timing rules apply in the case of second qualifying events. These rules are described later in this section.

Once the benefits and risk management department receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

2. Length of COBRA Continuation Coverage. COBRA continuation coverage is a temporary continuation of coverage.

   a. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), divorce or legal separation, or a Dependent child losing eligibility for coverage as a Dependent child, COBRA continuation coverage may last for up to 36 months.

   b. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage may last for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

      i. Disability extension of 18-month period of COBRA continuation coverage: If any qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and the benefits and risk management department is notified within 60 days of the date of the determination and before the end of the initial 18-month period, all qualified beneficiaries can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This notice should be sent in writing to the benefits and risk management department.

      ii. Second qualifying event extension of 18-month period of COBRA continuation coverage: If another qualifying event occurs while receiving COBRA continuation coverage, the Covered Spouse and Dependent Children can get additional months of COBRA continuation coverage, up to a total maximum of 36 months. This extension is available to the Covered Spouse and Dependent Children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Covered Dependent Child when that child stops being eligible under the Plan as a Dependent child. In all of these cases, the benefits and risk management department must be notified of the second qualifying event within 60 days of the second qualifying event and within the original 18- or 29-month COBRA continuation period. **If the required notice is not provided to the benefits and risk management department within the required period, COBRA continuation coverage will not be extended**.

3. Election of COBRA Continuation Coverage. Continuation coverage must be elected within an election period of 60 days. The 60-day period starts on the later of:
   a. the date coverage would otherwise terminate because of a qualifying event; or
   b. the date the Employer furnishes notice of the right to elect continuation coverage.

Notice mailed to the last known address which the Employer has on record for a qualified Covered Person will start the 60-day election period. Notice will be deemed provided to each Dependent child of a Covered Employee if a single notice is provided to the Covered Employee or the Covered Employee's spouse and if, on the basis of the most recent information available to the Plan, the Dependent child resides at the same location as the individual to whom such notice is provided. Notice will be deemed provided to a Covered Employee and the Covered Employee's spouse by furnishing a single notice addressed to both the Covered Employee and the Covered Employee's spouse, if, on the basis of the most recent information available to the Plan, the Covered Employee and the Covered Employee's spouse reside at the same location.

Election of continuation coverage by any qualified Covered Person shall be deemed to include an election of continuation on behalf of any other qualified Covered Persons whose health coverage under this Plan would otherwise terminate by reason of the same Qualifying Event unless specified otherwise on the COBRA enrollment form. However, each qualified beneficiary has an independent right to elect continuation coverage. If the Employee rejects any coverage, a Dependent may elect to retain any rejected coverage.

4. Payment for COBRA Continuation Coverage. The full contribution must be paid to the Employer. This includes any portion of the contribution which was previously paid by the Employer and a 2% administrative fee. Except as provided below, all payments must be made via personal check, money order, or cashier's check. When making premium payments, write the name of the qualified beneficiary and "COBRA" in the memo portion of the check or money order. Make checks and money orders payable to Plano ISD. (Cash payments will be allowed only by prior arrangement with the benefits and risk management department. Cash payments must be accompanied by written note containing the name of the qualified beneficiary and "COBRA".) All payments must be mailed via U.S. first class mail or hand-delivered to Plano ISD, Benefits and Risk Management Department, 6301 Chapel Hill Blvd, Plano, Texas, 75093.

   a. First payment: The first payment must be made within 45 days of election of COBRA continuation coverage. If this first payment is not made within that 45 days, all rights to COBRA continuation coverage under the Plan will be lost. The first payment must cover the cost of the continuation coverage from the time coverage under the Plan would have otherwise ended, up to the time of the first payment. Any claims submitted for expenses incurred after the qualifying event may be denied until all premiums which are due have been paid.

   b. Subsequent payments: Payments are required for each subsequent month of COBRA continuation coverage. Under the Plan, these payments are due on the first day of each month. Although subsequent payments are due on the first day of each month, there is a 30-day grace period to make each payment. COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, a subsequent payment made later than its due date but during its grace period may result in coverage under the Plan being suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

   c. Failure to make payment before the end of a grace period for that payment will result in cancellation of coverage and loss of all rights to COBRA continuation coverage under the Plan.

5. Termination of COBRA Continuation Coverage. If elected, COBRA continuation coverage can continue until the earliest of the following:

   a. the Covered Person's failure to pay the required contribution in a timely fashion; or

   b. the date a Covered Person becomes covered under any other group health plan as an employee or otherwise, unless such plan contains an exclusion or limitation provision with respect to any pre-existing condition of the Covered Person until such time the exclusion or limitation is no longer

applicable to such condition. Any benefits will be subject to the coordination of benefits provision of this Plan; or

c. the expiration of 18 months from the date of the Qualifying Event if the event is termination or reduction of the Employee's employment. However, continuation may be extended an additional 11 months if:
   1. a Covered Person is determined under Titles II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of continuation coverage; and
   2. notice is furnished to the benefits and risk management department within 60 days of the date of such determination and prior to the end of the original 18-month period of continuation coverage (the notice must include a copy of the Social Security Administration disability determination, a written request by a qualified beneficiary to extend coverage, the names of the affected qualified beneficiaries, and such other information as is required by the benefits and risk management department); and
   3. the appropriate additional contribution is paid for all months after the 18th.

d. the date on which it is determined that the Covered Person is no longer disabled under Titles II or XVI of the Social Security Act if the person's Qualifying Event was termination or reduction of hours of the Employee's employment and if continuation has been extended beyond 18 months. Notification should be made to the benefits and risk management department within 30 days of any final determination that the person is no longer disabled under Titles II or XVI of the Social Security Act; or

e. the expiration of 36 months from the date of the original Qualifying Event if the event was:
   1. Employee's death, divorce or legal separation; or
   2. Dependents' loss of coverage because the Employee became covered for Medicare benefits; or
   3. a Dependent child ceasing to be a Dependent as defined herein; or

f. the date of the Employee's death, if the Qualifying Event was the Plan Sponsor's filing of bankruptcy; or the death of the Employee's spouse, if the Employee died before the bankruptcy. Upon the Employee's death, Dependent children are entitled to 36 months of continuation of coverage; or

g. the date on which a Covered Person becomes entitled to Medicare; or

h. the date on which the Plan is terminated in its entirety; or

i. the Covered Person's request to terminate coverage; or

j. any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage.

6. Required Notices to the Plan. A COBRA participant must notify the Plano ISD benefits and risk management department of the following events. Notice to the benefits and risk management department may be done in writing, in person, or by telephone, and may be provided by a Covered Employee or Covered Dependent. The benefits and risk management department will provide a form for the Covered Employee's signature and will inform him or her of the documentation required to process the qualifying event. **If the required notice is not provided to the benefits and risk management department within the required period described below, COBRA continuation coverage will not be available**.

   Notify the Plan within 60 days:
   - A newborn or newly-adopted child that is to be added to COBRA continuation coverage under the Plan. (Notification within 60 days ensures that coverage will begin on the date of birth, date of adoption, or date of placement for adoption.)

- A change in marital status that would result in addition or deletion of family members from coverage.
- A covered child no longer being eligible as a Dependent child under the Plan.
- Death of a qualified beneficiary.
- A determination by the Social Security Administration that a qualified beneficiary is disabled. (Notification within 60 days and before the end of the initial 18-month period will protect the qualified beneficiaries' rights to an extension of continuation coverage.) Please note: A qualified beneficiary must also notify the Plan within 30 days if the Social Security Administration later determines that the qualified beneficiary is no longer disabled.
- The former employee's enrollment in Medicare.
- A qualified beneficiary becoming covered by another group health plan.
- A second qualifying event as described in this notice.
- Any name or address changes.

7. For More Information

More information about COBRA continuation coverage and the Employee's and Dependent's rights under the Plan is available by contacting the Plano ISD benefits and risk management department, or by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

The name, address, and phone number of the Plano ISD benefits and risk management department are set forth below.

Plano ISD Benefits and Risk Management Department
6301 Chapel Hill Blvd
Plano, Texas 75093
469-752-8138

V. GENERAL PROVISIONS

A. ENTIRE PLAN DOCUMENT - NO CONTRACT

The Plan document constitutes the entire Plan. The Plan shall not be deemed to constitute a contract of employment, or contract for benefits, or give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee. Nothing in the Plan shall be construed as creating any vested rights to benefits in favor of any Covered Person or any other person except with respect to claims that have actually been incurred by any such person that would otherwise be eligible for payment under the Plans, as in effect at the time the claim or expense was incurred.

No term, condition, or provision of the Plan shall be deemed waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

If any provision of any Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

B. AMENDMENTS TO OR TERMINATION OF PLAN

The Plan may be amended, canceled, or discontinued at any time by the adoption of a formal written instrument by the Employer without the consent of, or notice to, any Covered Person or beneficiary. In the event of a material amendment of the Plan, information describing the change will be distributed within a reasonable period of time after the later of the date the amendment is adopted or effective; provided that the failure to provide such information shall not make or be construed to make the amendment ineffective. All treatment received by a Covered Person is subject to the benefits in effect on the date of treatment, regardless of whether or not such treatment was covered when the sickness or injury was diagnosed or earlier treated. Furthermore, amendments apply to all Covered Persons with respect to all expenses incurred after the effective date thereof, including those persons who are covered, and those treatments that are initiated or contemplated, before the amendment becomes effective, unless otherwise specified in the amendment.

C. ASSIGNMENT

Benefits under the Plan may not be assigned, transferred, or in any way made over to another party by any person without the written consent of the Employer, Risk Pool, or Contract Administrator. Notwithstanding anything in the Plan to the contrary, the Plan shall not be construed to make the Employer, Risk Pool, or Plan liable to any third-party to whom a Covered Person, beneficiary, or other person is liable for care, treatment, services, or otherwise. The interest of any person under the Plan is not subject to the claims of such person's creditors (other than the Plan/Risk Pool) and may not be voluntarily or involuntarily transferred, assigned, alienated, or encumbered (other than to or by the Plan/Risk Pool) without the specific written consent of the Employer, Risk Pool, or Contract Administrator.

D. OPERATION AND ADMINISTRATION OF THE PLAN

The Risk Pool has the authority to control and manage operation and administration of the Plan.

1. General administration - The general administration of the Plan is vested in the Plan Sponsor. The Plan Sponsor shall have all powers and duties necessary or proper, as determined in its discretion, to administer the Plan and to discharge its duties under the Plan.

2. Discretion to interpret - The Plan Sponsor shall have absolute discretion to construe and interpret any and all terms and provisions of the Plan, including, but not limited to, the discretion to resolve ambiguities, inconsistencies, or omissions conclusively, provided, however, that all such discretionary interpretations and decisions shall be applied in a uniform and nondiscriminatory manner to all Covered Persons similarly situated.

3. Right to delegate - The Plan Sponsor may from time to time allocate to one or more of the Employer's officers, employees, or agents, and may delegate to the Contract Administrator or any other person or organization, any of its powers, duties, and responsibilities with respect to the operation and administration of the Plan, including, without limitation, the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claims, the determination of reasonable, customary, and medically necessary medical expenses and procedures, the discretion to decide matters of fact and interpret Plan provisions and may employ and authorize any person to whom any of its responsibilities have been delegated to employ persons to render advice with regard to any responsibility held hereunder.

E. PROCEDURE FOR FUNDING THE BENEFITS

The Employer and eligible Employees will contribute to the Plan the amount determined by the Employer to be appropriate for the benefits to be provided under the Plan. Such amount is subject to change at any time during the Plan year. By electing to participate in the Plan and/or receiving benefits under the Plan, each Covered Employee and Covered Dependent and any beneficiaries thereof agree to the deduction of required contributions from the wages otherwise payable to the Covered Employee and/or from any benefits payable under the Plan.

F. OVERPAYMENT OF BENEFITS

Any misstatement by a Covered Person which results in an overpayment becomes the responsibility of the Employee and/or Covered Person. The Plan reserves the right to recover any overpayment of plan benefits from that provider if the Plan made direct payments to such providers.

G. FACILITY OF PAYMENT

If, in the opinion of the Contract Administrator, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Contract Administrator may, at its option, make such payment directly to health care provider, or to the guardian or conservator, or the parents of minor child, or an individual or individuals as have, in the Contract Administrator’s discretion to that person having the custody, the care and principal support of the Covered Person.

In the event of the death of the Covered Person, the payment shall be made to the personal representative of the Covered Person's estate. Any payment made by the Contract Administrator in good faith pursuant to this provision, shall fully discharge the Plan and/or the Contract Administrator to the extent of such payment.

H. USE OF TERMS

As used herein the singular form of any word shall include the plural wherever necessary for the proper interpretation of this Plan, and wherever used herein a pronoun in the masculine gender shall be considered as including the feminine gender unless the context clearly indicates otherwise.

VI. COMPLIANCE WITH TEXAS LOCAL GOVERNMENT CODE CHAPTER 172

A. RISK POOL

1. The Employer does hereby establish a Risk Pool to provide certain coverages for its eligible employees and their Dependents as set forth in the Plan. Employer may provide workers' compensation and other coverages through the Risk Pool to the extent permitted by law.

   The Risk Pool is not insurance or an insurer under the Insurance Code or other laws of this state, and the Texas State Board of Insurance does not have jurisdiction over the Risk Pool.

2. Contributions paid by the Employer's employees for coverage shall be deposited to the credit of the Risk Pool's fund and used as provided by rules of the Risk Pool and the Plan.

3. The Risk Pool by contract may purchase insurance coverage for persons who are covered by the Risk Pool from an insurance company authorized to do business in Texas.

4. The Risk Pool or its' agents may not represent to persons who apply for coverage or who are covered by the Risk Pool that the coverage being provided is insurance.

5. The Risk Pool is a legal entity that may contract with an insurer licensed to do business in Texas to assume any excess of loss of a benefit contract. Notwithstanding any provision of the Texas Insurance Code or any other law governing insurance in Texas, an insurer authorized to do business in Texas may assume the excess of loss of a benefit contract.

   The Risk Pool does not maintain excess loss coverage or reinsurance.

B. SUPERVISION AND ADMINISTRATION OF THE RISK POOL

1. The Employer shall select Trustees to supervise the operation of the Risk Pool.

2. The Risk Pool may be administered by a staff employed by the Risk Pool, an entity created by the Employer, or a third party administrator known as a contract administrator.

3. Before entering into a contract with a person to be a contract administrator of the Risk Pool, the Trustees shall require that person to submit information necessary for the Trustees to evaluate the background, experience, and financial qualifications and solvency of that person. The information submitted by a prospective contract administrator other than an insurance company must disclose:

   a. any ownership interest that the prospective contract administrator has in an insurance company, group hospital service corporation, health maintenance organization, or other provider of health care indemnity; and

   b. any commission or other benefit that the prospective administrator will receive for purchasing services or coverage for the Risk Pool.

4. An attorney employed by a contract administrator, provider of excess loss coverage, or reinsurer may not be simultaneously employed by the Risk Pool unless, before the attorney is employed by the Risk Pool, the contract administrator, provider of excess loss coverage, reinsurer, or attorney discloses to the Risk Pool's Board of Trustees that the attorney is employed by the contract administrator, provider, or reinsurer.

5. If the State of Texas enacts a law providing for the licensing or registration of contract administrators, the Risk Pool in contracting for administrative services may only contract for services of a contract administrator licensed or registered under the law.

C. TRUSTEE TRAINING

1. Trustees who act as fiduciaries for the Risk Pool must have at least 16 hours of combined professional instruction with four hours of instruction in each of the following areas:

   a. law governing the establishment and operation of risk pools by political subdivisions;

   b. principles of self-insurance and risk pools, including actuarial and underwriting principles and investment principles;

   c. principles relating to reading and understanding financial statements; and

   d. the general fiduciary duties of trustees.

2. A trustee must complete the required training no later than the 180th day after the date of selection as Trustee.

D. EXCESS LOSS COVERAGE AND REINSURANCE

1. The Risk Pool may purchase excess loss coverage or reinsurance to insure the Risk Pool against financial losses that the Risk Pool determines might place the solvency of the Risk Pool in financial jeopardy.

2. If the Risk Pool does not purchase excess loss coverage or reinsurance, the Administrator shall give written notice to each person who applies for coverage from the Risk Pool that the Risk Pool does not maintain excess loss coverage or reinsurance. The Administrator shall provide the notice before coverage is issued to an applicant and shall give the applicant the opportunity to decline the coverage.

3. If the Risk Pool cancels or does not renew excess loss coverage or reinsurance, the Administrator shall give notice to each Covered Person that the coverage has been canceled or has not been renewed and shall give each an opportunity to cancel coverage. The Administrator must give the notice and opportunity to cancel coverage not later than the 30th day after the date on which the Risk Pool cancels or does not renew the excess loss coverage of reinsurance.

E. INVESTMENTS

1. The Trustees shall invest the Risk Pool's money in accordance with Subchapter A, Chapter 2256, of the Texas Government Code to the extent of that law can be made applicable.

2. In addition to investments authorized under the Public Funds Investment Act of 1987, the Trustees of the Risk Pool may invest the Risk Pool's money in any investment authorized by the Texas Trust Code (Subtitle B, Title 9, Property Code).

F. AUDITS

1. The Trustees shall have the fiscal accounts and records of the Risk Pool audited annually by an independent auditor.

2. The person who performs the audit must be a certified public accountant or public accountant licensed by the Texas State Board of Public Accountancy.

3. The independent audit shall cover the Risk Pool's fiscal year.

4. The Trustees shall file annually with the State Board of Insurance a copy of the audit report. A person may request the State Board of Insurance to provide copies of any item included in an audit report on payment of the cost of providing the copies.

G. INSOLVENCY

1. The Trustees shall declare the Risk Pool insolvent if the Trustees determine that the Risk Pool is unable to pay valid claims within 60 days after the date the claims are verified.

2. If the Risk Pool is declared insolvent by the Trustees, the Risk Pool shall cease operation on the day of the declaration, and the Trustees shall provide for the disposition of the Risk Pool's assets, debts, obligations, losses, and other liabilities.

3. A Covered Person may institute proceedings to have the Risk Pool declared insolvent by petitioning a district court in Travis County to declare the Risk Pool insolvent. If the district court, after notice and hearing, determines that the Risk Pool is insolvent, the court shall appoint a receiver to take charge of and dispose of the Risk Pool's assets, debts, obligations, losses and other liabilities.

4. After a receiver takes charge of the assets and determines outstanding debts, obligations, losses, and other liabilities, the receiver shall give notice of his determination to all Covered Persons.

H. PAYMENT OF CONTRIBUTIONS AND PREMIUMS

1. The Employer may pay all or part of the contributions for coverage from local funds, including federal grant or contract pass-through funds, that are not dedicated by law to some other purpose.

2. The Employer also may pay all or part of the contributions for coverage for eligible employees, retirees, and Dependents.

3. On written approval of an employee, the Employer may deduct from the employee's compensation an amount necessary to pay that person's and his or her Dependent's contributions.

4. State funds, except federal grant or contract fund passed through the state to the Employer or other state funds as permitted by the Texas Insurance Code and other applicable law, may not be used to purchase coverage or to pay contributions.

I. APPLICATION OF CERTAIN LAWS

The Risk Pool is not insurance or an insurer under the Insurance Code and other laws of this state, and the State Board of Insurance does not have jurisdiction over the Risk Pool.

J. SUBROGATION

The Risk Pool shall have a right of reimbursement and be subrogated to any and all recoveries and rights of recovery of a Covered Person for personal injuries or sickness from any and all sources.

K. AMENDMENT

The Board of Trustees of the Employer may amend the provisions of this Risk Pool at any time and from time to time pursuant to the amendment provision of the Plan or in accordance with applicable law.

VII. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. SCOPE

The following provisions regarding protected health information and electronic protected health information apply solely to the extent the Plan (or any relevant portion thereof) is a "health plan" covered by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For purposes of this Section, the terms "protected health information" and "electronic protected health information" shall have the meaning specified by the privacy and security regulations under HIPAA.

The following provisions are intended to comply with the privacy regulations under HIPAA and shall be construed solely for that purpose. Such provisions shall not be construed to provide or mean that the Plan is a health care provider, practices medicine, or makes medical treatment decisions. The Plan reimburses or pays for a portion of the cost of eligible health care expenses and does not directly provide health care or practice medicine.

B. PERMITTED USES AND DISCLOSURES

The Plan may use protected health information to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the privacy regulations thereunder. Without limiting the foregoing, the Plan may use and disclose protected health information for "payment," "treatment," and "health care operations" purposes as such terms are defined by the HIPAA privacy regulations.

In addition to using protected health information for the purposes described above, protected health information may be disclosed by the Plan to the Employer, and the Employer may use and disclose protected health information, for plan administration purposes, for enrollment purposes, and for any other purposes consistent with an individual's authorization or permitted by the HIPAA privacy regulations. In addition, "summary health information" may be disclosed by the Plan to the Employer and may be used and disclosed by the Employer for purposes of obtaining premium bids for health insurance coverage under the Plan or modifying, amending, or terminating the Plan. However, protected health information that is genetic information cannot be used for underwriting purposes.

C. EMPLOYER CERTIFICATION

1. The Plan will not disclose protected health information to the Employer for plan administration purposes unless the Plan receives from the Employer a certification that the applicable Plan documents have been amended to incorporate the following provisions. Therefore, the Employer certifies and agrees that it will:

    - not use or further disclose protected health information other than as permitted or required by the Plan documents or as required by law;
    - ensure that any agents to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
    - not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer (unless authorized by the individual and/or permitted by the HIPAA privacy regulations);
    - report to the Plan any use or disclosure of the protected health information that is inconsistent with the uses or disclosures provided for and of which it becomes aware;
    - make available protected health information to the affected individual in accordance with section 164.524 of the HIPAA privacy regulations;
    - make available protected health information for amendment at the request of the affected individual and incorporate any amendments to protected health information in accordance with section 164.526 of the HIPAA privacy regulations;

- make available the information required to provide an accounting of disclosures to an affected individual in accordance with section 164.528 of the HIPAA privacy regulations;

- make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the applicable requirements of the HIPAA privacy regulations;

- if feasible, return or destroy all protected health information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure that the adequate separation described below is established.

2. With respect to protected health information disclosed by the Plan to the Employer for use and/or disclosure by the Employer for plan administration purposes:

   - such information may be disclosed to employees in the Benefits and Risk Management department or other departments and positions with oversight responsibility for the Plans, including employees with oversight responsibility for claims payment and third party claims administration;

   - such information may be used by the persons described above only for purposes of the plan administration functions that the Employer performs for the Plan; and

   - compliance with the provisions above relating to disclosure for plan administration purposes shall be monitored and enforced by the Plan Sponsor. The Plan Sponsor shall establish rules for effectively resolving any instances of noncompliance. Such rules are incorporated herein by this reference.

D. SECURITY REQUIREMENTS

The following provisions of this Section D. do not apply to the extent the only electronic protected health information disclosed to the Employer for plan administration purposes (1) is disclosed pursuant to an individual's authorization; (2) is summary health information disclosed for the purpose of obtaining premium bids or modifying, amending, or terminating the Plan; or (3) is enrollment, disenrollment, or participation information.

The Plan Sponsor or its delegate (including, if applicable, the Employer) will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes.

With respect to electronic protected health information, the Plan Sponsor will ensure that the requirements of Section C.2. above are supported by reasonable and appropriate security measures.

With respect to electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes, the Plan Sponsor will ensure that any agent to whom the Employer provides such information agrees to implement reasonable and appropriate security measures to protect the information.

The Plan Sponsor and the Employer will report to the Plan any "security incident" (as such term is defined by the HIPAA security regulations) of which it becomes aware with respect to electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes.

E. BREACH NOTIFICATION

The Plan shall provide notice of a breach of unsecured protected health information as may be required under the HIPAA privacy regulations.