The attached Summary Plan Description (SPD) and Summaries of Material Modification (SMM's) are copies of those that applied to the named plan as of October 24, 2003. The originals of the SMM's have been signed by an authorized representative of the Plan Administrator for this plan. For a signed copy of any SMM, contact the Plan Administrator.

These copies are provided for the convenience of plan participants and covered persons, and are not intended to replace the actual plan documents on file with the Plan Administrator, or the SPD and SMM's that were distributed to the Plan Participants in accordance with ERISA, or any other applicable law. Any discrepancies between these copies, and the actual SPD or SMM's will be resolved in favor of the original documents as maintained by the Plan Administrator. These documents may be amended by the Plan Administrator at any time, and such amendments will prevail over these documents.

LAWRENCEBURG COMMUNITY SCHOOLS
DENTAL BENEFIT PLAN

SUMMARY PLAN DESCRIPTION
EFFECTIVE OCTOBER 1, 1996

MEDICAL BENEFITS ADMINISTRATORS, INC.

Established in 1989, Medical Benefits Administrators, Inc. (MBA) is a subsidiary of Medical Benefits Mutual Life Insurance Co., one of the oldest health insurance firms in the United States. In 1938, the Company entered the insurance business operating under the name Hospital Services Association. Later, it became known as HSA of Ohio.

The name, Medical Benefits Mutual, was adopted in 1987, signaling the Company's establishment as a full-fledged mutual life insurance company. Medical Benefits Administrators, Inc. builds on this great service tradition and commitment to the future by delivering the services the marketplace demands.

MBA is pleased to have been chosen as your Benefit Administrator. MBA is committed to the fundamental criteria which distinguish us from the crowd. The first is a commitment to excellent claims administration. The second is a commitment to long term relationships with the people we serve.

We will appreciate your comments and strive to make any dealings with us as simple as possible. If you have any questions about a claim, we invite you to call us or to drop in at our offices at 1975 Tamarack Road, Newark, Ohio 43055.

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ARTICLE I

PLAN INFORMATION

NAME OF PLAN
The name of the Plan is the Lawrenceburg Community Schools Dental Benefit Plan.

PURPOSE OF THE PLAN
Lawrenceburg Community Schools executes this document, including any amendments, to establish a dental benefit plan for the exclusive benefit of the participating employees, and their Dependents, and to grant such Participants and Dependents legally enforceable rights under this Plan. While Lawrenceburg Community Schools has every intention of continuing this Plan indefinitely, it reserves the right to amend or terminate the Plan, and the benefits provided hereunder, at any time.

The Plan Administrator has issued a Summary Plan Description to each Participant which summarizes the benefits to which that person is entitled, to whom benefits are payable, and the provisions of this Plan principally affecting the Participant and his or her covered Dependents.

EFFECTIVE DATE
The Effective Date of this Plan is October 1, 1996.

AMENDMENT OR TERMINATION
Lawrenceburg Community Schools may amend or terminate the Plan at any time by means of a writing signed by a person authorized to do so on behalf of the Lawrenceburg Community Schools. Any such amendment or termination shall become effective upon its execution or on such date as may be specified in that writing. Such amendment, modification or termination may result in the termination of Participant and Dependent coverage under the Plan. Expenses incurred prior to any Plan termination will be paid as provided under the terms of the Plan prior to such termination. Any termination of the Plan will be communicated to the Participants.

Lawrenceburg Community Schools reserves the right, at any time and from time to time, to modify or amend, in whole or in part, any or all of the provisions of the Plan.

PLAN ADMINISTRATOR TAX ID NUMBER (EIN)
35-1147459

PLAN ADMINISTRATOR
Lawrenceburg Community Schools
1 Stadium Lane
Lawrenceburg, Indiana 47025
(812) 537-7204

PLAN NUMBER
501

GROUP NUMBER
10104

PLAN YEAR
The Plan Year is a time period defined for fiscal purposes and used for certain Plan reporting and disclosure requirements. The Plan Year will begin on October 1st and end on September 30th of each year.

CALENDAR YEAR
The Calendar Year is the period beginning January 1st and ending December 31st which is used in the application of deductible, coinsurance and benefit maximum amounts.

TYPE OF ADMINISTRATION
Contract Administration.

DESCRIPTION OF PLAN
The Plan is an employee health and welfare benefit plan providing dental benefits. A copy of the Plan documents and insurance contracts, if any, are on file at the Plan Administrator's office and may be read by any Covered Person at any reasonable time. In the event of any discrepancy between any summary of this Plan and the actual provisions of the Plan document, the Plan document shall govern.

The Plan shall not be deemed to constitute a contract between the Company and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any employee at any time.

NAMED FIDUCIARY
Lawrenceburg Community Schools
1 Stadium Lane
Lawrenceburg, Indiana 47025
(812) 537-7204

AGENT FOR SERVICE OF LEGAL PROCESS
Lawrenceburg Community Schools
1 Stadium Lane
Lawrenceburg, Indiana 47025
(812) 537-7204

In addition, service of legal process may be made upon the Plan Administrator.

FUNDING
The Plan is funded by the Employer. Funds for payment of claims considered under the Plan are forwarded to account(s) from which claims are to be paid.

SOURCE OF CONTRIBUTIONS
The Plan is currently funded by contributions made by the Employer, Lawrenceburg Community Schools and employees participating in the Plan. Participant Contributions are required for both Participant and Dependent Coverage under this Plan.

The Employer shall, subject to the applicable collective bargaining agreements, from time to time, evaluate the funding method of the Plan benefits and determine the amount to be contributed by the Employer and the amount to be contributed, if any, by the Participants.

COLLECTIVE BARGAINING AGREEMENT
This Plan is established by the Employer, Lawrenceburg Community Schools, and is subject to a collective bargaining agreement between the Employer and the Lawrenceburg Federation of Teachers. A complete list of the employer(s) and the employee organization(s) sponsoring the Plan may be obtained by an Covered Person upon written request and is available for examination by Covered Persons at the Plan Administrator’s office.

The Plan is maintained pursuant to a collective bargaining agreement. Copies of the collective bargaining agreement is on file at the Plan Administrator's office and may be read by any Covered Person at any reasonable time.

ASSIGNMENT
A Covered Person's benefits may not be assigned, except by consent of the Company, other than to providers of Plan benefits.

BENEFIT ADMINISTRATOR
Medical Benefits Administrators, Inc.
1975 Tamarack Road
P. O. Box 1099
Newark, Ohio 43058-1099
(614) 522-8425
(800) 423-3151

ARTICLE II

SCHEDULE OF DENTAL BENEFITS

2.1 GENERAL INFORMATION

This Schedule of Dental Benefits is intended to provide only a general description of your benefits. This Plan contains limitations and restrictions which are described later in this booklet and could affect any benefits which may be payable.

2.2 DENTAL PLAN PREDETERMINATION OF BENEFITS

Before starting a course of treatment for which the charge is expected to be more than $200, a Dental Treatment Plan should be submitted in an acceptable form to the Benefit Administrator. A Predetermination of Benefits payable under this Plan will then be provided. For more information about the Predetermination of Benefits provisions, see Section 7.4.

2.3 DENTAL DEDUCTIBLE

Per Individual	$50.00 per Calendar Year
Per Family (Cumulative)	$150.00 per Calendar Year

The Calendar Year Deductible applies to all classes of services.

2.4 DENTAL COINSURANCE AMOUNTS

	Deductible	Coinsurance
Class I (Preventive)	Applies	80%
Class II (Basic)	Applies	80%
Class III (Major)	Applies	80%
Class IV (Orthodontic)	Applies	50%

Please see additional limitations in the schedule of Dental Plan Maximum Benefits set forth in Section 2.5 of the Plan.

2.5 DENTAL PLAN MAXIMUM BENEFITS

The dental plan maximum benefits and limitations are shown below. Both Calendar Year and lifetime maximums indicate the actual benefits payable under the Plan.

Class I, Class II, Class III, combined	$750.00 Calendar Year Maximum
Class IV (Orthodontics)	$500.00 Lifetime Maximum Limited to Dependent children who are less than nineteen (19) years of age when treatment begins

ARTICLE III
DEFINITIONS

3.1 GENERAL PLAN DEFINITIONS

ACTIVELY AT WORK or ACTIVE WORK
The terms "Actively at Work" or "Active Work" mean the active expenditure of time and energy in the service of the Company. A Participant shall be deemed Actively at Work while working the full number of hours shown in Section 5.2 and on each day of a regularly paid vacation and on a regular non-working day on which he or she is not Totally Disabled, if the Participant was Actively at Work on the last preceding regular working day. In addition, individuals acting as independent contractors, consultants, a member of the Board of Directors, individuals on retainers or retirees are not considered Actively At Work unless each meets the requirements of Section 5.2.

BENEFIT ADMINISTRATOR
The term "Benefit Administrator" means the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the administration, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written administration agreement. If no Benefit Administrator is appointed or retained (as a result of the termination or expiration of the administrative agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Benefit Administrator in writing, the term will mean the Plan Administrator.

As of the Effective Date, the Benefit Administrator of the Plan is Medical Benefits Administrators, Inc.

CALENDAR YEAR
The term "Calendar Year" means the period of time from January 1st, at 12:00 a.m. midnight, through the next December 31st.

COBRA
The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COMPANY
The term "Company" means Lawrenceburg Community Schools.

COVERED EXPENSES or COVERED DENTAL EXPENSES
The terms "Covered Expenses" or "Covered Dental Expenses" mean expenses incurred by a Covered Person for any necessary treatments, services or supplies (except as otherwise specified in the Plan) that are not specifically excluded from coverage elsewhere in this Plan.

COVERED PERSON
The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

DEDUCTIBLE
The term "Deductible" means the amount of Covered Dental Expenses incurred by a Covered Person in a Calendar Year before any other such Covered Expenses can be considered for payment at the percentages stated in the Schedule of Dental Benefits and this Plan.

The Deductible is the amount that each individual Covered Person must pay during a Calendar Year before the Plan begins paying benefits for that person.

The Family Deductible (the amount shown in Section 2.3) is the maximum amount that three (3) or more family members with Family coverage must pay in Deductible expense during one (1) Calendar Year. Once this cumulative Family Deductible is reached, the Deductible will be

considered satisfied for all Family members covered under the Plan during the remainder of the Calendar Year.

DENTAL TREATMENT PLAN
The term "Dental Treatment Plan" means the Dentist's report of proposed treatment which:

A. is written on a form approved by the Plan Administrator and provided by the Benefit Administrator;
B. contains a description of the procedures to be performed;
C. includes an estimate of the Dentist's charges; and
D. is accompanied by any diagnostic material that the Plan might require, including x-rays and other diagnostic aids.

DENTIST
A person who is licensed to practice dentistry within the state where the dental service is being performed and who is operating within the scope of his or her license.

DEPENDENT
The term "Dependent" means:

A. The Participant's legal spouse. Such spouse must have met all requirements of a valid marriage contract in the state in which such parties were married; or
B. The Participant's child who meets all of the following conditions:
    1. Is unmarried.
    2. Is a natural child, stepchild, a child legally adopted, a child for whom adoption proceedings have been commenced by the Participant, who is Placed for Adoption with the Participant, or a child for whom the Insured has Legal Guardianship;
    3. Is less than nineteen (19) years of age. This requirement is waived if the child is at least nineteen (19) years of age but less than twenty-five (25) years of age, is dependent upon the Participant for support, and is a Full-Time Student. The age requirement above is also waived for any mentally or physically handicapped child who is incapable of self-sustaining employment and is chiefly dependent upon the Participant for support and maintenance, provided the child suffered such incapacity prior to attaining nineteen (19) years of age. Proof of incapacity must be furnished to the Plan Administrator, or its designee, within thirty-one (31) days of the date the child's coverage would have ended due to age.

This definition and all provisions of this Plan are intended to comply with state and federal law as both regard "Qualified Medical Child Support Orders" and "Medical Child Support Orders," as those terms are defined in the law.

The Plan Administrator has the right to obtain sufficient proof of Dependent status from any Participant under the Plan who is requesting coverage of his or her Dependents.

The term "Dependent" excludes these situations:

A. a spouse who is legally separated or divorced from the Participant. Such spouse must have met all the requirements of a valid separation agreement or divorce decree in the state granting such separation or divorce;
B. any person on active military duty; or
C. any person who is covered under this Plan as an individual Participant.

DEPENDENT COVERAGE
The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of a dental condition of a Dependent.

EFFECTIVE DATE
The term “Effective Date” means the first day coverage under this Plan is effective. The Effective Date of this Plan is October 1, 1996.

EMPLOYER
The term "Employer" means Lawrenceburg Community Schools.

EXPERIMENTAL
The term “Experimental” means dental procedures, treatment or supplies which do not meet accepted dental practices as established by the American Dental Association.

FAMILY
The term "Family" means a covered Participant and his or her covered Dependents.

FULL-TIME EMPLOYMENT
The term "Full-Time Employment" means a basis whereby a Participant is employed, and is compensated for services, by the Company for at least the number of hours per week stated in the eligibility requirements described in Article V. The work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Participant to travel.

FULL-TIME STUDENT
The term "Full-Time Student" means an individual enrolled in and attending an accredited school, college or university on a full-time basis.

LEGAL GUARDIAN or LEGAL GUARDIANSHIP
The terms “Legal Guardian” or “Legal Guardianship” mean a person, or the status of a person and his or her ward, who has been appointed by a state court with specific jurisdiction over guardianships and estates, to have the care and management of a minor child. The Legal Guardian must have guardianship of the person of the minor child, and not merely the estate of such child. An order granting a person legal custody of a minor child, without the appointment of the person as the child’s Legal Guardian, does not create a Legal Guardianship.

MEDICALLY NECESSARY or MEDICAL NECESSITY
The term “Medically Necessary” or “Medical Necessity” mean a service or supply given by a covered provider that is required to diagnose or treat the person’s dental condition, and which the Plan determines is:

A. appropriate with regard to standards of good dental practice;
B. not solely for the convenience of the patient or the provider; and
C. the most appropriate supply or level of service which can safely be provided.

MEDICARE
The term "Medicare" means the programs established by Title I of Public Law 89-98, as amended entitled "Health Insurance for the Aged Act," and which includes parts A and B of Subchapter XVIII of the Social Security Act, as amended from time to time.

NAMED FIDUCIARY
The term "Named Fiduciary" means the individual or entity which has the authority to control and manage the overall operation of the Plan.

PARTICIPANT
The term "Participant" means a person who is directly employed and compensated for services by the Company, who meets the eligibility requirements and who is properly enrolled in the Plan.

PLACED FOR ADOPTION or PLACEMENT FOR ADOPTION
The terms "Placed For Adoption" or "Placement For Adoption" mean the assumption and retention by such Participant hereunder of a legal obligation for total or partial support of such

child in anticipation of adoption of such child. The child's placement with such Participant terminates upon the termination of such legal obligation.

PLAN
The term "Plan" means the Dental Benefit Plan, as described in and administered by the Lawrenceburg Community Schools Dental Benefit Plan.

PLAN ADMINISTRATOR
The entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services.

PLAN YEAR
The term "Plan Year" means a period of time used for certain reporting and disclosure requirements of the Plan. The Plan Year will begin on October 1st and end on September 30th of each year.

PREDETERMINATION OF BENEFITS
The term “Predetermination of Benefits” means the method by which the Plan determines covered services and Covered Dental Expenses that will be paid for a proposed service or course of treatment. The Predetermination of Benefits amount is shown in Section 2.2.

REASONABLE AND CUSTOMARY
The term "Reasonable and Customary" refers to the designation of a charge as being the usual charge made by a Dentist or other provider of services and supplies, medication or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill or expertise.

SERVICE IN THE UNIFORMED SERVICES
The term “Service in the Uniformed Services” means performance of duty in the Armed Forces or Uniformed Services for a period of five years or less, on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty in the Armed Forces, the Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States in time of war or emergency. Service in the Uniformed Services also includes a period for which an individual is absent from a position of employment for the purpose of an examination to determine the fitness of the person for duty in the Armed Forces or the commissioned corps of the Public Health Service.

3.2 COMMON DENTAL TERMS

ABUTMENT
A tooth or root that retains or supports a fixed Bridge or a removable prosthesis.

ACID ETCH
The etching of a tooth with a mild acid to aid in the retention of Composite filling material.

ACRYLIC
Plastic material used in the fabrication of Dentures and Crowns and occasionally as a restorative filling material.

AMALGAM
A metal alloy usually consisting of silver, tin, zinc and copper combined with liquid pure mercury and used as restorative material in operative dentistry.

ALVEOPLASTY
Surgical preparation of the ridge for Dentures.

ANESTHESIA
Local - The condition produced by the administration of specific agents to achieve the loss of pain sensation in a specific location or area of the body. **General** - The condition produced by the administration of specific agents to render the patient completely unconscious and without pain sensation.

APICOECTOMY
The surgical removal of the apex or tip of the tooth root.

APPLIANCE
A device used to provide function, therapeutic (healing) effect, space maintenance, or as an application of force to teeth to provide movement or growth changes as in Orthodontics. **Fixed** - One that is attached to the teeth by cement or by adhesive materials and cannot be removed by the patient. **Removable** - One that can be taken in and out of the mouth by the patient. **Prosthetic** - Used to provide replacement for a missing tooth.

BITEWING
A type of dental x-ray film that has a central tab or wing upon which the teeth close to hold the film in position. They are commonly called detecting x-rays because they show decay better than other x-rays.

BRIDGE, BRIDGEWORK or PROSTHETIC APPLIANCE
Fixed - Pontics or replacement teeth retained with Crowns or Inlays cemented to the natural teeth, which are used as Abutments. **Fixed, Removable** - One which the dentist can remove but the patient cannot. **Removable** - A Partial Denture retained by attachments which permit removal of the Denture. Normally held by clasps.

CARIES
A disease of progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

COMPOSITE
Tooth colored filling material primarily used in the anterior teeth.

CROWN
A natural Crown is the portion of a tooth covered by enamel. An artificial Crown (cap) restores the anatomy, function and esthetics of the natural Crown.

DENTAL HYGIENIST
A person who has been trained to clean teeth, and provide additional services and information on the prevention of oral disease.

DENTURE
A device replacing missing teeth. The term usually refers to full or Partial Dentures but it actually means any substitute for missing natural teeth.

ENDODONTICS
Procedures to prevent and treat diseases of the dental pulp.

FLUORIDE
A solution of fluorine which is applied topically to the teeth for the purpose of preventing dental decay.

GINGIVECTOMY
The removal of gum tissue around the necks of teeth.

GINGIVOPLASTY
The recontouring of gum tissue.

GINGIVAL CURETTAGE
The removal of diseased gum tissue.

IMPLANT
A device surgically inserted into or onto the jaw bone. It may support a Crown or Crowns, Partial Denture, complete Denture or may be used as an Abutment for a fixed Bridge.

IMPRESSION
A negative reproduction of a given area. It is made in order to produce a positive form or cast of the recorded teeth and/or soft tissues of the mouth.

INLAY
A Restoration, usually of cast metal, made to fit a prepared tooth cavity and then cemented into place.

MALOCCLUSION
An abnormal contact and/or position of the opposing teeth when brought together.

OCCLUSION
The contact relationship of the upper and lower teeth when they are brought together.

ONLAY
A cast Restoration that covers the entire chewing surface of the tooth.

ORAL LESIONS
Wounds or sores in the mouth.

ORTHODONTICS
The branch of dentistry primarily concerned with the detection, prevention and correction of abnormalities in the positioning of the teeth in their relationship to the jaws.

OSSEOUS SURGERY
Surgery performed on the alveolar bone, including flap entry and closure.

PALLIATIVE
An alleviating measure. To relieve, but not cure.

PARTIAL DENTURE
A prosthesis replacing one or more, but less than all, of the natural teeth and associated structures; may be removable or fixed, one side or two sides.

PEDODONTICS
The specialty of children's dentistry.

PERIODONTICS
The diagnosis and treatment of gum disease.

PONTIC
The part of a fixed Bridge which is suspended between the Abutments and which replaces a missing tooth or teeth.

PROPHYLAXIS
The removal of tarter and stains from the teeth. The cleaning of the teeth by a Dentist or Dental Hygienist.

REBASE
A process of refitting a Denture by the replacement of the entire Denture-base material without changing the occlusal relations of the teeth.

RELINE
To resurface the tissue-borne areas of a Denture with new material.

RESTORATION
A broad term applied to any Inlay, Crown, Bridge, Partial Dentures, or complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

RETENTION TREATMENT
The period of Orthodontic treatment during which the individual is wearing an Appliance to maintain the teeth in position.

ROOT CANAL THERAPY
The complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber and root canals, and filling these spaces with a sealing material.

SCALING
The removal of calculus (tarter) and stains from teeth with special instruments.

SEALANT
A resinous agent applied to the grooves and pits of teeth to reduce decay.

SILICATE
A relatively hard and translucent restorative material that is used primarily in the anterior teeth.

SPLINTING
Stabilizing or immobilizing teeth to gain strength and/or facilitate healing.

TOPICAL APPLICATION
Painting the surface of teeth, as in Fluoride treatment or application of an anesthetic formula to the surface of the gum.

VERTICAL DIMENSION
The degree of jaw separation when the teeth are in contact.

ARTICLE IV
CLAIM PROCEDURES

4.1 NOTICE AND PROOF OF CLAIM

Written notice and proof of loss (ordinarily a completed claim form) must be given to the Benefit Administrator, as the entity designated by the Plan Administrator to handle claims, within (90) days after the occurrence or commencement of any loss covered by this Plan. Failure to give such notice and proof within the time required will neither invalidate nor reduce any claim if it is shown that: (1) it was not reasonably possible for the claimant to file written notice and proof within that time; and (2) written notice and proof are given as soon as reasonably possible, but no later than one (1) year after the loss occurs or commences, unless the claimant is legally incapacitated.

When a Covered Person's coverage terminates for any reason, written proof of claim must be given to the Benefit Administrator, as the entity designated by the Plan Administrator to handle claims, within ninety (90) days of the date of termination of coverage, if the Plan remains in force. Failure to give such notice and proof within the time required will neither invalidate nor reduce any claim if it is shown that: (1) it was not reasonably possible for the claimant to file written notice and proof within that time; and (2) written notice and proof are given as soon as reasonably possible, but no later than one (1) year after the termination of coverage, unless the claimant is legally incapacitated.

Upon termination of the Plan, final claims must be received within ninety (90) days of termination. In any of the events described above, notice and proof of claim will be determined at the discretion of the Plan Administrator.

The Plan Administrator shall approve, partially approve or deny a claim within ninety (90) days of its submission. If special circumstances require more than ninety (90) days, the Plan Administrator shall have up to an additional ninety (90) days to complete its review upon notice to the claimant. If a claim is denied (in whole or in part) the Plan Administrator shall provide the Covered Person with a written notice containing: (1) the reasons for the denial, including reference to the Plan provisions upon which the denial is based; (2) a description of additional information which would permit payment of the claim; and (3) an explanation of the claim review procedures of the Plan.

In order to pay claims, the Benefit Administrator, as the entity designated by the Plan Administrator to handle and pay claims, has the right to obtain sufficient information from Covered Person under the Plan. Claims will be denied if the Benefit Administrator, as the representative of the Plan Administrator, does not receive sufficient documentation supporting any claim.

4.2 APPEALING A CLAIM

A Covered Person may have the denial reviewed by the Plan Administrator by written application to the Plan Administrator within ninety (90) days following denial of the claim. The Covered Person may review pertinent documents related to the determination and submit issues and comments in writing to the Plan Administrator.

The Plan Administrator shall make a decision on the request for review within sixty (60) days of the date of application unless special circumstances require an additional sixty (60) day extension. Within this period, the Plan Administrator shall notify the Covered Person of its decision, the reasons for the decision, and provisions of the Plan which form the basis of the decision. In conducting its review, the Plan Administrator may request pertinent documents from the Covered Person.

4.3 EXAMINATION

The Plan Administrator shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and as often as it may reasonably require during the pending claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where it is not forbidden by law.

4.4 LEGAL PROCEEDINGS

No action at law or in equity shall be brought to recover benefits under the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the claim procedures provisions of the Plan, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof is required by the Plan.

4.5 PLAN ADMINISTRATOR DISCRETION

Nothing is this Plan precludes the Plan Administrator from exercising full discretionary authority and responsibility with respect to all aspects of Plan administration and interpretation. The Plan Administrator shall have all powers necessary to carry out the purposes of the Plan, including supplying any omissions in accordance with the intent of the Plan and deciding all questions concerning eligibility for participation in the Plan and concerning the amount of benefits payable to a Covered Person.

ARTICLE V
COVERAGE AND ELIGIBILITY

5.1 COVERAGE UNDER THIS PLAN

Coverage provided under the Plan for a Participant shall be in accordance with the Participant Eligibility, Participant Effective Date and Participant Termination provisions included herein.

5.2 ELIGIBILITY

Only employees of the Company who meet all of the following conditions shall be deemed eligible for coverage as a Participant under the Plan:

A. The employee is employed by the Company on a permanent, full-time or part-time basis for at least twenty (20) hours per week;

B. The employee is Actively At Work;

C. The employee is one of the following:

1. A certified employee of the Company (teacher or administrator);

2. A classified employee who has been continuously employed by the Company for a period of thirty (30) days beginning with the date of his or her hire. Such individual shall become eligible for coverage on the first of the month following the date he or she has been so employed for thirty (30) days. If an employee is employed by the Company for any or all of this period prior to his or her entry into Service in the Uniformed Services, this period of previous employment shall be credited towards the partial or full satisfaction of any waiting period imposed under this Plan if the employee is re-employed by the Company at the expiration of the term of Service in the Uniformed Services

All Participants must agree to any Participant Contribution for such coverage, if applicable.

5.3 DEPENDENT COVERAGE

A Participant eligible to elect Dependent Coverage shall be any Participant whose Dependents meet the definition of a Dependent, set forth in Article III of the Plan. A Participant must make written request for Dependent Coverage and agree to any applicable Participant Contribution for such coverage. Each Participant will become eligible to elect Dependent Coverage on the latest of the following:

A. The date he or she becomes eligible for Participant coverage; or

B. The date on which he or she first acquires a Dependent.

5.4 PARTICIPANT EFFECTIVE DATE

Participant coverage under the Plan shall become effective with respect to an eligible person on the date he or she becomes eligible, provided written application for such coverage is made within thirty-one (31) days of the date of his or her eligibility. If application for coverage is made after this thirty-one (31) day period, or after coverage under this Plan was previously terminated because required Participant Contributions were not made, the individual will be considered a late entrant, and the restrictions listed in Section 5.7 shall apply.

If an eligible person is not Actively At Work on the date the Participant's coverage would otherwise become effective, his or her coverage shall become effective on the day he or she returns to Active Work.

All Participant coverages under the Plan shall commence at 12:01 A.M. standard time, on the date such coverage is effective, provided such Participant is able to be Actively At Work at such time. If the Participant is not Actively At Work on the date the Participant's coverage would otherwise take effect, but was able to do so at 12:01 A.M. standard time had such work been commenced at that time, such Participant shall be eligible for coverage on that date.

5.5 DEPENDENT EFFECTIVE DATE

If a Participant makes written request for Dependent Coverage hereunder within thirty (30) days of the date he or she becomes eligible for Dependent Coverage, on a form approved by the Plan Administrator, subject to the provisions of this section, and agrees to the applicable Participant Contribution for such coverage, if any, his or her Dependent(s) shall become covered on the later of the date the Dependent meets the eligibility requirements or the date the Participant becomes covered. If application for coverage is made after this thirty-one (31) day period, or after coverage under this Plan was previously terminated because required Participant Contributions were not made, the individual will be considered a late entrant, and the restrictions listed in Section 5.7 shall apply.

5.6 NEWBORN CHILDREN

If the Participant already has Dependent Coverage in effect as of the date of birth, the Participant's Newborn will be automatically covered. If the Participant does not have Dependent Coverage in effect as of the date of birth, application must be made for the Newborn within the thirty-one (31) days after the birth. In either case, coverage will be effective on the date of birth. If application for coverage is made after this thirty-one (31) day period, the Newborn will be considered a late entrant, and the restrictions listed in Section 5.7 shall apply

5.7 COVERAGE RESTRICTIONS APPLICABLE TO LATE ENTRANTS

If a Participant and/or his or her Dependent(s) are enrolled in this Plan more than thirty-one (31) days after the date they become eligible, or are reenrolled in the Plan after coverage was previously terminated due to failure to make any applicable Participant Contributions, coverage under this Plan for such individuals is restricted, as follows:

A. For the first six (6) months that the individual is a Covered Person under this Plan, he or she shall be entitled to coverage for Class I services only;

B. For the Covered Person's sixth (6th) through twelfth (12th) month of coverage, he or she shall be entitled to coverage for Class II services, in addition to the Class I services;

C. In addition to Class I and Class II services, if the Covered Person is covered at least one (1) year, but not more than two (2) years, he or she shall also be entitled to coverage for Class III services; and

D. If the Covered Person is covered at least two (2) years, he or she is entitled to coverage for all services for which such Covered Person is otherwise eligible under the provisions of this Plan.

Charges not covered due to this provision are not considered as Covered Dental Expenses, and cannot be used to satisfy this Plan's Deductible.

A Covered Person is entitled to coverage for treatment of injuries which occurred while he or she is covered under this Plan, regardless of how long such person is covered under this Plan prior to the injury.

5.8 PARTICIPANT TERMINATION

Participant coverage terminates immediately upon the earliest of the following dates:

A. The date the Participant's employment terminates;
B. The date the Participant fails to meet the eligibility requirements listed in Section 5.2;
C. The last day of the period for which the Participant has made any required Participant Contribution for coverage;
D. The date the Plan is terminated or, with respect to any benefit of the Plan, the date of termination of such benefit.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the Family and Medical Leave provisions as described in Section 5.11, and COBRA continuation coverage as described in Article VI. This Plan will also comply with the continuation provisions contained in the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) as they apply to Participants entering Service in the Uniformed Services.

5.9 DEPENDENT TERMINATION

Dependent Coverage terminates immediately upon the earliest of the following dates:

A. The date on which the Dependent ceases to be a Dependent, as defined in the Plan;
B. The date of termination of the Participant's coverage under the Plan; or
C. The last day of the period for which the Participant has made any required Participant Contribution for Dependent Coverage.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the Family and Medical Leave provisions as described in Section 5.11, and COBRA continuation coverage as described in Article VI.

5.10 EXTENSION OF BENEFITS FOR TREATMENT STARTED BEFORE TERMINATION OF COVERAGE

If an individual's coverage under this Plan is terminated for any reason other than the termination of the Plan for all Participants, benefits under this Plan may be extended for services which were started prior to the date such individual's coverage was terminated, and which are completed within thirty-one (31) days after coverage ends, if one of the following conditions exists:

A. the expense is for a Crown, Bridge or cast Restoration, and the tooth was prepared before coverage under this Plan terminated;
B. the expense is for a Prosthetic Device, and the master Impression was made before coverage under this Plan was terminated; or
C. the expense is for a root canal treatment, and the pulp chamber was opened before coverage under this Plan was terminated.

Benefits for Orthodontic treatment will only be paid until the end of the month in which coverage under this Plan is terminated. The final payment will be pro-rated.

5.11 FAMILY AND MEDICAL LEAVE PROVISIONS

This Plan intends to comply with the Family and Medical Leave Act of 1993 (FMLA) regarding the maintenance of health benefits during any period that an eligible employee takes

a leave of absence in accordance with the Company's FMLA policy, if the Company is subject to such law. In applicable situations, FMLA allows an eligible employee to maintain group health plan coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave. Employee eligibility requirements, the obligations of the Company and employees concerning conditions of leave, and notification and reporting requirements are specified in the Company's FMLA policy. If the Company is subject to FMLA, any Plan provision which conflicts with FMLA is superseded by FMLA to the extent such provision conflicts with FMLA. Questions regarding rights and/or obligations under FMLA should be directed to a Company representative or the Plan Administrator.

ARTICLE VI

CONTINUATION COVERAGE UNDER COBRA

6.1 RIGHT TO ELECT CONTINUATION COVERAGE

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he or she may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the 60-day period beginning on the later of:

A. the date of the qualifying event; or

B. the date the Qualified Beneficiary was notified of his or her right to continue coverage.

6.2 NOTIFICATION OF QUALIFYING EVENT

If the Qualifying Event is divorce, legal separation or a Dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company of the Qualifying Event within 60 days of the event in order for coverage to continue. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the section below entitled "Total Disability" in order for coverage to continue.

6.3 LENGTH OF CONTINUATION COVERAGE

A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Group Health Plan for:

A. up to 18 months from the date of the Qualifying Event; or

B. a Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce or entitlement to Medicare, and Dependent children who have become ineligible for coverage may continue under the Group Health Plan for up to 36 months from the date of the Qualifying Event; or

C. effective for Plan Years on or after December 19, 1989 but prior to January 1, 1997 (regardless of the date of the Qualifying Event), if a Qualified Beneficiary is determined to be Totally Disabled on the date of the Qualifying Event, he or she may continue coverage for up to 29 months from the date of the Qualifying Event, provided the Qualified Beneficiary notifies the Company of the determination of his or her Total Disability under the Social Security Act:

   1. before the end of the original 18 month continuation period; and
   2. within 60 days following the date of such determination.

D. effective January 1, 1997 (regardless of the date of the Qualifying Event), if a Qualified Beneficiary is determined to be Totally Disabled at any time during the first sixty (60) days of Continuation Coverage, he or she may continue coverage for up to 29 months from the date of the Qualifying Event, provided the Qualified Beneficiary notifies the Company of the determination of his or her Total Disability under the Social Security Act:

   1. before the end of the original 18 month continuation period; and
   2. within 60 days following the date of such determination.

E. up to 36 months from the date of the Qualifying Event.

6.4 TERMINATION OF CONTINUATION OF COVERAGE

Continuation Coverage will automatically end earlier than the applicable 18 or 36-month period for a Qualified Beneficiary if:

A. the required monthly contribution for coverage is not received by the Company within 30 days following the date it is due;

B. the Qualified Beneficiary becomes covered under any other Group Health Plan containing an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the pre-existing condition applies to the Qualified Beneficiary. This provision applies to:

   1. all Qualifying Events occurring after December 31, 1989; and
   2. with respect to Qualified Beneficiaries who elected coverage after December 31, 1988, the period for which the required premium was paid or payment was attempted but rejected;

C. for Totally Disabled Qualified Beneficiaries continuing coverage for up to 29 months, the last day of the month coincident with or following 30 days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled;

D. the Qualified Beneficiary becomes entitled to Medicare benefits; or

E. the Company ceases to offer any Group Health Plans.

6.5 MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is 18 months, and a second Qualifying Event occurs during the 18-month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage," to continue coverage under the Group Health Plan for up to 36 months from the date of the first Qualifying Event. In addition, if a Qualified Beneficiary who was a Covered Employee becomes entitled to benefits under Medicare (whether or not this is Qualifying Event), a Qualified Beneficiary (other than the Covered Employee) may elect to continue coverage for a maximum of 36 months from the date of the initial Qualifying Event, to the extent another period of Continuation Coverage is not required by law under COBRA.

6.6 TOTAL DISABILITY

Prior to January 1, 1997, in the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled at the time of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of 29 months as long as the Qualified Beneficiary notifies the Employer:

A. prior to the end of 18 months of Continuation Coverage that he or she was disabled as of the date of the Qualifying Event; and

B. within 60 days of the determination of Total Disability under the Act.

Effective January 1, 1997, regardless of the date of the Qualifying Event, a Qualified Beneficiary meets the requirements of this section if the Total Disability existed at any time during the first sixty (60) days of the Qualified Beneficiary's Continuation Coverage, provided the Employer is notified of the Total Disability within the time limitations shown above.

The Employer will charge the Qualified Beneficiary an increased contribution for Continuation Coverage extended beyond 18 months pursuant to this Section.

If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

A. the Qualified Beneficiary shall notify the Employer of this determination within 30 days; and

B. Continuation Coverage shall terminate the last day of the month following 30 days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

6.7 CARRYOVER OF DEDUCTIBLES AND PLAN MAXIMUMS

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible and co-payment features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

6.8 PAYMENTS OF PREMIUM

The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

A. The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.

B. For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for continuation coverage months 19-29.

C. Contributions for coverage may, at the election of the payer, be paid in monthly installments.

If Continuation Coverage is elected, the first monthly contribution for coverage must be made within 45 days of the date of election.

Without further notice from the Company, the Qualified Beneficiary must pay the monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within 30 days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage," Subsection A.

No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

6.9 DEFINITIONS

For purposes of this Article VI, unless specifically stated otherwise, the following definitions apply:

A. “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

B. "Code" means the Internal Revenue Code of 1986, as amended.

C. "Company" means the Employer, as defined in Article III.

D. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.

E. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.

F. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.

G. "Qualified Beneficiary" means:

1. a Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering the Covered Employee ineligible for coverage under the Plan; and
2. a covered spouse or dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below. Effective January 1, 1997, Qualified Beneficiary also includes any child who is born to or Placed for Adoption with the Covered Employee during the period of Continuation Coverage.

H. "Qualified Event" means the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

1. termination of a Covered Employee's employment (other than gross misconduct) or reduction in the Covered Employee's hours of employment;
2. the death of the Covered Employee;
3. the divorce or legal separation of the Covered Employee from his or her spouse;
4. the Covered Employee becoming entitled to Medicare coverage; or
5. a child ceasing to be eligible as a dependent child under the terms of the Group Health Plan.

I. "Totally Disabled" or "Total Disability" means totally disabled as determined under Title II or Title XVI of the Social Security Act.

6.10 COBRA BANKRUPTCY PROVISION UNDER TITLE XI

For purposes of this subsection only:

A. "Qualified Beneficiary" means:

1. a Covered Employee who retired on or before the date of the Qualifying Event and who was covered as a retiree under the Group Health Plan;
2. an individual who was covered under the Group Health Plan as a surviving spouse of a deceased retiree on the day before the date of the Qualifying Event; and
3. a Dependent of either of the above described individuals who was covered under the Group Health Plan on the day before the date of the Qualifying Event.

B. "Qualifying Event" means the substantial elimination of coverage under the Group Health Plan within one (1) year before or after the Company files a petition in bankruptcy under Title XI of the United States Code.

If a Qualified Beneficiary experiences a Qualifying Event, as defined in this provision, he or she may elect to continue coverage under the Group Health Plan if he or she pays the monthly contribution specified from time to time by the Company and makes his or her election in accordance with the provision above entitled "Right to Elect Continuation Coverage." Continuation Coverage for a Qualified Beneficiary who is a retiree and his or her Dependents who are Qualified Beneficiaries will continue for the life of the retiree. When the retiree dies, his or her Qualified Beneficiaries may elect to continue coverage for up to 36 additional months.

If a surviving spouse and Dependent children are covered as beneficiaries of a deceased retiree when the loss of coverage due to bankruptcy occurs, they may elect to continue coverage until the death of the surviving spouse. Upon the death of the surviving spouse, the Continuation Coverage terminates.

Continuation Coverage elected under this provision will automatically end earlier than the periods specified above if the required contribution for coverage is not paid on a timely basis or if the Company ceases to offer any Group Health Plans.

ARTICLE VII

DENTAL EXPENSE BENEFITS

7.1 COINSURANCE PERCENTAGE AND DEDUCTIBLE

The Plan will pay the percentage stated in the Schedule of Dental Benefits for the amount listed in such schedule, except that the Covered Person, not the Plan, must pay the amount needed to satisfy the Deductible listed therein. In no event shall the amount paid exceed the Plan Benefit Maximum, as described below and as stated in the Schedule of Dental Benefits.

The Deductibles apply to all Covered Expenses for each Calendar Year. The Deductible(s) will be applied as explained in the definition of Deductible set forth in Article III.

7.2 ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator may allocate the Deductible amount to any eligible charges and apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and binding upon the Covered Person and all assignees.

7.3 PLAN BENEFIT MAXIMUMS

The total dental expense benefits payable for a Covered Person for Orthodontic Services while covered under this Plan shall not exceed the lifetime maximums shown in the Dental Plan Benefit Maximum, as specified in Section 2.5, even though the Covered Person may not have been continuously covered. The total Calendar Year benefits for Class I, Class II and Class III dental services shall not exceed the Calendar Year Maximum shown in Section 2.5.

7.4 PREDETERMINATION OF BENEFITS

When charges for a proposed dental treatment plan for a Covered Person is expected to be more than $200, the Covered Person's Dentist should submit a Dental Treatment Plan showing the proposed services and fees to the Benefit Administrator, as the entity designated by the Plan Administrator to handle claims. The Benefit Administrator will then determine the benefits which would be payable for each dental service according to the terms of the Plan, and will return the Dental Treatment Plan to the Dentist. Actual payment of any benefits will be contingent upon the Covered Person's eligibility for such benefits under this Plan at the time the services are rendered.

The Covered Person and his or her Dentist can then discuss the proposed procedures and the benefits payable under this Plan. When the treatment is completed, the Covered Person's Dentist should file a claim indicating the date each service was performed, and submit it for consideration.

If this Predetermination of Benefits process is not followed before treatment begins, coverage under this Plan will be determined by taking into account alternate procedures or services for the dental condition. This determination will be based upon acceptable standards of dental practice. The maximum amount payable may be based on the charge for a dental service which provides acceptable treatment at the least expensive charge.

Predetermination of Benefits is not required for courses of treatment under $200, emergency treatment, routine oral examinations, x-rays, Prophylaxis, or Fluoride treatment.

7.5 MISSING TEETH EXCLUSION

The replacement of teeth that are missing when the individual becomes a Covered Person under this Plan will not be considered a Covered Dental Expense, unless the Prosthetic Device which replaces such teeth also replaces one or more natural teeth which are lost or extracted after the individual becomes a Covered Person under this Plan.

7.6 COVERAGE FOR INDIVIDUAL'S COVERED UNDER COMPANY'S PRIOR PLAN

If the individual was covered under the Company's prior dental plan, and such individual was enrolled in this Plan on the Plan Effective Date, immediately after coverage under the prior plan was terminated, coverage may be provided for services which were started prior to the date the individual became a Covered Person under this Plan if the prior plan would have covered such service had coverage not terminated. Coverage for such services under this Plan shall be limited to the lessor of the following:

A. the amount which would have been payable under this Plan had the services commenced after the Effective Date; or

B. the amount which would have been payable under the prior plan had coverage not terminated.

Any benefits actually paid by the prior plan due to any extension of benefits provision shall be deducted from the amount listed in A. or B. above, as applicable.

ARTICLE VIII

DESCRIPTION OF BENEFITS

8.1 DENTAL BENEFITS - COVERED EXPENSES

Covered Dental Expenses for dental services include charges for the services listed below. All covered dental services must be furnished by or under the supervision of a Dentist. The services must be the usual and necessary treatment for a dental condition.

Other dental services not specifically listed below may be considered as Dental Covered Expenses under this Plan, at the discretion of the Plan Administrator, if such services are considered as appropriate treatment for the Covered Person's condition by the American Dental Association, and the treatment provides the least expensive professionally adequate result.

Covered Dental Expenses for the services listed below will be based upon the Reasonable and Customary charge for such services. Certain services have limitations on the frequency with which they are recognized as a Covered Expense. These limitations are noted below.

8.2 CLASS I - PREVENTIVE SERVICES

The Plan will pay Covered Dental Expenses for the following procedures at the percentage level shown for Class I services in Section 2.4, subject to the Deductible listed in Section 2.3 and the coinsurance listed in Section 2.4, up to the combined Calendar Year maximum shown in Section 2.5. Any of the following procedures which are performed in connection with Orthodontic treatment will be considered and paid as Class IV services:

A. Prophylaxis, limited to one (1) treatment in any six (6) consecutive month period. The allowance includes the complete removal of explorer-detectable calculus, soft deposits, plaques, stains and the smoothing of tooth surfaces above the gingival attachment.

B. Topical Application of Fluoride, including Prophylaxis, limited to Covered Persons under age fourteen (14) and to one (1) treatment in any six (6) consecutive months.

C. Space maintainers, limited to Covered Persons under age sixteen (16) and to the initial Appliance only, including:
   1. fixed, unilateral, band or stainless steel Crown type; or
   2. removal, bilateral type.

   The allowance includes all adjustments in the first six (6) months after installation.

D. Fixed and removable Appliances to inhibit thumbsucking, limited to Covered Persons under age fourteen (14) and to the initial Appliance only. The allowance includes all adjustments in the first six (6) months after installation.

E. Diagnostic services, including examination, diagnosis and the following x-rays:
   1. full mouth series of at least fourteen (14) films, including Bitewings, if needed, limited to once in any sixty (60) consecutive months;
   2. Bitewing films, limited to a maximum of four (4) films, in one visit, in any twelve (12) consecutive month period;
   3. Intraoral periapical or occlusal x-rays, single films;
   4. Extraoral superior or inferior maxillary film; or
   5. Panoramic film, maxilla and mandible, allowable only when necessary to diagnose accidental injury, or in conjunction with cyst or tumor removal.

F. dental Sealants, limited to the unrestored permanent molars of Covered Persons under age sixteen (16) and to one treatment in any thirty-six (36) consecutive month period.

G. office visits and examinations, including:

1. oral examinations, limited to one (1) examination in any six (6) consecutive month period; or

2. Emergency Palliative treatment and other non-routine, unscheduled visits. This is only covered as a separate service if no other service, except x-rays, is rendered during the visit.

8.3 CLASS II - BASIC SERVICES

The Plan will pay Covered Dental Expenses for the following procedures at the percentage level shown for Class II services in Section 2.4, subject to the Deductible listed in Section 2.3, up to the combined Calendar Year maximum shown in Section 2.5. Any of the following procedures which are performed in connection with Orthodontic treatment will be considered and paid as Class IV services:

A. diagnostic consultations with a Dentist other than the one providing treatment, limited to one (1) consultation for each dental specialty in any twelve (12) consecutive month period. These services are only covered if no other service is rendered during the visit.

B. diagnostic services, including examination and diagnosis, and the following:

1. diagnostic casts, when necessary to diagnose complex restorative cases; or

2. biopsy and examination of oral tissue.

C. restorative services. Multiple Restorations on one (1) surface will be considered as one (1) Restoration. The allowance includes insulating base and local Anesthesia. Restorative services includes the following:

1. Amalgam Restoration for primary or permanent teeth for cavities involving one surface, two surfaces and three or more surfaces.

2. Synthetic Restorations, including curing light and etchant for the following:

a) anterior teeth - per Restoration:

(1) Acrylic or plastic filling for Class I and III types;

(2) Composite resin for Class I and III types 2330; or

(3) Composite resin involving incisal angle.

b) bicuspid teeth - Composite resin for Class V type.

3. Crowns, Acrylic or plastic, without metal, or stainless steel.

4. pins or pin retention, exclusive of restorative material, used in lieu of cast Restorations.

5. recementation of Inlay, Onlay, Crown and Bridge.

D. The following Endodontic services, including all Endodontic treatment within twelve (12) months:

1. pulp capping, direct, for full or new pulpal exposure.

2. remineralization (Calcium Hydroxide), as a separate procedure.

3. vital pulpotomy.

4. apexification, therapeutic apical closure.

5. Root Canal Therapy on non-vital (nerve-dead) teeth, including anterior, bicuspid or molar teeth. The allowance includes routine X-rays and cultures, but excludes final Restoration.
6. Apicoectomy, as a separate procedure or in conjunction with other Endodontic procedures. The allowance includes retrograde filling.

E. The following Periodontic services, including the treatment plan, local anesthetics and post-operative care:
   1. non-surgical services, including:
      a) periodontal root planing as necessary for substantial bone and attachment loss, limited to one (1) treatment per area in any twenty-four (24) month period;
      b) occlusal adjustment not involving Restorations and done in conjunction with Periodontic surgery, per quadrant. Covered services are limited to one (1) time per area of the mouth in any twelve (12) consecutive month period.
   2. surgical services, limited to one (1) treatment per area in any thirty-six (36) month period, including:
      a) Gingivectomy, per tooth, limited to less than three (3) teeth and not incidental to Crown preparations;
      b) Osseous Surgery, per quadrant, including all necessary associated surgical procedures; and
      c) mucogingival surgery, including pedicle soft tissue graft, sliding horizontal flap and free soft tissue graft.

F. oral surgery, including the diagnosis, treatment plan, local anesthetics and post-surgical care, for the following:
   1. extractions, including:
      a) uncomplicated non-surgical extraction, one (1) or more teeth;
      b) surgical removal of erupted teeth, involving tissue flap and bone removal; and
      c) surgical removal of impacted teeth;
   2. alveolectomy, per quadrant;
   3. stomatoplasty with ridge extension, per arch;
   4. removal of mandibular tori, per quadrant;
   5. excision of hyperplastic tissue;
   6. excision of pericoronal gingiva, per tooth;
   7. removal of palatal torus;
   8. removal of cyst or tumor, not associated with the removal of impacted teeth;
   9. incision and drainage of an abscess;
   10. closure or oral fistula or maxillary sinus;
   11. reimplantation of tooth;
   12. frenectomy;
   13. suture of soft tissue injury;
   14. sialolithotomy for removal of salivary calculus;
   15. closure of salivary fistula;
   16. dilation of salivary duct;
   17. sequestrectomy for osteomyelitis or bone abscess, superficial; or

18. maxillary sinustomy for removal of tooth fragment or foreign body.

G. the following prosthodontic services (specialized techniques and characterization are not covered), including:
   1. Denture repairs, Acrylic:
      a) repairing Dentures, no teeth damaged;
      b) repairing Dentures and replacing one (1) or more broken teeth;
      c) replacing one (1) or more broken teeth, no other damage;
   2. Denture repairs, metal. The Covered Expense is based on the extent and nature of the damage, and on the type of materials involved;
   3. full or Partial Denture Rebase, jump case, limited to once per Denture in any thirty-six (36) consecutive month period;
   4. full or Partial Denture Reline, limited to once per Denture in any twelve (12) consecutive month period, including:
      a) office Reline;
      b) cold cure;
      c) laboratory Reline;
   5. Denture adjustments, limited to adjustments by a Dentist other than the one providing the Denture, and to adjustments that are more than six (6) months after the initial installation;
   6. tissue conditioning, limited to a maximum of two (2) treatments per arch in any twelve (12) consecutive month period;
   7. adding teeth to Partial Dentures to replace extracted natural teeth; and
   8. repairs to Crowns and Bridges. The Covered Expense is based upon the extent and nature of damage and the type of materials involved.

H. general Anesthesia in connection with surgical procedures only.

I. injectable antibiotics needed solely for the treatment of a dental condition.

8.4 CLASS III - MAJOR DENTAL SERVICES

The Plan will pay Covered Dental Expenses for the following procedures at the percentage level shown for Class III services in Section 2.4, subject to the Deductible listed in Section 2.3, up to the combined Calendar Year maximum shown in Section 2.5. Any of the following procedures which are performed in connection with Orthodontic treatment will be considered and paid as Class IV services:

A. restorative services. Cast Restorations and Crowns are covered only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material. Covered charge includes insulating bases, temporization and minor associated gingival involvement. Covered restorative services include the following:
   1. Inlays;
   2. Onlays, in the presence of an Inlay;
   3. Crowns and posts, including:
      a) Acrylic with metal;
      b) porcelain;
      c) porcelain with metal;
      d) full cast metal (other than stainless steel);
      e) cast post and core, in addition to Crown (not a thimble coping);

f) steel post and Composite or Amalgam core, in addition to Crown;
g) cast dowel pin, one piece cast with Crown; and
h) Crown build-up necessitated by loss of natural tooth structure.

B. prosthodontic services (specialized technique and characterizations are not covered), including:
1. fixed Bridges. Each Abutment and each Pontic make up a unit on a Bridge;
2. Bridge Abutments;
3. Bridge Pontics, including:
a) cast metal;
b) sanitary;
c) plastic or porcelain with metal; and
d) slotted Pontic.
4. simple stress breakers, per unit;
5. Dentures. Allowance includes all adjustments done by the Dentist furnishing the Denture in the first six (6) months after installation. Temporary Dentures older than one (1) year old are considered to be a permanent Appliance. Covered Expenses include:
a) full Dentures, upper or lower;
b) Partial Dentures, including base, all clasps, rests and teeth, for the following:
(1) unilateral, one (1) piece chrome casting, clasp attachment, including Pontics;
(2) upper, with two (2) chrome clasps with rests, Acrylic base;
(3) upper, with chrome palatal bar and clasps, Acrylic base;
(4) lower, with two (2) chrome clasps with rests, Acrylic base;
(5) lower, with chrome lingual bar and clasps, Acrylic base; and
(6) stayplate base, upper or lower, anterior teeth only.

8.5 CLASS IV - ORTHODONTIC SERVICES

The Plan will pay Covered Dental Expenses for all Covered Persons subject to the Deductible shown in Section 2.3, at the percentage level shown for Class IV services in Section 2.4, up to the lifetime Orthodontic maximum shown in Section 2.5. Orthodontic services are only covered for Dependent children who are less than nineteen (19) years old when the active Appliance is first placed.

Any Class I, Class II or Class III service performed in connection with Orthodontic treatment is paid as a Class IV service. Covered Expenses include the following:

A. surgical exposure of impacted or unerupted teeth in connection with Orthodontic treatment, including routine x-rays, local anesthetics and post-surgical care;
B. active Appliances, all types, including:
1. diagnostic services;
2. the treatment plan;
3. the fitting, making and placing of the active Appliance; and
4. all related office visits, including post-treatment stabilization.

The amount payable is determined by calculating the total Covered Expense from the treatment plan. This amount is divided into equal quarterly payments, which will be spread out over the

shorter of two (2) years, or the proposed length of treatment. The initial payment is made when the active Appliance is first placed. Subsequent payments are made at the end of each three (3) month period, as long as the treatment is continued and the person remains a Covered Person under this Plan, or until the maximum benefit is reached, whichever comes first.

ARTICLE IX

9.1 DENTAL PLAN GENERAL BENEFIT EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all dental benefits provided by this Plan:

A. Charges for oral hygiene, plaque control or diet instruction.

B. Charges for precision attachments.

C. Charges for treatment which does not meet accepted standards of dental practice, or for treatment which is Experimental in nature.

D. Charges for any Appliance or Prosthetic Appliances used to:
   1. change Vertical Dimension;
   2. restore or maintain Occlusion, except as covered as a Class VI expense;
   3. splint or stabilize teeth for Periodontic reasons;
   4. replace tooth structure lost as a result of abrasion or attrition; and
   5. treat disturbances of the temporomandibular joint.

E. Charges for any services furnished for cosmetic reasons. This includes, but is not limited to:
   1. characterizing and personalizing Prosthetic Appliances; and
   2. making facings on Prosthetic Appliances for any teeth in back of the second bicuspid.

F. Charges for replacing an Appliance or Prosthetic Appliance with a like Appliance or device, unless it is at least ten (10) years old and cannot be made useable, or it is damaged while in the Covered Person's mouth in an injury suffered which the individual was a Covered Person under this Plan, and cannot be repaired.

G. Charges for replacing a lost, stolen or missing Appliance or Prosthetic Appliance or making a spare Appliance or device.

H. Charges for treatment needed due to an on the job or job related injury or a condition for which benefits are payable under Workers' Compensation or similar laws.

I. Charges for treatment for which no charge is made, including treatment furnished by one of the following:
   1. the Covered Person's employer, labor union or similar group in its dental or medical department or clinic;
   2. a facility owned or run by any governmental body; or
   3. any public program, with the exception of Medicaid, paid for or sponsored by any government body.

   If a charge which is otherwise a Covered Expense under this Plan is made by any of the above, and the Covered Person is legally obligated to pay such charge, the charge will be covered under this Plan.

J. Any charge in excess of the amount, age and frequency limitations stated elsewhere in this Plan.

K. Any charge to the extent that such charge was paid under the provisions of any medical plan provided by the Company. The amount paid under the medical plan shall be deducted from the amount otherwise payable under this Plan for the same charges.

L. Charges in excess of the Reasonable and Customary charge for the service in question.

M. Charges for Orthodontic treatment for Participants or Participant's spouses, or when the Covered Person was nineteen (19) or older when the first active Appliance was placed.

N. Charges excluded under the missing tooth exclusion as described in Section 7.5.

O. Charges for services which are specifically excluded under any provision of this Plan.

P. Charges for services rendered or received from a Close Relative of the Covered Person.

Q. Charges incurred as a result of: a) insurrection, war or any act of war, whether declared or undeclared, including resistance to armed aggression; b) any act incident to such insurrection, war or act of war; or c) participation in a riot.

R. Charges, expenses or liabilities incurred as the result of, or during, the commission of a felony, or during the commission of an assault in which the Covered Person was the aggressor.

ARTICLE X

DUPLICATION OF BENEFITS & COORDINATION OF BENEFITS

10.1 COORDINATION OF BENEFITS

Coordination of benefits (COB) is a feature that prevents duplicate payment under this Plan and other health insurance or prepayment plans, including Medicare Part A or Part B or other types of insurance. A Covered Person may have coverage under this Plan, some other health plan of coverage or other kind of insurance policy at the same time. Other health plans of coverage include a group or group-type sickness and accident insurance policy or program, a group or group-type contract of a health maintenance organization (HMO) or other pre-payment, group or individual practice plan, the portion of any group or group type hospital policy which provides indemnification in excess of $100 per day, or any insurance or insurance type contract which is not available to the public at large but is available to an individual through membership in an organization or group. Other kinds of insurance policies include an automobile insurance policy's medical payments, uninsured motorists coverage and under-insured motorists coverage. For example, a Covered Person may be covered by his or her employer's group insurance program and also by the group program provided by a spouse's employer. Or, such person may be covered by his or her employer's group insurance and also have coverage under a parent's group plan. This Plan follows rules established by Indiana law to decide which plan pays first and how much the other plan must pay.

This Plan will pay the Plan benefits without regard to benefits paid by the following kinds of coverage:

A. Individual (not group) types of coverages, other than those listed above;
B. Medicaid;
C. Group hospital indemnity plans which pay less than $100 per day;
D. School accident coverage; or
E. any law or plan when, by law, its benefits are in excess of those of any private or non-governmental plan.

If a claim is filed under this Plan for services or supplies that are also covered under another plan or insurance policy, for instance, one of the plans or policies listed in the first paragraph, payments will be "coordinated." This means that this Plan will adjust its benefit payments so that combined payments under this and any other health plan(s) or insurance policy will be no more than the usual, customary, and reasonable fee payments as determined by the plan with the higher allowance.

Once a Covered Person has provided the Plan with information about other health benefit plans and health benefits provided by other insurance policies under which he or she has coverage, the Plan will handle the coordination. This will be done according to the "Order of Benefit Determination." The Order of Benefit Determination works as follows:

A. The plan that pays first is called the primary plan. Any other plan that covers the individual is called the secondary plan. A group or individual plan or policy that does not contain a COB feature is always primary.
B. A plan that covers a person as the primary insured, Participant or the contract holder is primary. In the two examples given, the coverage through the person’s Employer would be primary. The coverage through a spouse's or parent's employer would be secondary.
C. If a person is covered as a Dependent child of two working parents, the plan of the parent whose birthday falls earliest in the year has primary responsibility for paying the claim. The plan of the parent with the later birthday becomes the secondary plan. If both parents have the same birthday, the parent whose

coverage has been in effect the longest is primary. The ages of the respective parents are not relevant. This method of coordinating benefits is commonly referred to as the "birthday rule." If the other plan has some other coordination rule (for example, a "gender rule" which states that the father's plan is always primary), the coordination rules of that plan will be followed. If divorced or separated parents each have group health care coverage that includes a Dependent, the primary plan will be determined as follows:

1. If a court decree makes one parent responsible for health care expenses, the plan of that parent will be primary, provided that the entity that would be obligated to pay the benefits has actual knowledge of the court's order;
2. If the parents have joint custody pursuant to a court decree, and no court order exists regarding responsibility for health care expenses, then the "birthday rule" will be applied;
3. If one parent has primary custody, and no court order exists establishing responsibility for payment of health care expenses with the other parent, the medical expenses should be submitted to the plans, if applicable, of the following persons in the order listed:
   a) the parent with custody of the child; then
   b) the spouse of the parent with custody of the child; and then
   c) the parent without custody of the child.

D. A plan that covers a person as an active employee or as a dependent of an active employee is primary to a plan that covers a person as an inactive employee, such as a laid-off or retired employee or as a dependent of a laid-off or retired employee.

E. There are some situations in which none of these rules apply. Here the program which has been in effect longer is primary. An example would be when a person who works two jobs has health coverage through both employers.

F. A plan or policy that covers a specific event may be primary to a plan that provides general coverage. For example, if a person is injured in an automobile accident with an uninsured motorist, his or her automobile policy's uninsured motorists coverage would be primary to a group health plan if both policies had similar provisions regarding other insurance.

G. For all other situations not described above, the order of benefits will be determined in accordance with the Indiana Insurance Department rule on Coordination of Benefits

If coverage under this Certificate is primary, benefits will be paid as if the Covered Person had no other coverage. But if this coverage is secondary, the Plan's payments will be calculated by subtracting the primary plan's benefits from the Allowable Expense for the services and supplies. For purposes of this provision, the term "Allowable Expense" means a Reasonable and Customary item of expense for dental care which is covered, at least in part, by any of the plans involved. Allowable Expenses do not include the following:

A. Expenses covered under plans providing coverage only for vision or medical care, or hearing aid programs, unless coverage is otherwise provided for such expenses in this Plan; or

B. Any penalty or reduction in benefits imposed by the primary plan because an individual failed to comply with the primary plan's provisions.

of course, the Plan will not pay more when secondary than the Plan would if primary. A Covered Person will only be eligible for the full benefits of this Plan as described in this Plan document (subject to any reduction for coordination of benefits) if such person has followed all of the Plan's procedural requirements, including precertification and preauthorization

requirements. By accepting coverage under this Plan, a Covered Person has agreed to do two things to enable the Plan to coordinate benefits. First, such Covered Person will supply the Plan with information about other coverage when asked. Second, if the Plan makes a payment and later find out that the coverage under this Plan should not have been primary, the Covered Person will return the excess amount to the Plan. The Plan has the right to obtain information needed to coordinate benefits from others as well, i.e. insurance companies and other persons, for instance.

10.2 SUBROGATION

The Plan shall be subrogated to any and all rights of recovery that the Covered Person has against any third party in connection with the Injury or Illness with respect to which the payments are made, including claims by the Covered Person for automobile uninsured and underinsured insurance. In addition, without any limitation to the Plan's right to subrogate, the Plan shall have the right to be reimbursed from any recovery made by the Covered Person.

The Covered Person is obligated to cooperate with the Plan Administrator to do whatever may be necessary to protect the Plan's rights, including signing and delivering any necessary papers. The Covered Person shall not do anything to prejudice the rights of the Plan. It is the responsibility of the Covered Person to notify the Plan Administrator, in writing, as soon as practicable, of any possible claim against a responsible third party, or any automobile uninsured or underinsured insurance coverage.

To the extent that the insurance available from or on behalf of a third party is insufficient to satisfy in full the Plan's subrogation claim and any claim by the Covered Person, the Plan's subrogation claim shall have priority and shall be first satisfied in full before any insurance and assets are applied to the Covered Person's claim.

If the Covered Person makes any recovery for the Injury or Illness with respect to which the Plan has made payments, then, to the extent of payments made by the Plan, the Plan shall automatically have a lien against any such recovery fund. The Covered Person (or his or her agent, representative or attorney) shall hold such money in trust for the Plan and take all appropriate and reasonable steps to immediately repay the Plan.

The Plan's right of recovery under this subrogation provision shall not be reduced or offset by any claims of the Covered Person, any claim of the Covered Person's attorney for attorney's fees, or any expenses incurred in connection with enforcing the Plan's rights of recovery against a third party.

This Plan will comply with Sections 609(b)(1), (2) and (3) of the Employee Retirement Income Security Act with regard to Covered Persons eligible for Medicaid. An Employee's or Dependent's eligibility for, or participation in, Medicaid will not affect determination of whether or not payments should be made. Under state and federal law, should a Covered Person be entitled to payment of a claim under this Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the Covered Person's right to payment under this Plan to the extent of the amount paid by Medicaid, and reimbursement under this Plan will be made in that amount directly to the state.

10.3 MEDICARE BENEFITS

This provision prevents duplication of benefits for Covered Dental Expenses when medical or dental care benefits are available from Medicare. Benefits under this Plan will be reduced to the extent that a Covered Person is reimbursed or entitled to reimbursement for those expenses by Medicare. Any individual at any time entitled to enroll in Medicare will be considered enrolled in Part A and Part B even if the individual did not enroll.

Under the Tax Equity and Fiscal Responsibility Act of 1982, as amended (TEFRA), active employees and/or their spouses who are 65 or over may choose to have the Company program

as primary coverage, in which case Medicare may pay benefits on a secondary basis. Otherwise, an employee may elect to drop out of the Company program and choose Medicare as primary coverage. Employees in this category who are enrolled under this Plan will remain so enrolled with this Plan as primary coverage unless an option form is on file indicating otherwise.

This Plan intends to comply with the federal Social Security Act, as amended, and other applicable laws, as such apply to Medicare benefits.

LAWRENCEBURG COMMUNITY SCHOOLS
DENTAL PLAN
SUMMARY PLAN DESCRIPTION

SUMMARY OF MATERIAL MODIFICATIONS NO. 1

This Summary of Material Modifications is a description of important changes which have been made to the Plan. You should read these changes carefully and keep this document with your copy of the Summary Plan Description. If you have any questions about these changes, you should contact the Plan Administrator for more information.

The Lawrenceburg Community Schools Dental Benefit Plan Summary Plan Description (hereinafter referred to as "SPD") is hereby amended and modified as set forth below. Such amendments are effective as stated below.

1.) Effective August 1, 1999, the cover of the SPD is amended by adding the following statement thereto:

> **"THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE COMPANY AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT."**

2.) Effective August 1, 1999, the term "Benefit Administrator," wherever such term appears in the SPD, shall be amended to read "Benefit Manager."

3.) Effective August 1, 1999, the section of Article I entitled "**AMENDMENT OR TERMINATION**," as set forth on page 5 of the SPD, is amended in its entirety as follows:

> "**AMENDMENT OR TERMINATION**
> Lawrenceburg Community Schools may amend or terminate the Plan at any time by means of a writing signed by a person authorized to do so on behalf of the Lawrenceburg Community Schools. Any such amendment or termination shall become effective upon its execution or on such date as may be specified in that writing. Such amendment, modification or termination may result in the termination of Participant and Dependent coverage under the Plan. Expenses incurred prior to any Plan termination will be paid as provided under the terms of the Plan prior to such termination. Any termination of the Plan will be communicated to the Participants.
>
> The terms of the Plan cannot be amended or modified by oral statement(s). Only the Plan Administrator can interpret the terms of the Plan.
>
> Lawrenceburg Community Schools reserves the right, at any time and from time to time, to modify or amend, in whole or in part, any or all of the provisions of the Plan."

4.) Effective August 1, 1999, the definition of "**COMPANY**" as set forth in Article III, entitled "**DEFINITIONS**," on page 9 of the SPD, is amended in its entirety as follows:

"The term "Company" means Lawrenceburg Community Schools, the Plan sponsor."

5.) Effective August 1, 1999, the definition of "**EMPLOYER**," as set forth in Article III, entitled "**DEFINITIONS**," on page 11 of the SPD, is amended in its entirety, as follows:

"**EMPLOYER**
The term "Employer" means the Company and any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Internal Revenue Code of 1986, as amended, that adopts this Plan for the benefit of its employees, whose participation in the Plan is approved by the President (or any duly authorized officer) of the Company. An employer may withdraw from the Plan by delivering to the Plan Administrator written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective."

6.) Effective August 1, 1999, the definition of **"PLAN ADMINISTRATOR,"** as set forth in Article III, entitled **"DEFINITIONS,"** on page 12 of the SPD, is amended in its entirety, as follows:

"**PLAN ADMINISTRATOR**
The entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services. As of the Plan Effective Date, the Plan Administrator is Lawrenceburg Community Schools."

7.) Effective August 1, 1999, Article III, entitled "**DEFINITIONS**," as set forth on page 9 of the SPD, is hereby amended by adding the following definition thereto:

"LIFETIME
The term "Lifetime" is a word used in the Plan in reference to benefit maximums and limitations. The term "Lifetime means the total time period of a Covered Person's coverage under this Plan, regardless of the number of breaks in that coverage. Under no circumstances does the term "Lifetime" mean the duration of a Covered Person's life."

8.) Effective October 1, 1996, section 5.4, entitled "**PARTICIPANT EFFECTIVE DATE**," as set forth in Article V on page 18 of the SPD, is amended in its entirety as follows:

"5.4 PARTICIPANT EFFECTIVE DATE
Participant coverage under the Plan shall become effective with respect to an eligible person on the date he or she becomes eligible, provided written application for such coverage is made within thirty-one (31) days of the date of his or her eligibility. If application for coverage is made after this thirty-one (31) day period, or after coverage under this Plan was previously terminated because required Participant Contributions were not made, the individual will be considered a late entrant, and the restrictions listed in Section 5.7 shall apply. Such individual shall become effective for coverage on the first of the month following the date the written application for coverage is approved by the Plan Administrator.

If an eligible person is not Actively At Work on the date the Participant's coverage would otherwise become effective, his or her coverage shall become effective on the day he or she returns to Active Work.

All Participant coverages under the Plan shall commence at 12:01 A.M. standard time, on the date such coverage is effective, provided such Participant is able to be Actively At Work at such time. If the Participant is not Actively At Work on the date the Participant's coverage would otherwise take effect, but was able to do so at 12:01 A.M. standard time had such work been commenced at that time, such Participant shall be eligible for coverage on that date.

9.) Effective October 1, 1996, section 5.5, entitled "**DEPENDENT EFFECTIVE DATE**," as set forth in Article V on page 19 of the SPD, is amended in its entirety as follows:

"5.5 DEPENDENT EFFECTIVE DATE

If a Participant makes written request for Dependent Coverage hereunder within thirty (30) days of the date he or she becomes eligible for Dependent Coverage, on a form approved by the Plan Administrator, subject to the provisions of this section, and agrees to the applicable Participant Contribution for such coverage, if any, his or her Dependent(s) shall become covered on the later of the date the Dependent meets the eligibility requirements or the date the Participant becomes covered. If application for coverage is made after this thirty-one (31) day period, or after coverage under this Plan was previously terminated because required Participant Contributions were not made, the individual will be considered a late entrant, and the restrictions listed in Section 5.7 shall apply. Such individual shall become effective for coverage on the first of the month following the date the written application for coverage is approved by the Plan Administrator.

10.) Effective October 1, 1996, section 5.7, entitled "**COVERAGE RESTRICTIONS APPLICABLE TO LATE ENTRANTS**," as set forth in Article V on page 19 of the SPD, is amended in its entirety as follows:

"COVERAGE RESTRICTIONS APPLICABLE TO LATE ENTRANTS

If a Participant and/or his or her Dependent(s) are enrolled in this Plan more than thirty-one (31) days after the date they become eligible, or are reenrolled in the Plan after coverage was previously terminated due to failure to make any applicable Participant Contributions, coverage under the Plan shall become effective the first of the month following approval by the Plan Administrator. Coverage under this Plan for such individuals is restricted, as follows:

A. For the first six (6) months that the individual is a Covered Person under this Plan, he or she shall be entitled to coverage for Class I services only;

B. For the Covered Person's sixth (6th) through twelfth (12th) month of coverage, he or she shall be entitled to coverage for Class II services, in addition to the Class I services;

C. In addition to Class I and Class II services, if the Covered Person is covered at least one (1) year, but not more than two (2) years, he or she shall also be entitled to coverage for Class III services; and

D. If the Covered Person is covered at least two (2) years, he or she is entitled to coverage for all services for which such Covered Person is otherwise eligible under the provisions of this Plan.

Charges not covered due to this provision are not considered as Covered Dental Expenses, and cannot be used to satisfy this Plan's Deductible.

A Covered Person is entitled to coverage for treatment of injuries which occurred while he or she is covered under this Plan, regardless of how long such person is covered under this Plan prior to the injury."

11.) Effective August 1, 1999, section 6.3 "**LENGTH OF CONTINUATION COVERAGE**," as set forth in Article VI on page 22 of the SPD, is amended by deleting item E. in its entirety.

12.) Effective August 1, 1999, the title of Article X, as set forth on page 36 of the SPD, is changed from '**DUPLICATION OF BENEFITS & COORDINATION OF BENEFITS**," to "**GENERAL INFORMATION**".

13.) Effective August 1, 1999, Article X, entitled '**GENERAL INFORMATION**," as set forth on page 36 of the SPD is amended by adding thereto the following new sections:

"10.4 RIGHT OF RECOVERY

If payments are made under the Plan that should not have been made, the Plan may recover that incorrect payment. The Plan may recover this payment from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made to the Participant, the Plan may deduct it when making future payments directly to the Participant.

10.5 FACILITY OF PAYMENT

Whenever a Covered Person or Provider to whom payments are directed to be made is mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Plan Administrator nor the Benefit Manager shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative, if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, Benefit Manager or any fiduciary shall not be liable to any person as a result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

10.6 ADMINISTRATION OF THE PLAN

Except as otherwise specifically provided for in the Plan, the Plan Administrator shall have the exclusive authority to control and manage the operation and administration of the Plan and shall be Named Fiduciary of the Plan for purposes of ERISA. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions thereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under ERISA and all other applicable law.

The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient; provided however, that both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Employer shall indemnify any employee to whom duties are delegated by the Plan Administrator pursuant to this section from and against any liability that such employee may incur in the administration of the Plan, except for liabilities arising from the recklessness or willful misconduct of such employee.

The Plan Administrator shall be responsible for controlling and managing the operation and administration of this Plan, including, but not limited to, the power:

A. to employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;
B. to construe and interpret this Plan;
C. to adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;
D. to decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;
E. to prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;
F. to authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;
G. to prepare and to distribute, in such manner as it deems appropriate, information explaining the Plan;
H. to apply consistently and uniformly to all Covered Persons in similar circumstances its rules, regulations, determinations and decisions;
I. to prepare and file such reports and to complete and to distribute such other documents as may be required to comply fully with the provisions of ERISA and all other applicable laws, and all regulations promulgated thereunder; and
J. to retain counsel (who may, but need not, be counsel to the Company), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of the Plan.

The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan document, the decision of the Plan Administrator shall be final and binding on the Participants, Dependents, and all other persons. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof and may not be reversed by a court of competent jurisdiction unless the court finds the determination to be arbitrary and capricious.

10.7 NON-ALIENATION AND ASSIGNMENT

The Plan shall not be liable for any debt, liability, contract or tort of any employee or Covered Person. The Plan shall pay all benefits due and payable for Covered Expenses directly to the Covered Person who incurred the Covered Expenses, and no Plan benefits

shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service provider; provided further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service provider shall be binding on the Plan only if:

A. the Plan Administrator or Benefit Manager is notified of such assignment prior to payment of benefits;
B. the assignment is made on a form provided by, or approved by, the Plan Administrator or the Benefit Manager; and
C. the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator or Benefit Manager.

10.8 FAILURE TO ENFORCE

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

10.9 FIDUCIARY RESPONSIBILITIES

No fiduciary of the Plan shall be liable for any acts or omission in carrying out his, her or its responsibilities under the Plan, except as may be provided under ERISA and other applicable laws. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to such fiduciary under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in ERISA and other applicable laws.

10.10 DISCLAIMER OF LIABILITY

The Plan is not responsible for the efficiency or integrity of any health care provider delivering services or supplies utilized by the Participant. The Plan is not liable in any way for the effect of delivery of such services or supplies, the results of actions taken as a result of such services or supplies being limited or not covered by the Plan, nor any limitations imposed on the cost sharing responsibility of the Plan.

Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, Benefit Manager, or any Employer for the acts or omissions of any health care provider from whom a Covered Person receives care, or for the acts or omission of any Physician from whom the Covered Person receives care under the Plan, or for any acts or omissions of any provider of services or supplies under this Plan."

Lawrenceburg Community Schools hereby adopts the above amendments to the Lawrenceburg Community Schools Dental Benefit Plan Summary Plan Description effective on the dates set forth above.

ADOPTED this _____ day of _____, 1999.

PLAN ADMINISTRATOR FOR THE
LAWRENCEBURG COMMUNITY SCHOOLS
DENTAL BENEFIT PLAN

LAWRENCEBURG COMMUNITY SCHOOLS
DENTAL BENEFIT PLAN

SUMMARY PLAN DESCRIPTION
SUMMARY OF MATERIAL MODIFICATIONS NO. 2

This Summary of Material Modifications is a description of important changes which have been made to the Plan. You should read these changes carefully and keep this document with your copy of the Summary Plan Description. If you have any questions about these changes, you should contact the Plan Administrator for more information.

The Lawrenceburg Community Schools Dental Benefit Plan Summary Plan Description (hereinafter referred to as "SPD") is hereby amended and modified as set forth below. Such amendment is effective as of April 1, 2000.

The address of Lawrenceburg Community Schools is changed and shall read as such wherever such address appears in the Plan document:

"Lawrenceburg Community Schools
300 Tiger Boulevard
Lawrenceburg, Indiana 47025
(812) 537-7204"

Lawrenceburg Community Schools hereby adopts the above amendment to the Lawrenceburg Community Schools Dental Benefit Plan Summary Plan Description effective on April 1, 2000.

ADOPTED this _____ day of _____, 2001.

_____
PLAN ADMINISTRATOR FOR THE
LAWRENCEBURG COMMUNITY
SCHOOLS DENTAL BENEFIT PLAN

LAWRENCEBURG COMMUNITY SCHOOLS
DENTAL BENEFIT PLAN

SUMMARY PLAN DESCRIPTION
SUMMARY OF MATERIAL MODIFICATIONS NO. 3

This Summary of Material Modifications is a description of important changes which have been made to the Plan. You should read these changes carefully and keep this document with your copy of the Summary Plan Description. If you have any questions about these changes, you should contact the Plan Administrator for more information.

The Lawrenceburg Community Schools Dental Plan Summary Plan Description (hereinafter referred to as "SPD") is hereby amended and modified as set forth below. Such amendments are effective as of the dates set forth below.

1.) Effective April 14, 2004, Section 3.1, entitled "**GENERAL PLAN DEFINITIONS**," as set forth in Article III of the SPD, is amended by adding thereto the following new definitions:

"**PROTECTED HEALTH INFORMATION**
The term "Protected Health Information" means Health Information that either identifies an individual, or for which there is a reasonable basis to believe can be used to identify an individual and which is one (1) of the following:

A. transmitted by electronic media, including:
    1. the internet;
    2. an extranet;
    3. leased lines;
    4. dial-up lines;
    5. private networks; and
    6. those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
B. maintained in any electronic media; or
C. transmitted or maintained in any other form or medium."

"**HEALTH INFORMATION**
The term "Health Information" means any information, whether oral or recorded in any form or medium that:

A. is created or received by this Plan, or a Plan designee; and
B. relates to any of the following:
    1. the past, present or future physical or mental health or condition of an individual;
    2. the provision of health care to an individual; or
    3. the past, present or future payment for the provision of health care to an individual."

"**SUMMARY HEALTH INFORMATION**

The term "Summary Health Information" means information that may be individually identifiable Health Information that:

A. summarizes the claims history, claims expenses or type of claims experienced by Covered Persons under this Plan; and

B. from which the following information has been removed:

1. names;
2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;
3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge;
4. telephone numbers;
5. fax numbers;
6. electronic mail addresses;
7. social security numbers;
8. medical record numbers;
9. Plan identification numbers; or
10. Other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i)."

2.) Effective November 4, 2002, Section 6.1 entitled **"RIGHT TO ELECT CONTINUATION COVERAGE,"** as set forth in Article VII of the SPD, is hereby amended in its entirety as follows:

"6.1 RIGHT TO ELECT CONTINUATION COVERAGE

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he or she may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:

A. the date of the qualifying event; or

B. the date the Qualified Beneficiary was notified of his or her right to continue coverage.

If a Covered Employee has been determined to be an Eligible TAA Recipient or an Eligible Alternative TAA Recipient, as those terms are defined in the Trade Act of 2002, and his or her petition for certification for trade adjustment assistance (TAA) under the Trade Act of 1974 was submitted on or after November 4, 2002, such Covered Employee and his or her Dependents who lost coverage under the Plan due to a job loss which qualified such employee for TAA assistance shall be entitled to a second sixty (60) day election period (if continuation coverage was not elected during the period described above) beginning on the first day of the month in which the Covered Employee is determined to be TAA eligible, provided such election is made within six (6) months of the original loss of coverage. If elected under this provision, coverage shall begin on the first day of the month in which the Covered Employee is determined to be TAA eligible. The period of time between the original termination of coverage, and the coverage which is elected pursuant to this paragraph will not be regarded for purposes of determining whether the individual has experienced more than a sixty-two (62) day break in coverage under the Creditable Coverage provisions of this Plan."

3.) Effective February 13, 2004, Section 6.5, entitled "**MULTIPLE QUALIFYING EVENTS**," as set forth in Article VII of the SPD, is amended by deleting the last sentence therein.

4.) Effective April 14, 2004, the SPD is amended by adding the following new article thereto:

"**ARTICLE XI**

PRIVACY

11.1 PRIVACY OF HEALTH INFORMATION

This provision is intended to bring this Plan into compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. Such procedures will be in effect for this Plan for all transactions performed on or after April 14, 2004. Health Information transmitted or maintained by the Plan will be subject to the provisions described in this article.

11.2 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Protected Health Information will only be disclosed or used by the Plan under one of (1) the following conditions:

A. with the specific consent of the individual who is the subject of the Protected Health Information, provided that the Plan obtains any required authorization;

B. for payment of claims submitted to the Plan or the review of any grievances or appeals involved in such activities which are generated by the Covered Person or his or her authorized representatives; or

C. for other reasonable purposes necessary to operate the Plan, to the extent that such Protected Health Information is required for such purposes, including:

1. quality assessment and improvement activities;
2. evaluation of Plan performance;
3. underwriting and premium rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
5. business planning and development of the Plan;
6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service and the resolution of internal grievances; and
7. other health care operations listed under 45 C.F.R. § 164.501.

No other use or disclosure of Protected Health Information is permitted by this Plan.

11.3 DISCLOSURES OF HEALTH INFORMATION TO THE COMPANY

The Plan Administrator will disclose, or permit the disclosure of, Health Information to the Company only as described below:

A. for any of the purposes and under the conditions described in Section 11.2;

B. as Summary Health Information, if requested by the Company for the following purposes:

1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. modifying, amending or terminating the Plan; or

C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the Company for the purpose of performing Plan administrative functions;

Prior to any disclosure of Health Information to the Company, such entity must agree:

A. not to use or further disclose the information other than as permitted or required by this section, or as required by law;

B. that it will ensure that any agents, including subcontractors, employed by the Company or Plan Administrator for Plan administration or other Plan purposes to whom it provides Protected Health Information, including, but not limited to, the Benefit Manager, any Utilization Review Service or pharmacy benefit manager, agree to the same restrictions and conditions that apply to the Company with respect to such information;

C. not to use or disclose the Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Company; and

D. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware;

E. that it will make available Protected Health Information to the subject of such information, and allow amendment to such information as described in Section 11.4 and Section 11.5;

F. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of Protected Health Information, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that section;

G. that it will make available its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;

H. that it will, if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form, and that it will not retain any copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, that it will limit further uses and disclosures to those purposes which make the return or destruction of the information infeasible; and

I. that it will provide for adequate separation between the Plan and the Plan Sponsor by implementing the following procedures:

1. access to Protected Health Information will only be provided to the Company's Business Manager;
2. that access to and use by such employees or other persons as described above will be limited to the plan administration functions that the Company performs for the Plan; and

3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the Company's established employee discipline and termination procedures.

11.4 ACCESS OF COVERED PERSONS TO PROTECTED HEALTH INFORMATION

A Covered Person or other individual has the right of access to inspect and obtain a copy of Protected Health Information about such person as long as such information is maintained by the Plan, except for:

A. psychotherapy notes;
B. information complied in reasonable anticipation, or for use in, a civil, criminal or administrative proceeding or action; or
C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524.

Any such request must be made to the Plan Administrator a writing signed by the Covered Person whose information is being requested. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will provide access to the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

11.5 AMENDMENT RIGHTS

A Covered Person or other individual has the right to have the Company amend Protected Health Information or other information about such individual as long as such information is maintained by the Plan.. The Plan Administrator will deny such a request if:

A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on the requested amendment;
B. the information is not currently maintained in any record by the Plan;
C. the information would not be available for inspection under the reasons cited in Section 14.4; or
D. the information in the Plan's records is accurate and complete.

Any request for amendment of Protected Health Information must be provided in writing to the Plan Administrator and signed by the Covered Person or individual who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities which it has knowledge of such entity's receipt of any information which has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial which includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information."

The Lawrenceburg Community Schools hereby adopts the above amendments to the The Lawrenceburg Community Schools Dental Plan Summary Plan Description effective on the dates set forth above.

ADOPTED this _____ day of _____, 2004.

_____

PLAN ADMINISTRATOR FOR THE
LAWRENCEBURG COMMUNITY SCHOOLS
DENTAL PLAN