Group Dental and Vision Benefits*

SUMMARY PLAN DESCRIPTION

Effective July 1, 2014

CABELL COUNTY BOARD OF EDUCATION
DENTAL AND VISION BENEFIT PLAN

* *Administered by:*

AMERICAN BENEFIT CORPORATION
3150 US Route 60, East, Ona, WV 25545
304.525.0331

NOTE: This is Summary of Benefits only. The complete Plan Description is available on the Cabell County School website: *www.cabellschools.com*

ADMINISTRATIVE INFORMATION

This booklet is a "Summary Plan Description" as defined by the Employee Retirement Security Act of 1974. The Plan is administered by American Benefit Corporation.

Name Of Plan
Cabell County Board of Education Dental and Optical Plan

Name and Address of Employer
Cabell County Schools
2850 28th Street
Huntington, WV 25702

Plan Administrator
Cabell County Board of Education

Employer Identification Number
EIN #55-6000306

Plan Number
0003

Type Of Plan
Dental and Vision Expense Plan

Plan Administrator And Agent For Service of Legal Process
Conrad "Jody" Lucas
Cabell County Board of Education
2850 Fifth Avenue
Huntington, WV 25702
(304) 528-5000

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator.

Third Party Administrator
American Benefit Corporation
3150 US Route 60- Ona, West Virginia 25545
304/781-3911 304/525-6005 - fax

Claims Submission
Cabell County Schools
3150 US Route 60 Ona, West Virginia 25545

Eligibility Administration
American Benefit Corporation
3150 US Rt 60
Ona, WV 25545
304/781-3911

ELIGIBILITY

EMPLOYEES ELIGIBLE UNDER THE PLAN

To be eligible for coverage under the Plan, an individual must be in a regularly employed position.

If you and your spouse are both covered as employees under this Plan, your children may only be covered as dependents of you or your spouse.

DEPENDENTS ELIGIBLE UNDER THE PLAN

Dependents who are eligible include:

- Your legal spouse;
- Your biological of adopted children, stepchildren or other children for whom you are the court-appointed guardian under age 26.

Children ages 18 to 26 who have employer-sponsored insurance coverage available in which they could be covered as a policyholder are not eligible for coverage.

From time to time ABC may conduct eligibility audits to verify that dependents in the plan qualify for coverage. If you are audited, you will have to produce documentation for the dependent in question, including your most recent Federal tax return showing that you've claimed the dependent(s) on your taxes. If you cannot prove that the dependent qualifies for coverage, coverage will be terminated retroactively to the date the dependent would otherwise have been terminated, and the Plan will pursue reimbursement of any claims paid during the time the dependent was ineligible.

WHEN DOES COVERAGE BEGIN

Employee Coverage

Coverage for you begins on the first day of the calendar month following the date you:

1. become an employee;
2. begin working for Cabell County Board of Education or any other Board approved entity; and
3. you complete and submit an enrollment form to the Personnel Office.

Dependent Coverage

Dependent coverage begins on the first day of the calendar month on which:

1. coverage begins for you; and
2. you complete and submit an enrollment form to the Personnel Office. Coverage commences the first day of the calendar month following receipt of a completed enrollment form.

CONTINUATION OF COVERAGE UPON RETIREMENT

In order for you to qualify for continuation of benefits, you must retire under Board guidelines. Coverage must be elected within 60 days of retirement.

WHEN DOES COVERAGE END

Employee Coverage

Your coverage ends on the earlier of:

1. the last day of the month in which you were physically present on the job or a Board approved medical leave;
2. the date you are no longer in a class of employees eligible to be covered by the Plan;
3. the last day of the month through which the required contribution, if any, is paid for the purchase of your coverage; or
4. the date the Plan is terminated.

Dependent Coverage

Dependent coverage ends the earliest of:

1. the date your coverage ends;
2. when the dependent is no longer an eligible dependent; or
3. the last day of the month through which the required contribution, if any, is paid for the purchase of dependent coverage.

WHEN DOES RETIREE COVERAGE END

Retiree coverage ends the earlier of:

1. the last day of the month through which the required contribution is paid for the purchase of retiree coverage;
2. the date retiree coverage is deleted from the Plan; or
3. the date the Plan is terminated.

WHEN DOES RETIREE DEPENDENT COVERAGE END

1. the last day of the month through which the required contribution is paid for the purchase of retiree dependent coverage;
2. the date retiree coverage is deleted from the Plan; or
3. the date the Plan is terminated.

COORDINATION WITH OTHER HEALTH BENEFITS

All Dental and Vision Benefit provisions are subject to the COORDINATION OF BENEFITS provisions.

If an employee or an eligible dependent is entitled to benefits under any other plan or, would have been eligible except for their failure to enroll (as defined below), that will pay part or all of the expense incurred, the amount of benefits payable under the plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. In no event will the amount paid by this plan exceed the amount that would have been paid if there were no other plan involved.

The term "Plan" includes any plan providing benefits or services for or by reason of Dental and Vision treatment for which benefits or services are provided: (a) group, blanket or franchise insurance coverage, (b) group Blue Cross / Blue Shield and any other pre-payment coverage provided on a group basis, (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans or any other employee benefits organization plans or any other arrangement of benefits for individuals of a group and (d) any coverage under governmental programs or any coverage required or provided by any statute.

The rules for determining which plan is the primary carrier plan are as follows:

1. A plan without a non-duplication clause always pays first.

2. The plan covering the patient as employee (rather than as dependent) pays first.

3. The plan covering a child as a dependent of the parent whose birthday occurs first during the calendar year pays first. In the case of divorced parents, the following line of benefit determination is applied:

    a. The plan of the custodial parent;
    b. The plan of the spouse of the custodial parent;
    c. The plan of the non custodial parent;
    d. The plan of the spouse of the non-custodial parent.

If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

4. Except insofar as three (3) may apply first, when a participant is covered as an employee under two (2) plans, or as a dependent under two (2) plans, the plan under which the patient has been covered the longer time pays first. In

determining the length of time the individual has been covered under a given plan, we will consider two (2) successive plans covering a given group to be one continuous plan so long as the claimant concerned was eligible for coverage within twenty-four (24) hours after the prior plan terminated.

WHEN IN ACCORDANCE WITH THE ABOVE RULES, IT IS DETERMINED THIS PLAN HAS SECONDARY RESPONSIBILITY, ONLY THOSE COVERED CHARGES FOR WHICH THE PARTICIPANT IS RESPONSIBLE IN ABSENCE OF COVERAGE UNDER THIS PLAN WILL BE CONSIDERED.

DENTAL SCHEDULE OF BENEFITS

ELIGIBLE CHARGES
All charges will be based on Usual, Reasonable and Customary Charges.

<table>
<tr><th>TYPE</th><th colspan="2">DEDUCTIBLE CALENDAR YEAR</th><th>PAYMENT FACTOR</th><th>MAXIMUM</th></tr>
<tr><td>I</td><td colspan="2">$0</td><td>100%</td><td rowspan="3">$1,500 Combined</td></tr>
<tr><td>II</td><td rowspan="2">Individual $25</td><td rowspan="2">Family $50</td><td>90%</td></tr>
<tr><td>III</td><td>60%</td></tr>
<tr><td>IV</td><td colspan="2">$0</td><td>50%</td><td>$1,750 Lifetime</td></tr>
<tr><td colspan="5">*Dental plan year maximums have been removed for pediatric services (not including orthodontia)</td></tr>
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DENTAL CARE

Type I Expenses (Preventive and Diagnostic Treatment)

1. Charges for cleaning and scaling of teeth but not more often than once every 6 months.
2. Charges for fluoride application to a child's teeth to age 19 years, but not more often than once in a Plan year.
3. Charges for space maintainers and their fittings.
4. Charges for diagnostic x-rays.
5. Charges for emergency treatment for relief of dental pain on a day for which no other benefit other than for x-rays is payable hereunder.
6. Oral examinations where no other service except x-rays are provided, but not more than once every 6 months.
7. Sealants for dependent children up to 19 years, one treatment per tooth every 36 months.

Type II Expenses (Basic/Routine)

1. Initial amalgam, silicate, acrylic or composite restorations.
2. Replacement of an amalgam, silicate, acrylic or composite restorations.
3. Charges for extraction of one or more teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw, but not including additional charges for removal of stitches or post-operative examination.
4. Charges for treatment of gums and supporting structure of the teeth.

5. Charges for root canals and other endodontic treatment.
6. Charles for general anesthetics and their administration in connection with oral surgery, periodontics, fractures or dislocations.
7. Charges for injectable antibiotics administered by a dentist or physician.
8. Charges for re-cementing inlays or crowns at least 90 days after the date the inlay or crown was provided.
9. Relining, rebasing or repairing of an existing prosthesis (fixed bridgework, removable partial or complete dentures) at least 90 days after the date the installation or repair of the prosthesis was performed.
10. Consultation required by the attending dentist.
11. Bruxism Appliance covered.
12. Occlusal Guards covered, replacement every three (3) years.

Type III Expenses (Major Treatment)

1. Charges for fillings and crowns necessary to restore the structure of teeth broken down by decay or injury, but

a. the charge for a crown or gold filling will be limited to the charge for a silver, porcelain or other filling unless the tooth cannot be restored with such other material, and

b. the charge for replacement of a crown or gold filling is covered only if the crown or filling is over 5 years old.

2. Charges for full or partial dentures, fixed bridges, or adding teeth to an existing denture while the person is covered for this benefit and to replace such teeth or to replace an existing prosthesis which is over 5 years old and cannot be made serviceable.

3. Surgical Implants and related services.

Charges for specialized techniques involving precision attachments, personalization or characterization are not covered. Additional charges for adjustment within 6 months from installation are not included as covered dental charges.

Type IV Expenses (Orthodontic Treatment for Eligible Dependent Children)

Coverage for Orthodontic Treatment is limited to persons who are not more than 19 years of age when the course of treatment commences.

Only dental expenses for the following services are eligible:

1. Charges for treatment, services and supplies to correct malocclusion of the teeth, for the following conditions only:
    a. Extreme bucco-lingual version of the teeth (either unilateral or bilateral).
    b. Protrusion of the maxillary teeth of more than 4 mm.

c. Protrusive or retrusive relation of the maxillary or mandibular arch of at least one cusp.

2. One series of cephalometric x-rays every 24 months.
3. One set of study models only for each person while insured.

A "course of treatment" means the period which commences on the date the first orthodontic appliance is installed for active treatment and ceases on the date of the removal of the last orthodontic appliance for such treatment. Successive courses of orthodontic treatment commencing while covered will be considered as one course of orthodontic treatment unless the succeeding course commences more than two years after the termination of the immediately preceding course.

Benefits for a courser of treatment will be paid in arrears. Payments will be made in monthly installments from the date active treatment commences for the duration of the estimated treatment period.

Each course of treatment will be subject to the Maximum Amount for Orthodontic Treatment.

Expense Benefits for Employees and Dependents

Payment will be made at the applicable percentage rates stated in the Schedule of Benefits for the covered dental charges listed on the following pages incurred on account of the employee or dependent which exceed the deductible amount described below up to the Maximum Amount per Plan year stated in the Schedule of Benefits.

Except as described in the section entitled "After Coverage Terminates" such expenses must be incurred and the services and supplies furnished while the employee or dependent are covered.

A charge will be deemed incurred as of the date the service is rendered or the supply is furnished, except that such charge will be deemed incurred.

1. with respect to fixed bridgework, crowns, inlays, onlays, or gold restorations, on the first date of preparation of the tooth or teeth involved,
2. with respect to full or partial dentures, on the date the impression was taken, and
3. with respect to endodonitics, on the date the tooth was opened for root canal therapy.

Deductible Amount

The amount of the deductible is specified in the Schedule of Benefits. It applies separately to the employee and each dependent per Plan year, except that

1. Not more than a total deductible of $50 will be applied against all covered dental charges incurred during any one Plan year by members of a family.

Covered Dental Charges

Covered dental charges are the charges of a dentist or physician for the services and supplies listed below required for dental care and treatment of any disease, defect of accidental injury, or for preventive dental care.

Not included is any charge in excess of the Reasonable and Customary charges made

1. For similar services and supplies by dentists or physicians in the locality concerned, or
2. Where alternate services or supplies are customarily available for such treatment, for the least expensive service or supply resulting in professionally adequate treatment.

Treatment Plan

Employees are encouraged to request a Pre-treatment Estimate of benefits payable, when the total cost associated with the proposed dental work is expected to exceed $200. The dental claim form contains a provision for requesting such information prior to the date treatment is rendered.

A treatment plan is a plan of dental services (including x-rays) which indicates the patient's dental needs, gives a written description of the proposed treatment necessary in the professional judgment of the attending dentist, and shows the cost of the proposed treatment.

The filing of a treatment plan should help to avoid any misunderstanding as to the extent of coverage. This process identifies coverage and clarifies benefit specifications, such as deductibles, coinsurance and limits. Also, it gives the patient and dentist an opportunity to review the proposed treatment and the extent of coverage before any work is started.

After Coverage Terminates

The benefits described herein are also provided for covered dental charges:

1. For services or supplies furnished within 90 days after coverage terminates if the charges were incurred while coverage was in force, and
2. Incurred within 90 days after coverage terminates if any accident resulting in injury to natural teeth sustained while coverage was in force causes continuous total disability from the date of termination; provided benefits are not payable for such expenses under any other group insurance policy or plan.

DENTAL LIMITATIONS

Not covered under any section of these benefits are chargers for:

1. Treatment by someone other than a dentist or physician, except where performed by a duly qualified technician under the direction of a dentist or physician;
2. Dental treatment required as a result of self-inflicted injury, war, whether declared or not, riot or insurrection.
3. Charges for broken appointments or forms preparation.
4. Services and supplies cosmetic in nature.
5. Training in or supplies used for dietary counseling, oral hygiene or plaque control.
6. Replacement of an existing prosthesis (fixed bridgework, removable partial or complete dentures) which has been lost, mislaid or stolen.
7. Dental treatment involving the use of gold if such treatment could have been rendered at a lower cost by means of a reasonable substitute.
8. Replacement of existing prosthodontic appliances unless:
    a. The existing appliance is at least five years old and cannot be made serviceable;
    b. The existing appliance is temporarily installed after the effective date of this plan.
    c. The replacement appliance is made necessary as the result of an initial placement of an opposing denture;
    d. The replacement is made necessary as a result of an accidental injury.
9. Services or supplies which do not meet accepted standards of dental practice including charges for services or supplies which are experimental in nature.
10. Examinations for use by a third party.
11. Emergency prescriptions or other drugs and/or medicaments.
12. Dental procedures which do not directly involve the teeth or the tissues or bones which support the teeth.
13. Charges for athletic mouth guards.
14. Charges for duplicate prosthetic device or any other duplicate appliance.
15. Services and supplies rendered for full mouth reconstruction, orthognathic surgery or for a correction of temporal mandibular joint dysfunction (TMJ).

VISION SCHEDULE OF BENEFITS (revised 7-1-14)

For the following items benefits will be paid up to the maximum amount as shown below:

SERVICE / PROCEDURES	MAXIMUM
EXAMINATIONS	$120 Per Person Every 12 Months
FRAMES	$150 Per Person Every 24 Months
LENSES, PAIR SINGLE VISION	$75 Per Person Every 12 Months
BIFOCAL	$100 Per Person Every 12 Months
TRIFOCAL	$125 Per Person Every 12 Months
LENTICULAR	$100 Per Person Every 12 Months
Photochromatic Lens Treatment (Transitions)	$100
CONTACT LENSES	$225 Per Person Every 12 Months
MEDICALLY NECESSARY CONTACTS If prescribed (a) where visual acuity is not correctable to 20/40 in the better eye except by the use of contact lenses, or (b) as a requirement following cataract surgery, or (c) when such person is being treated for a condition such as Keratoconus or Anisometropia and contact lenses are customarily prescribed as a part of the treatment, are covered up to a lifetime maximum of $240.	$225 Per Person Every 12 Months
*For pediatric services all items listed will be paid up to 100% of the stated amount plus 10% of the additional cost	
Annual Maximum per Person = $500	

Vision Care
Expense Benefits for Employees and Dependents

If, while covered, an employee or any eligible dependents incur covered vision care expenses, payment will be made up to the applicable maximum amount shown on the Schedule of Visual Services and Supplies as stated in the Schedule of Benefits. If the scheduled amount for such service or supply is greater than the charges therefore such excess amount will be added to the scheduled amount for any other service or supply for which charges are incurred within 60 days of the date on which the first charge was incurred.

All vision care benefits must be rendered on a prescription basis by an optometrist, ophthalmologist or physician.

Benefits are to be provided on a reasonable and customary basis at 100% up to the limits listed in the Schedule of Visual Services and Supplies as stated in the Schedule of Benefits.

VISION LIMITATIONS

Not covered under any section of these benefits are chargers for:

1. Services or supplies which are covered in whole or in part under any other Medical Expense Benefits or Vision Care. Benefits provided by the Plan Sponsor or the State;
2. Special procedures, such as orthoptics or vision training, and special supplies, such as non-prescription sunglasses and subnormal vision aids;
3. Anti-reflective coatings or charges for tinting and charges for sunglasses or light-sensitive glasses in excess of the amount which would be a covered expense for non-tinted glasses;
4. Services or supplies received principally for cosmetic purposes;
5. Expenses incurred without the recommendation of a licensed physician, opthamologist or optometrist; or
6. Any service or supply no listed in the Schedule of Benefits.

GENERAL LIMITATIONS AND EXCLUSIONS

No payment will be made under this Plan for expenses incurred in connection with:

1. Care or treatment given by or in any facility owned or operated by the federal government unless the covered employee or covered dependent would be required to pay such charges in the absence of coverage;
2. Disease for which you or your covered dependent are entitled to benefits under any workers' compensation law or act, or accidental injury arising out of or in the course of employment;
3. Charges which are in excess of the usual, customary and reasonable charge based upon the general level of charges made by others rendering similar service in the same geographic area for services of lie severity;
4. Bodily injury sustained or sickness contracted while on duty with any armed forces of any country or international organization;
5. Services rendered by a member of the patient's immediate family or any one residing with the patient;
6. Treatment or services related to injuries sustained while committing a felony;
7. Treatment or services for an intentionally self-inflicted injury;
8. Treatment or services which are experimental or investigative in nature;
9. Treatment or services incurred after the date of termination of the person's coverage, except as provided herein;
10. Telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
11. Services received in or from an institution owned or operated by the federal government where there is no obligation to pay in the absence of insurance;
12. Services or supplies received as a result of disease, defect or injury due to an act of war, declared or undeclared;