DIXON PUBLIC SCHOOLS DISTRICT #170
Non-DESPA Support Staff

Health Care Plan

Benefit Booklet/Plan Document
Effective July 1, 2013

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Notice to Plan Participants

The Plan has a Hospital Pre-Admission Certification, Continued Stay Review Program. The District has contracted with Hines & Associates to administer the program. This program is designed to help you and your family avoid unnecessary hospital confinements and to assure that you and your dependents are receiving appropriate, quality medical care. It is not the intention of the Plan to dictate or direct medical care, only to assure appropriate care. Whenever possible you should discuss your course of treatment in advance with your physician.

Please refer to the sections, "Hospital Pre-admission Certification/Continued Stay Review Program" for an explanation of this program.

Note: *If you (or your dependent) do not contact Hines & Associates prior to a scheduled hospital confinement (or within 48 hours following an emergency admission or maternity admission) an additional $200 deductible will be applied before any benefits are paid for that confinement. This deductible is in addition to the calendar year deductible. The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.*

Introduction

This document describes the coverage provided under the Health Care benefit program (which includes a Preferred Provider Network) that is designed to help protect you and your eligible dependents against the financial effects of illness or injury.

This booklet, and the benefits described within it, is drafted to be compliant with applicable laws, including the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), and otherwise is intended to replace all previously distributed materials. Although the Plan Administrator hopes and expects to continue the coverage described in this booklet, the Plan Administrator necessarily reserves the right to either modify or discontinue the benefits under the Plan at any time. You will be notified in writing of any material changes to the Plan. If benefits are discontinued, benefits will be paid for eligible expenses incurred prior to the date of termination.

A description of the Group Life and Accidental Death and Dismemberment Insurance Plan coverage which is provided by the District for active employees is described in a separate Certificate of Insurance issued by the insurance company. Please refer to this certificate for an explanation of the Life and Accidental Death and Dismemberment insurance coverage provided to you.

This document, and the benefits described within it, is intended to supersede all previously distributed materials. Although we expect to continue the coverage described, we necessarily reserve the right to either modify or discontinue the benefits under the Plan at any time. You will be notified in writing of any material changes to the Plan.

Coverage under the Plan is not a guarantee of employment with the District.

Note: The Health Care Plan is not a policy of Worker's Compensation insurance. Please contact the Business Office for information on insurance available to you if your illness or injury is work related.

Eligibility and General Plan Provisions

Who is Eligible for Coverage

You are eligible for coverage if you are permanently employed by the District on a full-time basis and are working an average of 30 or more hours per week during the measurement period. Temporary employees or employees who work less than 30 hours per week are not eligible. In addition, an active employee age 65 or older who makes a written election to be covered by Medicare instead of the Plan is also not eligible for coverage.

You may also elect to cover your eligible dependents. Dependents eligible under the Plan are:

1. Your lawful spouse. ***A spouse will not be eligible to enroll if coverage is available at the spouse's place of employment.***

2. Civil Union partner as defined: A Civil Union partner of the opposite sex or same sex, with whom you have entered into a legal civil union. Such civil union must meet all the requirements of a valid civil union in the state of Illinois. A copy of your completed civil union certificate will be required at enrollment. Any newly acquired Civil Union Partner will be eligible to enroll in the Plan within the same time requirements as a newly acquired Spouse.

   Your partner in a same-sex marriage, or an opposite sex or same sex civil union or a similar relationship other than common law marriage, that was legally entered into in another state will also be eligible under this provision. You will be required to provide proof of a valid, legal union in that state, e.g. a copy of your marriage or civil union certificate.

   Your partner must be a resident of the same country as you.

   A civil union partner will not be eligible to enroll if coverage is available at the partner's place of employment.

3. Your dependent children to age 26. Children eligible for coverage under the Plan include your natural child, step child, legally adopted child, a child who has been placed with you for adoption pursuant to an interim court order, foster child, a child for whom you have been appointed legal guardian or have legal custody, and a child who is recognized under a Qualified Medical Child Support Order.

   Grandchildren (unless you have legal guardianship or legal custody) or your parents are not eligible even though they may be supported by you.

If both you and your spouse are employees of the District, you may not be covered as both an employee and as your spouse's dependent. In addition, your children may be

considered as eligible dependents of either you or your spouse, but not both. If a child's parents are divorced and both are enrolled for Family coverage with the District, the child will only be considered the dependent of the parent whose birthday, excluding year of birth, falls earlier in the calendar year. When both parents have the same birthday, excluding year of birth, the child will be considered the dependent of the parent who has been covered under the plan for the longest period of time. However, when a court order or divorce decree assigns responsibility for a child's medical or dental expenses to a specific parent, the child will only be considered the dependent of the named parent.

Note: 1- Coverage will be subject to a limitation of benefits for all pre-existing conditions as described in the section "Limitation of Coverage for Pre-Existing Conditions".

2- Benefits payable by the Plan may be reduced as described in the section "Coordination With Other Plans" for persons covered under more than one plan.

Who Pays for the Coverage

You and the District share the cost of coverage for yourself and your dependents if you elect dependent coverage. The Business Office will advise you of the amount that will be deducted from your paycheck for coverage when you enroll.

If you elect to make your contribution for coverage on a pre-tax basis under the District's Section 125 Plan, you will only be allowed to change your coverage election at the beginning of the Plan year, or, if sooner, within the 31-day period following a major life change as defined in the Section 125 Plan. If you elect to make your contributions for coverage on an after tax basis you will not be subject to this Section 125 enrollment limitation.

If you qualify for continued coverage after your employment ends, you will be provided with information regarding the premium and payment procedure at that time.

When Coverage Begins

Employee Coverage

Your coverage will normally begin at 12:00 A.M. on the first day you are employed as an eligible employee of the District or your employment status changes from a part-time to an eligible full-time employee. You must file your written request for coverage within the 31-day period immediately following the date you first become eligible for coverage. If you request coverage after this 31-day period you will be considered a *special enrollee* or *late enrollee* as explained in the following section.

Coverage for Your Dependents

If you elect Family coverage when you first become eligible, coverage for your eligible dependents will begin on the day you become covered provided you complete the enrollment form electing Family coverage within 31-day period immediately following the date you first become eligible.

Once you are enrolled for Family coverage, any additional dependent acquired is covered beginning at 12:00 A.M. on the day on which he or she becomes an eligible spouse or child provided you complete the enrollment form within 31 days of acquisition.

If you do not have any eligible dependents when you first become covered and acquire an eligible dependent later, the dependent must be enrolled for coverage within 31 days following the date of acquisition. If the spouse or child is enrolled on a timely basis, the new dependent will become covered at 12:00 A.M. on the date you acquire him or her. If your request for Family coverage is made after this 31-day period your dependent(s) will be considered a *special enrollee* or *late enrollee* as explained in the following section.

Note: 1 - If you elect to make your contribution for coverage on a pre-tax basis under the District's Section 125 plan, you will only be allowed to change your coverage election during the Open Enrollment period held every November for a January 1 effective date or, if earlier, within 31 days following a major life change as defined in the Section 125 Plan.

2 - Please refer to the section "Limitations of Benefits for Pre-Existing Conditions" for information on the potential limitation of coverage.

Open Enrollment

The District will designate an Open Enrollment period during the month of November during which time you may:

- file an election to make your contributions for coverage on a pre-tax basis if you have not already done so;
- enroll yourself and/or your eligible dependents for coverage, if you or your dependents are not already enrolled for Family coverage. Please refer to the following section for an explanation of the enrollment process; or,
- voluntarily drop your Single or Family coverage.

If you apply for coverage during the Open Enrollment period, coverage will begin at 12:00 A.M. on the January 1 following the November open enrollment period.

Special Enrollees and Late Enrollees

An employee and/or dependent who do not enroll for coverage when first eligible will be considered either a "Special Enrollee" or a "Late Enrollee". The difference between the two is when coverage will become effective and the potential length of the pre-existing condition limitation waiting period.

You and/or your dependent(s) will qualify as a "Special Enrollee" if coverage was declined in writing when it was previously offered and any of the following apply:

1. you and/or your dependent(s) had coverage under another group health plan or health insurance coverage and that coverage ends as a result of "loss of eligibility", or incurring a claim that meets or exceeds a lifetime limit on all benefits, or because employer contributions toward the other coverage stopped. If the other coverage was COBRA continuation coverage, that coverage must have been exhausted. "Loss of eligibility" includes loss of coverage as a result of legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in the number of hours of employment, as well as loss of coverage due to the plan no longer offering any benefits to a class of similarly situated individuals (for example, part-time employees). It does not include a loss due to the failure of you and/or your dependent(s) to pay premiums or make contributions on a timely basis, or termination for cause;

2. you get married; or,

3. you acquire a new dependent child through birth, adoption, or placement for adoption.

If you and/or your dependent(s) qualify for coverage as a Special Enrollee, you must enroll for coverage within 31 days of the loss of the other coverage or marriage, the effective date of this coverage will be the first day of the calendar month after your request for coverage is made. If you and/or your dependents qualify for coverage as a Special Enrollee because of birth, adoption or placement of adoption, whichever is applicable and you enroll for coverage within a 31-days of the event, coverage will begin at 12:00 A.M. on the date you acquire a new dependent through birth or adoption.

If you and/or your dependent(s) are not a Special Enrollee as explained above or if you and/or your dependent(s) qualify as a Special Enrollee but do not enroll for coverage within 31 days of the occurrence that allows for a "special enrollment", you and/or your dependent(s) are a "Late Enrollee". Late Enrollees are only eligible for coverage during the open enrollment period held every November for a January 1 effective date.

Note: Coverage will be subject to a limitation of benefits for all pre-existing conditions as described in the section "**Limitations of Benefits for Pre-Existing Conditions**".

When Coverage Terminates

Effective Date of Termination for Employees

Your coverage under the Plan will end at 11:59 P.M. on the first to occur of the following days:

1. the last day of the month in which your employment terminates;
2. the day before you no longer meet the definition of an eligible employee;
3. if you are an active employee age 65 or older, the day you elect Medicare as your primary Health coverage;
4. if you request that your contributions for coverage be stopped or fail to make the required contributions, the last day of the period for which your contributions have been made;
5. the day on which you enter into the armed forces of any country on a full-time basis;
6. the day the Plan is terminated.

If your active employment ends because you begin a leave of absence and you are eligible for continued coverage based on the provisions of the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), or Chapter 105 of the Illinois Compiled Statutes section 5/10-20.7b, coverage will continue as so required provided you agree in writing to make any required contribution for coverage. Any such continuation will be integrated with any other continuation to which you may otherwise be eligible. Termination of the coverage continuation provided under these mandatory leaves or your failure to return from leave will be considered a 'qualifying event' under COBRA. If you waive coverage continuation during any of these leaves, coverage for you (and your dependents if Family coverage was in effect prior to your leave) will be reinstated at 12:00 A.M. on the first day you return to the District as an eligible employee and the pre-existing condition limitation will not apply to the extent that you (or your dependent) satisfied the limitation prior to beginning the leave."

If both husband and wife are eligible for coverage as employees and one spouse has been considered the covered employee and the other the covered dependent and the spouse carrying the Family coverage no longer qualifies as an employee, the Family coverage may be switched to the remaining employed spouse. In order to do this, the remaining spouse must provide the Business Office with his/her written request for Family coverage and agreement to make any required employee contributions within the 31-day period immediately following the date the former employee's coverage would otherwise have terminated. Any person who was covered under the former employee's coverage will then be covered under the remaining employed spouse as of 12:00 A.M. on the day following the date coverage would otherwise have been terminated.

Likewise, if a child's parents are divorced and are both covered under the Plan and the parent who has been covering the child as his or her dependent no longer qualifies as an

employee, at 12:00 A.M. on the day following termination the dependent child will be considered the dependent of the parent remaining under the Plan. However, if the remaining parent is not already enrolled for Family coverage, he or she must provide the Business Office with written request for Family coverage and agreement to make any required employee contributions within the 31-day period immediately following the date the former employee's coverage would otherwise have terminated.

Effective Date of Termination for Dependents

Coverage for your dependents will automatically terminate when your coverage ends or, if sooner, at 11:59 P.M. on the first day on which any of the following occurs:

1. for a spouse –

    a. you become legally divorced; or,
    b. if you are an active employee, the day on which he or she makes a written election to be covered by Medicare for Health coverage instead of the Plan.
    c. your spouse is eligible for coverage thru their employment

2. for a child who ceases to meet the applicable eligibility requirements.

3 you request that your contributions for Family coverage be stopped.

Note: You or your dependent are responsible for notifying the Business Office within 60 days following the date a dependent is no longer eligible for coverage because of divorce or because your child no longer meets the eligibility requirements. If the Business Office is not notified within 60 days following the date your dependent is no longer eligible for coverage, he or she will not qualify for COBRA coverage continuation.

You and/or your dependents may have the opportunity to continue coverage under the Plan for a period of time beyond the normal termination date. More information about extension of coverage is provided in the sections “Continuation of Coverage for Active Employees and Their Dependents”, “Continuation of Coverage for Employees Participating in the Illinois Municipal Retirement Fund (IMRF)” and “Continuation of Coverage under COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)”.

Certificate of Creditable Coverage Upon Termination

The Plan will issue a Certificate of Creditable Coverage, automatically and without charge under the following circumstances:

1. upon termination of coverage under the Plan;
2. for an individual who is a Qualified Beneficiary and has elected COBRA coverage, upon termination of COBRA continuation coverage; and,

3. upon reaching the Plan's maximum benefit payable under the Plan (please refer to the "Schedule of Health Care Benefits").

A Certificate of Creditable Coverage may be requested at any time within the 24-month period after coverage terminates, provided the Plan receives a written request for the Certificate by the former participant or his or her authorized representative. The Certificate of Creditable Coverage will be in the form required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To obtain a Certificate of Creditable Coverage, your request should be directed to:

IPMG Employee Benefits Services
225 Smith Rd.
St. Charles, IL 60174
1-800-423-1841

The name and address to which IPMG Employee Benefits Services should mail the Certificate of Creditable Coverage needs to be provided by the participant.

Continuation of Coverage for Active Employees and Their Dependents

Coverage may be continued beyond the day it would normally terminate for active employees and/or their dependents as explained in this section.

Continuation of Coverage During An Approved Leave of Absence

If you have been granted an approved leave of absence by the Board of Education you may continue coverage under the Plan as long as the necessary contributions are paid.

Continuation of Coverage If You Become Totally Disabled

If your active employment ends because you become totally disabled, coverage may be continued through the date on which your sick leave benefits end by making the required employee contribution. If your total disability continues beyond your sick leave benefit period, you will have to choose from one of the following options:

1. COBRA or,

2. if the District is making a contribution to the Illinois Municipal Retirement Fund in your behalf, the IMRF disability extension.

Continuation of Coverage for a Handicapped Child

Coverage can be continued beyond the attainment of the maximum age for a dependent child who is unable to support himself or herself because of a physical or mental handicap. Coverage can continue as long as the child is unmarried and unable to support

himself or herself. Coverage for the dependent will end if your coverage terminates, you stop your contributions for dependent coverage, or the Plan is ended.

Proof of incapacity must be submitted to the Business Office within 60 days after the date on which the dependent no longer will be eligible because of age, and at reasonable intervals thereafter. The dependent child must meet all of the eligibility requirements other than age to continue to be eligible. For example, if the dependent marries, he or she will no longer have coverage under the Plan. Information about extended coverage that may be available following the above continuation option is provided in the section, "Continuation of Coverage under COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)".

Continuation of Coverage for Surviving Dependents

If you die while covered under the Plan and enrolled for Family coverage, the District will continue to provide coverage for your surviving dependents *if* your spouse does not have group health coverage available to him or her through their employer at the time of your death. The coverage continuation will be provided until the earliest of the following dates:

1. the last day of the 90-day period immediately following the date of your death;

2. the day the Plan is ended.

This continuation will be integrated with the maximum 36-month continuation potentially available to your dependents under COBRA. Thus, following this 90-day continuation provided by the District, your dependents will potentially be eligible to extend coverage for another 33 months. Please refer to the section "Continuation of Coverage under COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)" beginning on page 13 for additional information on COBRA continuation.

Continuation of Coverage for Retirees

If you are retiring from the District you may continue your coverage until the last day of the month prior to your 65th birthday if the following qualifications are met:

a. your are a minimum age of 55 with at least 3 years of full-time employment immediately prior to the date of your retirement; and

b. you make the necessary contributions as required under the Plan.

Continuation of Coverage for Employees Participating in the Illinois Municipal Retirement Fund (IMRF)

If you are participating in the IMRF you can continue coverage for yourself and your covered dependents if:

1. you retire directly from active service with the District with an attained age and accumulated creditable service which qualify for immediate receipt of retirement pension benefits under Article 7 of the Illinois Pension Code; or,

2. you become disabled and are eligible and approved to receive disability benefits under Article 7 of the Illinois Pension Code immediately following completion of the 31-day period following the date of disability.

You must choose between this continuation option and continuation of coverage under COBRA (see the following section, *"Continuation of Coverage Under COBRA"*). You have 15 days after you are notified of your continuation rights to make your written IMRF election. If you elect to continue coverage, you will be eligible for coverage under the Plan on the same basis as any other active employee. However, you will have to pay the full cost of coverage. Your first premium must be paid within 30 days of the date of your written election and on a timely basis thereafter.

If you are an eligible IMRF retiree, you may continue coverage for yourself and your covered dependent(s) until 11:59 P.M. on the earliest of the following:

1. the day of your reinstatement or re-entry into active service as a participant in the IMRF;
2. the day you are convicted of an IMRF job-related felony which results in a loss of benefits pursuant to Section 7-219 of the Illinois Pension Code;
3. the day you die;
4. the last day of the period for which you have paid a premium by the applicable due date;
5. the day prior to the day you become covered under Medicare;
6. the day the Plan is ended.

If you are an IMRF disabled employee, coverage can continue for yourself and your covered dependent until 11:59 P.M. on the earliest of:

1. the day of your reinstatement or re-entry into active service as a participant in the IMRF;
2. the day you are convicted of an IMRF job-related felony which results in a loss of benefits pursuant to Section 7-219 of the Illinois Pension Code;
3. the day you die;
4. the day you exercise any refund option or accept any separation benefit available under Article 7 of the Illinois Pension Code;

5. the last day of the period for which you have paid a premium by the applicable due date;
6. the day prior to the day you become covered under Medicare;
7. the day the Plan is ended.

Continuation of Coverage Following the Death of an IMRF Pension Recipient

If you should die while continuing Family coverage, your surviving spouse and covered dependents may be eligible to continue coverage if:

1. the surviving spouse was married to you for at least 365 days prior to the date of your death and for at least 365 days prior to the date of your termination of active employment with the District; and,
2. for a surviving spouse of a retiree, he or she is eligible to receive a surviving spouse's pension from the Illinois Municipal Retirement Fund; or,
3. for a surviving spouse of a disabled employee, he or she was the designated beneficiary and elects to receive a monthly surviving spouse pension from the Illinois Municipal Retirement Fund in lieu of a lump sum death benefit; and,
4. the surviving spouse is not eligible for or, if eligible, does not elect continuation of coverage under COBRA.

If your surviving spouse and dependent children are eligible for coverage continuation, he or she will be eligible to continued coverage until 11:59 P.M. on the first of the following days to occur:

1. the day prior to the day the surviving spouse remarries if he or she remarries prior to his or her attainment of age 55;
2. the day the surviving spouse dies;
3. the last day of the period for which the surviving spouse has paid a premium by the applicable due date;
4. the day prior to the day the surviving spouse becomes covered under Medicare; or,
5. for a child, the day on which a child no longer meets the definition of an eligible dependent;
6. the day the Plan is ended.

Continuation of Coverage under COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Dixon Public School District #170 Group Health Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final

and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Dixon Public School District #170. COBRA continuation coverage for the Plan is administered by IPMG Employee Benefits Services, 225 Smith Rd., St. Charles, Illinois 60174, (800) 423-1841. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if,

on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

IPMG Employee Benefits Services
225 Smith Rd.
St. Charles, Illinois 60174

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect

continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a

Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Coordination With Other Plans

The Plan includes a Coordination of Benefits provision to avoid duplicating the benefits of another plan. A “plan” with which these Coordination of Benefits provisions apply include, but is not limited to, any group or blanket policy of insurance providing medical or dental benefits, a group hospital, Health Maintenance Organization, Preferred Provider Organization, or other group prepayment coverage, any coverage under any labor-management trusteed plan or union welfare plan, and any state or federal government program other than Medicaid, any coverage for students which is sponsored by, or provided through, a school or other educational institution, no-fault coverage by motor vehicle insurance statute or similar legislation, or a liability insurance policy by a third party who caused or contributed to the complaint injury.

When you or your dependent are covered under more than one plan (including an HMO), benefits may be subject to a reduction to the extent necessary to make the benefits payable under all plans equal to the total allowable expense incurred during the calendar year. An “allowable expense” means any necessary, reasonable, and customary item of expense which is covered under at least one plan covering the person for whom a claim is made. When Medicare is considered the primary payer of benefits and the provider of service accepts Medicare assignment, the “allowable expense” will be equal to the reasonable and customary amount approved by Medicare; this limitation will not apply if the provider does not accept Medicare assignment. When a plan provides its benefits in the form of services rather than in cash payments, the reasonable and customary cash value of the service performed is considered to be a benefit paid and the expenses will be denied under this plan. For example, if your spouse is covered under a Health Maintenance Organization (HMO), he or she will receive benefits in the form of services. No cash payment is provided to your spouse for reimbursement or cost incurred because an HMO generally reimburses the HMO service provider directly at 100%. If a person covered under an HMO elects to obtain treatment outside of the HMO service provider network and the HMO reimburses that type of treatment at 100% if the service would have been provided by an HMO service provider, the Plan will deny the charges incurred by the HMO and, therefore, no benefits will be paid by the Plan.

If you and/or your dependent are covered under more than one plan, the primary plan (the plan that pays benefits first) will be determined in the following manner:

1. a plan which does not have a coordination of benefits provision is the primary plan;
2. if a person is a covered employee under one plan, and a covered dependent under another plan, the plan that covers the person as an employee is the primary plan;
3. if a child is covered under more than one plan and the parents are not separated or divorced, the primary plan is:
    a. the plan of the parent whose birthday falls earlier in the year (for example, if one parent's birthday is March 25 and the other parent's birthday is July 6, the plan of the parent whose birthday is March 25 will be the primary plan); or,

b. if both parents have the same birthday, the plan which has covered the parent the longest will be the primary plan;

4. if a child is covered under more than one plan and the parents are separated or divorced, the primary plan is determined as follows:
   a. the plan of the natural parent having responsibility for the child's health care expenses by court decree pays first. If the court decree splits the responsibility equally between the divorced parents, the primary plan is the plan of the parent whose birthday, excluding year of birth, falls earlier in the calendar year. If both parents have the same birthday, then the plan which has covered the parent the longest will be the primary plan;
   b. in the absence of a court decree, -
      (1) the plan of the natural parent having legal custody pays; then,
      (2) the plan of the spouse (if any) of the natural parent with legal custody pays; then,
      (3) the plan of the natural parent without legal custody pays last;
5. if a person is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan;
6. if a person covered under a right of continuation pursuant to federal or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber is the primary plan before the plan providing continuation coverage;
7. if the order described above fails to establish the order of payment, then the plan under which the person has been covered for the longest period of time is the primary plan.

If this Plan is not the primary plan and the allowable expenses exceed the benefits paid by the other plans, this Plan will pay the balance of the allowable expenses incurred during the calendar year up to the total amount of benefits that would be paid by the Plan in the absence of this coordination of benefits provision. The amount paid by the Plan, as reduced, shall be considered full benefits paid and the District will be fully discharged from liability for such benefit under this Plan. The Plan will have the right to recover any benefit payment it makes in excess of this Plan’s portion of the allowable expense.

If you or a dependent have a claim for benefits and the Plan is not the primary plan, you should submit a copy of the Explanation of Benefits (EOB) you receive from the other plan to the claims administrator, IPMG Employee Benefits Services. An EOB is a statement from an insurer or claims processor that shows the action taken on a claim. If you need assistance in determining which plan is primary, you can contact IPMG between 8:00 A.M. and 5:00 P.M., Monday through Friday at (630) 789-2082 or 1-800-423-1841.

Note: The claims administrator on behalf of the District may, without the consent of or notice to any covered person, release or obtain from any insurance company, service company, benefit administrator or other person any information necessary to administer this Coordination of Benefits provision. In addition, any person

claiming benefits under this Plan will be required to furnish to the claims administrator any information that is necessary to administer this Coordination of Benefits provision.

Benefits for Persons Eligible for Medicare

The Plan will pay benefits primary to Medicare in the following circumstances ("Medicare" means the Health Insurance for Aged and Disabled Program established by Title XVIII of the Social Security Act of 1965, as then constituted or later amended):

1. if you are an active employee and you or your spouse are age 65 or older. However, if you make a written election to have Medicare as your primary Health coverage, you and your dependents will not be eligible for coverage under the Plan. If your spouse is age 65 or older when you are less than age 65 and your spouse elects Medicare as his or her primary Health coverage, he or she will not be eligible for coverage under the Plan;
2. if you are in a "current employment status" (as defined by Medicare) and you or your dependent are eligible for Medicare as the result of a disability condition, other than End Stage Renal Disease; or,
3. if you or your dependent are disabled due to End Stage Renal Disease, but only for the period of time defined by current legislation. After this time period, your benefits will be coordinated with Medicare.

For all other covered persons who become eligible for Medicare, the Plan will coordinate its benefits by the amount of Medicare benefits ***for which you (or your dependent) are entitled even if you have not enrolled***. Therefore, you should contact a Social Security office as soon as you or your dependent become eligible for Medicare.

Subrogation/Right of Reimbursement

If a covered person (including the person's heirs, guardians, executors or other representatives) receives any benefits arising out of an injury or illness (herein, referred to collectively as "Injury") for which the covered person has or may have any claim or right to recovery:

1. payments under this Plan shall be made on the condition that this Plan will be reimbursed out of the proceeds of such claim or right to recovery;

2. you may be requested to sign a Subrogation/Right of Reimbursement Agreement; and,

3. payment of benefits may be revoked, and the Plan may seek refunds of payments, where acknowledgement of the Plan's right under this Section is incomplete or impaired.

The covered person agrees:

1. to give the Plan notice of intent to pursue a claim against a responsible party, or any decision not to pursue such a claim, as provided in the paragraph below;

2. to refrain from doing anything to prejudice the Plan's rights to reimbursement or subrogation, or the pursuit of claims directly or indirectly to recover reimbursement of benefits paid;

3. to cooperate fully and exclusively with the Plan and its appointed agents regarding subrogation rights, including executing and delivering all instruments and papers (including the execution of a subrogation form) and do whatever else is necessary to fully protect any and all subrogation or reimbursement of rights;

4. that any such funds received will be held in constructive trust for the reimbursement of the Plan;

5. to direct any attorneys or fiscal intermediaries to hold recovery of all funds related to the Injury in trust for the benefit of the Plan, and to direct that such parties deal exclusively with the cost recovery agent for the Plan;

6. to assign to the Plan and its designees all rights against such agents and attorneys to enforce this direction; and

7. that the Plan will be reimbursed in full before any amounts (including, but not limited to, attorney fees or costs) incurred are deducted from such funds.

Recoveries subject to the Plan's reimbursement claims shall include funds or rights acquired by the covered person (1) from any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the covered person's own insurance coverage); (2) any person, entity, corporation, plan, association, liability coverage or other at fault party as a result of judgment, settlement, arbitration award, or any other arrangement; or (3) worker's compensation award, settlement or agreement.

Without limiting the preceding paragraph, this Plan will be subrogated to all claims, demands, actions and right of recovery against any person, corporation and/or other entity who has or may have caused, contributed to or aggravated the Injury which the covered person claims an entitlement to benefits under the Plan, and to any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance

policies or fund (this specifically includes, but is not limited to, the covered person's own insurance coverage).

The covered person agrees to notify the Plan of any decision to pursue other sources of recovery for Injury and to notify the Plan of this decision in writing within a reasonable time. If the covered person decides not to pursue any other claims, or fails to notify the Plan of a decision within a reasonable time, the covered person authorizes and assigns all choices in action and rights to the Plan to pursue, sue, compromise or settle any such claims in this name, to execute any and all documents necessary to pursue said claims, and agrees to cooperate with the Plan in the prosecution of any such claims. Regardless, any other provision, document or policy notwithstanding, the Plan alone, through the Plan Administrator and appointed agents, shall be the exclusive assignee of recovery rights (including subrogation rights) so that any other purported assignments are revoked and nullified. This provision imposes no obligation on the Plan to pursue the assigned rights, nor contribute any funds toward expenses of litigation or settlement.

The amount of the Plan's subrogation interest will be deducted first from any recovery by or on behalf of the covered person without regard to whether the covered person is made whole. This paragraph is intended as an express and complete repudiation of the "make whole" doctrine and should be interpreted consistent with this intention. If any party or insurance coverage or other source makes payment before this Plan pays, no benefits will be paid under this Plan to the extent of such payment."

Right of Recovery of Overpayment

In the event of any overpayment of benefits, the Plan will have the right to recover the amount of the overpayment. When an employee is paid a benefit greater than should have been paid under the Plan, the employee will be requested to refund the overpayment. If the refund is not received from the employee following a request of recovery, the amount of the overpayment will be deducted from the employee's future benefit payments. Similarly, if payment is made on the behalf of a covered employee or his or her dependent to a hospital, physician, dentist or other provider of health or dental care, and that payment is found to be an overpayment, the Plan will require a refund of the overpayment from that provider.

Reasonable and Customary Limit

The Plan will consider expenses up to the reasonable and customary limit. The "reasonable and customary limit" means: (a) for a preferred provider, the charge negotiated between that provider and the preferred provider network; or, (b) for a non-preferred provider, only the fee most commonly charged within the same geographical area for equivalent services, based on information provided from insurance companies, governmental payers (e.g., Medicare, Medicaid) and other plan administrators, taking into account the fees and prices generally charged for cases of comparable nature and severity at the time and place received. The Plan will not reimburse charges in excess of those considered reasonable and customary, nor will the excess be counted towards

satisfying the deductible or Co-insurance limit; you will be responsible for paying the excess. Because of this, whenever possible, you should discuss charges in advance with your doctor, the hospital and others who are to furnish treatment.

How to Apply for Benefits

What Information Is Needed

The use of the Health Care Plan Claim Form is optional. Doctors, hospitals and other service providers use forms that will provide the following information our claims administrator, IPMG needs for most claims:

- your name;
- the patient's name;
- the District's name;
- the name and address of the provider of care;
- the type of service rendered, with diagnosis and/or procedure codes;
- the date(s) of services; and,
- the amount of charges.

When submitting a bill directly to IPMG for reimbursement, please be sure the bill includes your name, the patient's name and the District's name. If IPMG needs additional information, they will contact either the provider of services or you for the information.

In addition to the claim detail, IPMG may also need additional information from you concerning your spouse's employer or, for your child(ren), confirmation of their student status or information concerning which parent has responsibility for the child's coverage if there has been a divorce. If this information is necessary in order to process the claim, IPMG will request the information directly from you in writing.

Where to File the Claim

All claims should be forwarded to:

IPMG Employee Benefits Services.
225 Smith Rd.
St. Charles, IL 60174

When to File the Claim

Claims must be submitted for reimbursement under the Plan within 12 months following the date on which the claim is incurred. For example, if you incur an expense on June 12, 2013, the claim must be submitted no later than June 12, 2014. If a claim is not submitted within this time period for reasons beyond your control, the claim may be eligible if you provide evidence of the circumstance which prevented earlier submission.

If the Plan is terminated, all claims must be submitted within 90 days of the termination date.

Review of a Denied Claim

If a claim is completely or partially denied, you will receive an explanation from the claims administrator. If you disagree with the decision on your claim, you may obtain a review by submitting a written request to:

Claim Appeal Administrator
IPMG Employee Benefits Services.
225 Smith Rd.
St. Charles, IL 60174

You will normally have a written decision on your appeal within 60 days.

Health Care Benefits

Schedule of Health Care Benefits

Benefits for the Eligible Expenses are provided based on the schedule outlined below. If you obtain services through a Preferred Provider, expenses incurred with the provider will be discounted based on the negotiated agreement with the Preferred Provider. A listing of hospitals, physicians and other service providers participating in the PPO network is available from the Business Office. Please refer to the section Preferred Provider Organization for additional information.

MAXIMUM BENEFIT, DEDUCTIBLE AND OUT-OF-POCKET LIMIT		
Calendar Year Maximum Benefit	$2,000,000 per person while covered under the Plan. $36,000 per person per calendar year for Autism Spectrum Disorders for dependent children under the age of 21. As of July 1st, 2014 the Calendar Year maximum will be eliminated.	
Deductible	***For Eligible Expenses Incurred Within the PPO Network***	***For Eligible Expenses Incurred Outside the PPO Network***
	The deductible is the first $500 per individual per calendar year. The maximum deductible per family is $1,500 per calendar year. Expenses applied toward the Deductible will be applied equally to the In-PPO Network and Out-of-PPO Network limit amounts.	
Expenses incurred and applied toward the deductible during the last 3 months of the calendar year (October, November and December) will be carried over and also applied toward the deductible for the following calendar year.		
Out-of-Pocket Limit	***For Eligible Expenses Incurred Within the PPO Network***	***For Eligible Expenses Incurred Outside the PPO Network***
	The "Out-of-Pocket Limit" is the maximum amount you will be required to pay as a result of your 10% co-insurance for eligible expenses incurred. The Out-of-Pocket Limit is $1,000 per person per calendar year.	The "Out-of-Pocket Limit" is the maximum amount you will be required to pay as a result of your 30% co-insurance for eligible expenses incurred. The Out-of-Pocket Limit is $2,000 per person per calendar year.
	Expenses applied toward the Out-of-Pocket limit will be applied equally to the In-PPO Network and Out-of-PPO Network limit amounts.	

	The Out-of-Pocket Limit does **not** include: • the calendar year deductible; • the $200 deductible applied towards hospital expenses incurred in conjunction with a confinement which is not pre-certified under the "Hospital Pre-Admission Certification Program"; or, • services incurred for alcohol drug dependency. However, prescription drugs expenses for these conditions will apply to the out of pocket.

BENEFITS FOR ELIGIBLE MEDICAL AND SURGICAL EXPENSES

	For Eligible Expenses Incurred Within the PPO Network	***For Eligible Expenses Incurred Outside the PPO Network***
Inpatient Hospital Services	After the calendar year deductible is satisfied, 90% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.	After the calendar year deductible is satisfied, 70% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.
Outpatient Hospital Services	After the calendar year deductible is satisfied, 90% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.	After the calendar year deductible is satisfied, 70% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.
Physician Services (Inpatient or Outpatient)	After the calendar year deductible is satisfied, 90% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.	After the calendar year deductible is satisfied, 70% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.

	For Eligible Expenses Incurred Within the PPO Network	***For Eligible Expenses Incurred Outside the PPO Network***
Preventive Care		
Women's Preventive Act services	100%, no deductible	Not covered
The following women's preventive services, are covered expenses: Breastfeeding support, supplies, and counseling; Screening and counseling for interpersonal and domestic violence; Screening for gestational diabetes; DNA testing for high-risk strains of HPV; Counseling regarding sexually transmitted infections, including HIV; Screening for HIV; Contraceptive methods and counseling; and Well woman visits.		
Preventive Adult Care	100%, no deductible	Not Covered
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, standard preventive x-rays and laboratory tests, immunizations/flu shots and services required by applicable law. A current listing of required preventive care can be accessed at: www.HealthCare.gov		
Preventive Child Care	100%, no deductible	80% after deductible
Includes: office visits, routine physical examination, laboratory tests, x-rays, hearing tests, vision tests, immunizations and other preventive care and services required by applicable law through age 18. A current listing of required preventive care can be accessed at: www.HealthCare.gov		
Shingle Vaccination for covered members 50 years old or older.	100%, no deductible	Not Covered
Prescription Drugs	After the calendar year deductible is satisfied, 70% of eligible expenses incurred up to the Out of Network Out-of-Pocket Limit, then 100% for the balance of the same calendar year. Prescriptions eligible under the Affordable Care Act are payable at 100%, no deductible except for Brand Name Contraceptives will be payable as stated above.	
All Other Eligible Expenses	After the calendar year deductible is satisfied, 90% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.	After the calendar year deductible is satisfied, 70% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.

BENEFITS FOR ELIGIBLE EXPENSES INCURRED FOR TREATMENT OF MENTAL DISORDERS AND/OR SUBSTANCE ABUSE		
	For Eligible Expenses Incurred Within the PPO Network	***For Eligible Expenses Incurred Outside the PPO Network***
Inpatient Hospital Treatment, Substance Abuse Treatment Facility or Partial Hospitalization Treatment Programs	After the calendar year deductible is satisfied, 90% of eligible expenses. The Out-of-Pocket limit does not apply.	After the calendar year deductible is satisfied, 70% of eligible expenses. The Out-of-Pocket limit does not apply.
	Eligible expenses are limited to a maximum of 20 days per person per calendar year.	
Outpatient Treatment	After the calendar year deductible, 50% of eligible expenses incurred up to a maximum of 30 visits per calendar year.	
Prescription Drugs	After the calendar year deductible is satisfied, 70% of eligible expenses. The Out-of-Pocket limit applies.	
Note: If you or your dependent do not comply with the Hospital Pre-admission notification procedures described beginning on page 55, a separate $200 deductible per hospital confinement will be applied before any benefits under the Plan are paid.		

Eligible Health Care Expenses

A charge for any of the services or supplies listed below will be considered eligible if: 1) it is medically necessary for the care of a patient's illness or injury; 2) it does not exceed the maximum benefit, if any, listed under the previous section; and, 3) it is not otherwise excluded under the Plan. To be considered medically necessary, the service or supply must be ordered by a physician acting within the scope of his or her license or certification and must be commonly and customarily recognized by the American Medical Association as appropriate in the treatment of the patient's diagnosed illness or injury and, when applicable, be approved by the Food and Drug Administration. The service or supply must not be educational in nature nor provided primarily for the purpose of medical or any other research. The term 'Eligible Expense' will also include surcharges imposed by the State of New York for health care expenses incurred on behalf of its residents or for expenses incurred at New York facilities. Such surcharges will be reimbursed by the Plan at one hundred percent.

In addition to the definition of the term "eligible expense", the following terms have the defined meaning as used in this Plan:

- an "Illness" means any physical or mental illness, disease or pregnancy;

- an "Injury" means a non-occupational bodily injury that is caused by an event that is sudden and not foreseen, and is exact as to time and place; and,

- a 'Physician' means a person licensed by his or her state of practice to practice medicine and render health or dental care services for treatments covered under the Plan and who is a Doctor of Medicine, a Doctor of Dentistry, a Doctor of Osteopathy, a Doctor of Podiatry, a Doctor of Psychiatry, a Doctor of Psychology, a Doctor of Ophthalmology, a Doctor of Optometry, a Doctor of Chiropractic and a Doctor of Naprapathy.

Expenses eligible under the Plan are:

1. Abortions -

   services or supplies in connection with an abortion when the life of the mother will be endangered if the fetus is carried to term;

2. Allergy Shots and Allergy Surveys;

3. Ambulance Transportation -

professional ambulance service to take a patient to or from the nearest hospital where necessary care can be given for the treatment of an illness or injury. When specialized care is medically necessary, transportation to the nearest facility equipped to provide such specialized treatment will also be eligible. When an individual is being transferred from a Hospital or Extended Care Facility to receive Home Health Care or Hospice Care at home, transportation by ambulance from the facility to the individual's home will also be eligible if medically necessary;

4. Ambulatory Surgical Facility -

services and supplies furnished by an Ambulatory Surgical Facility in connection with and in support of a surgical procedure within 72 hours prior to and following surgery. An 'Ambulatory Surgical Facility' is a facility accredited as such by the Joint Commission of the Accreditation of Health Care Organizations, or a facility which is state licensed and operated pursuant to law for the performance of surgery on an outpatient basis at the patient's expense;

5. Anesthetics -

anesthetics and their professional administration if administered by a physician, other than the operating surgeon, or by a Certified Registered Nurse Anesthetist;

6. Autism Spectrum Disorders –

Diagnosis and treatment of autism spectrum disorders that are prescribed by a physician for dependent children under the age 21 up to the maximum specified in the "Schedule of Health Care Benefits" for the following services:

a. psychiatric care
b. psychological care
c. habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
d. therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas:
    - self-care and feeding
    - pragmatic, receptive, and expressive language
    - cognitive functioning
    - applied behavioral analysis, intervention, and modification
    - motor planning
    - sensory processing

Autism Spectrum Disorders Treatment will not be subject to the Mental or Nervous Disorders maximums.

A treatment must be considered medically necessary if it is reasonably expected to:

- prevent the onset of an illness, condition, injury, disease or disability;
- reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or
- help an individual achieve or maintain maximum functional activity in performing daily activities.

7. Birthing Centers –

services and supplies provided by a licensed Birthing Center. A "Birthing Center" is a licensed place with the primary purpose of providing a place for live births, including prenatal and postpartum care, and which has a written agreement in force with at least one hospital for immediate transfer of patients who require treatment in a hospital;

8. Blood -

blood, blood plasma, and its administration, including autologous blood donations or the services of a blood donor;

9. Cardiac Rehabilitation Services –

outpatient cardiac rehabilitation services prescribed by a physician and under the supervision of a qualified medical individual to the extent that the services are medically necessary and considered an eligible expense by Medicare;

10. Chemotherapy;

11. Chiropractic Care;

12. Cosmetic Surgery –

cosmetic surgery to correct -

a. a congenital deformity; or,
b. conditions resulting from accidental injuries, scars that are the result of a covered surgical procedure, tumors or disease;

13. Dental Accident Care -

treatment provided for –

a. an accidental injury to natural teeth; or,

b. hospital expenses incurred in conjunction with a dental procedure when such procedure must be performed in a hospital due to the patient's medical or mental condition or age;

14. Diagnostic X-ray and Laboratory Services –

x-ray and laboratory services performed for the diagnosis of an illness or an injury;

15. Durable Medical Equipment –

rental of durable medical equipment. Benefits will also be provided for the purchase of durable medical equipment if it can be shown that long-term use is planned and purchase is likely to cost less than monthly rental, or that the equipment cannot be rented. If the equipment is purchased, the Plan will provide benefits for its repair or its replacement if required due to a change in the individual's physical condition. 'Durable Medical Equipment' means equipment that is (a) prescribed by a physician in conjunction with an illness or injury for use in your home; (b) can withstand repeated use; and, (c) is eligible under Medicare;

16. Extended Care Facility --

room and board charges and all other necessary services and supplies provided by a Extended Care Facility. An "Extended Care Facility" is an institution which is certified as a skilled nursing facility by Medicare, or an institution or distinct part of an institution, which has a transfer agreement with one or more hospitals and which is primarily engaged in providing comprehensive post-acute hospital and rehabilitative inpatient care and is duly licensed by the appropriate governmental authority to provide such services. An Extended Care Facility does not include an institution which provides only minimal care, educational care, custodial care services, care for the aged or an institution which primarily provides care and treatment for mental illness, drug addiction, or alcoholism;

17. Glasses or Contact Lenses –

the initial pair of glasses or contact lenses following cataract surgery or following an injury to the lens of the eye if an accident occurs;

18. Home Health Care -

charges by a Home Health Care Agency for services and necessary supplies provided in accordance with a Home Health Care Plan. Participation in a Home Health Care Plan must be recommended and supervised by the patient's primary attending physician and must replace a needed hospital stay or a stay in an Extended Care Facility.

A “Home Health Care Agency” is an agency licensed in the jurisdiction in which the home health services are delivered, a home health agency as defined by Medicare, or an agency or organization which provides a program of home health care and which is certified by the patient's physician as an appropriate provider of home health services and which has a full-time administrator, maintains written records of services provided to the patient, and has a staff that includes at least one physician and one registered nurse and provides full-time supervision by a physician or registered nurse. A “Home Health Care Plan” is a plan that provides for the care and treatment of an illness or injury and which is prescribed, in writing, by a physician as an alternative to confinement in a hospital or Extended Care Facility;

19. Hospice Care -

charges for care rendered by a Hospice for inpatient and outpatient care of a terminally ill person. A “terminally ill person” is one who has been medically determined to have a life expectancy of less than 6 months.

A “Hospice” is a facility that provides outpatient care or short-period stays for a terminally ill person in a home-like setting for either direct care or respite. This facility may be either free-standing or affiliated with a hospital, but must operate as an integral part of a hospice care program and have any required state registration or license;

20. Hospital Expenses -

charges by a hospital for semi-private room and board, intensive care or cardiac care unit and all other necessary services and supplies incurred as an inpatient or outpatient. Private room charges will be eligible only if isolation is medically necessary or if the hospital offers only private room accommodations; otherwise, eligible expenses will be limited to the hospital’s lowest daily rate.

A “hospital” means an institution accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations, or any institution which is state licensed and operated pursuant to law for the care and treatment of sick or injured persons on an inpatient basis, at the patient’s expense, with organized facilities for diagnosis within the confines of the institution, provides twenty-four hour nursing service by or under the direct supervision of a registered nurse, and has a staff of one or more licensed physicians available at all times. The term “hospital” does not include a hospital or institution which is licensed or used principally as a nursing, rest or convalescent home, a skilled nursing facility, a facility which is run for the care of the aged or which is operated primarily as a school;

21. Infertility -

charges for office visits, x-rays and laboratory necessary for the diagnosis of the condition; however, treatment of infertility is not covered under the Plan;

22. Maternity Expenses -

expenses incurred by you or your covered spouse, including services rendered by a Certified Registered Nurse Midwife or a Birthing Center for prenatal care, delivery and postpartum care rendered within 24 hours following delivery. Expenses related to a dependent daughter's pregnancy are not covered under the Plan.

The Plan will comply with the requirements of the Newborns' and Mothers' Health Protection Act of 1996, which stipulates that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a Caesarian section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours);

23. Mastectomy Expenses –

expenses incurred for the following services and supplies in conjunction with a mastectomy performed following an illness –

a. reconstruction of the breast on which the mastectomy has been performed;
b. surgery and reconstruction of the other breast to produce symmetrical appearance; and,
c. external prostheses.

Eligible expenses include physical complications of all stages of a mastectomy, including lymphedemas;

24. Medical and Surgical Dressing, Supplies, Casts, Splints, Trusses, Crutches and Leg,

Back, Arm and Neck Braces required in conjunction with an illness or injury;

25. Mental Disorders -

services rendered by a hospital, freestanding treatment facility, Partial Hospitalization Treatment Program or by a Psychiatrist, Psychologist, Licensed Clinical Social Worker or other counselor authorized by his or her state of practice

to provide counseling. As used in this provision, the following terms have the defined meaning:

- A "Mental Disorder" means any diagnosis listed in the *Mental Disorders* section of the current edition of the International Classification of Diseases, other than diagnoses listed under Alcohol and Drug Psychoses, Alcohol and Drug Dependence Syndrome and Nondependent Abuse of Drugs;
- A "Partial Hospitalization Treatment Program" means a program provided through a hospital, mental/nervous treatment facility or alcohol/substance abuse treatment facility which provides psychological therapy on an outpatient basis as an alternative to inpatient confinement or to provide transitional support following inpatient treatment and which meets the following requirements:

    a. provides care by one or more program therapists who are credentialed by the state in the field;
    b. is under the full supervision of a physician; and,
    c. maintains complete medical records on each patient;

26. Nursery Care -

    hospital charges for routine nursery care and all other necessary services and supplies provided for a healthy newborn dependent child while confined immediately following birth. Eligible expenses will also include the initial routine examination rendered by a physician for examination of the newborn and the performance of a circumcision during this confinement;

    Note: Expenses incurred for the above charges or for treatment of an illness of a newborn (for example, premature birth, congenital abnormality) will be eligible on the same basis as any other illness provided you enroll the child for coverage within the 31-day period immediately following the child's birth (see the section "When Coverage Begins" for more information on the enrollment procedure);

27. Nursing Services -

    services of a Registered Nurse, or a Licensed Practical Nurse while hospital confined. Eligible expenses will include services rendered by a Registered Nurse certified in the following specialty practices: Certified Registered Nurse Anesthetist, Certified Registered Nurse Midwife, Nurse Practitioner and massage therapy;

28. Occupational Therapy;

29. Optometric Services -

services rendered by an Optometrist provided that such services would have been eligible had such service been rendered by a physician;

30. Oral Surgery –

expenses incurred for the following surgical procedures including x-rays and anesthesia:

a. surgical removal of complete bony impacted teeth;
b. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
c. surgical procedures required to correct accidental injuries of jaws, cheeks, lips, tongue, roof and floor of the mouth;
d. excision of exostosis of the jaws and hard palate, provided the procedure is not performed in preparation for dentures or other prosthesis, treatment of fractures of facial bone, external incision and drainage of cellulitis, incision of accessory sinuses, salivary glands or ducts, reduction of dislocations, or excision of the temporomandibular joint;

31. Organ Transplants -

charges incurred in conjunction with the direct transplant of the following natural organ(s) from a living person to the covered person or tissue transplant from a human to a human, including transportation of the donor organ to the location of the transplant surgery:

a. bone marrow transplant, including stem cell transplantation and reinfusion and cord blood transplant;
b. heart, heart/lung, or heart valve transplant;
c. kidney transplant;
d. kidney/pancreas transplant;
e. liver transplant; and,
f. lung (single or double) transplant;
g. pancreas transplant.

An eligible transplant procedure will also include transplants that (1) are approved for Medicare coverage on the date the transplant is performed; and, (2) are not otherwise excluded under the Plan, e.g., the procedure is not experimental or investigational treatment.

The above transplant procedures must be performed at a Transplant Facility in order to be considered an eligible expense. A ‘Transplant Facility’ is a hospital or facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a transplant and:

- for organ transplants, it is an approved member of the United Network for Organ Sharing for such transplant or is approved by Medicare as a transplant facility for such procedure;

- for unrelated allogeneic bone marrow or stem cell transplants, it is a participant in the National Marrow Donor Program;

- for autologous stem cell transplants, it is approved to perform such transplant by (a) the state where the transplant is to be performed; or (b) Medicare; or, (c) the Foundation for the Accreditation of Hemopoietic Cell Therapy. Outpatient facilities must be similarly approved.

Skin, muscular-skeletal, cornea and parathyroid organ transplants are also eligible but are not subject to the above limitations.

Eligible expenses do not include cardiac rehabilitation services when not provided to the transplant recipient within 3 days following discharge from a hospital for the transplant surgery, transportation by air ambulance for the donor or the recipient, travel time and related expenses of a physician, and drugs which are experimental or investigational.

Expenses incurred by a covered individual who is a transplant donor will be eligible. However, if the donor is covered by this Plan but the recipient of the transplant is not, the recipient's plan will be primary for the donor's expenses and this Plan will be secondary. The recipient is not eligible for benefits under this Plan. If the recipient of the transplant is covered by this Plan but the donor is not, the donor's expenses will be eligible. However, payments made on behalf of the donor will be charged towards the recipient's maximum benefit. If both the donor and recipient are covered under the Plan, expenses incurred by the donor will be considered as part of the recipient's claim.

In addition to the standard benefits payable under this Plan, when a covered person participates in the “Special Transplant Program” offered through the District’s Excess Loss Insurance carrier, the covered person will have access to Centers of Excellence Transplant Facilities and be eligible for reimbursement of travel and lodging expenses. Expenses incurred at a Center of Excellence Transplant Facility will be considered at the In-PPO Network benefit level defined under the “Schedule of Health Care Benefits”..

32. Orthopedic Shoes -

charges for orthopedic shoes with a physician’s prescription to a maximum of 2 per year;

33. Oxygen and its Administration;

34. Physical Therapy -

    services of a licensed physical therapist for physical therapy;

35. Physician Services –

    a. services rendered by a physician for medical care provided on an inpatient or outpatient basis, including home care. Eligible expenses will also include services rendered by a qualified Physician Assistant;
    b. services rendered by a Surgeon and, when medically necessary, an Assistant Surgeon or Certified Surgical Assistant who is certified by the state in which he or she practices, for surgical procedures covered under the Plan. When the services of a Certified Surgical Assistant are rendered, the combined cost of the surgeon and Assistant's charge will be eligible up to the total usual and customary charge of the surgeon alone. A "surgical procedure" means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, the injection of sclerosing solutions, medically necessary abortions, and elective sterilizations, and circumcision;
    c. shock therapy treatments;
    d. radiation therapy treatments;
    e. chemotherapy;
    f. diagnostic services;

36. Prescription Drugs and Medicines -

    drugs and medicines which are prescribed by a physician, approved by the Food and Drug Administration (FDA) for use in the treatment of the individual's illness or injury and dispensed by a licensed pharmacist. Drugs and medicines which do not legally require a physician's written prescription are not eligible with the exception of insulin or antigens. A drug that has been approved by the FDA but is used for a purpose other than that for which the FDA has approved it may also be eligible if all of the following criteria are met:

    a. the drug is not otherwise excluded, for example, it is not for Experimental or Investigational Treatment; and,
    b. the use of the drug is appropriate and generally accepted for the condition being treated; and,
    c. if the drug is used for the treatment of cancer, the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, or The Compendia-Based Drug Bulletin, recognize it as an appropriate treatment for that form of cancer;

37. Preventive Care –

Covered Charges under Medical Benefits are payable for Preventive Care as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law. A current listing of required preventive care can be accessed at www.healthcare.gov

Includes:

- *Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;*
- *Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;*
- *Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and*
- *Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.*
- *EKG, CBC, Urinalysis, PSA and other standard preventive x-rays and lab tests.*
- *Mammograms*
    - a baseline mammogram for females age 35-39 years of age;
    - a mammogram every 1-2 years for females ages 40-49 and over;

38. Prosthetic Appliances -

prosthetic devices, special appliances and surgical implants required to replace all or part of an organ or tissue, or to replace all or part of the function of a non-functioning or malfunctioning organ or tissue. Eligible expenses will also include adjustments, repair and replacement of covered prosthetic devices, special appliances and surgical implants when required due to wear or a change in the patient's condition;

39. Radiation Therapy –

radiation therapy by x-ray, radium, radon and radioactive isotopes;

40. Renal Dialysis;

41. Respiratory Therapy –

respiratory therapy rendered by a qualified respiratory therapist;

42. Second Surgical Opinion Consultations -

consultation with a Board Certified Specialist to confirm the medical necessity of a non-emergency surgical procedure. Eligible expenses include any diagnostic testing

which may be required in conjunction with the consultation. The Specialist providing the surgical consultation may not be affiliated with the Board Certified physician who initially recommended the surgery. A "Board Certified Specialist" means a physician who holds the rank of Diplomat of an American Board (MD) or Certified Specialist (DO);

43. Self-Management of Diabetes –

    services, supplies and equipment prescribed by a physician for self-management of diabetes;

44. Shock Therapy;

45. Speech Therapy -

    services of a licensed speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to an illness or injury, or a congenital anomaly for which corrective surgery was performed prior to therapy;

46. Sterilization –

    elective sterilization procedures, but not their reversal;

47. Substance Abuse -

    services rendered by a hospital, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program, or by a Psychiatrist, Psychologist, Licensed Clinical Social Worker or other counselor authorized by his or her state of practice to provide counseling services, up to the maximum benefit specified under the "Schedule of Health Care Benefits". Eligible expenses include, but are not limited to, counseling, detoxification services and other ancillary services. As used in this provision, the terms noted have the following meaning:

    - "Substance Abuse" means any diagnosis listed under Alcohol and Drug Psychoses, Alcohol and Drug Dependence Syndrome and Nondependent Abuse of Drugs of the current edition of the International Classification of Diseases, except that tobacco and caffeine abuse are not included under this definition;
    - "Substance Abuse Treatment Facility" is a facility, other than a hospital, whose primary function is the treatment of alcoholism, chemical dependency or drug abuse and which is duly licensed by the appropriate state and local authority to provide such services;
    - "Partial Hospitalization Treatment Program" means a program provided through a hospital, mental/nervous treatment facility or alcohol/substance abuse treatment facility which provides psychological therapy on an outpatient basis as an alternative to inpatient confinement or to provide transitional support following inpatient treatment and which meets the following requirements:

a. it provides care by one or more program therapists who are credentialed by the state in the field;
b. it is under the full supervision of a physician; and,
c. it maintains complete medical records on each patient;

48. Temporomandibular Joint Dysfunction –

charges for treatment of temporomandibular joint dysfunction for surgery, office visits, consultations, registration, x-rays, injections, equilibrations, splints and appliances;

49. Weight Reduction -

charges for or related to ileo-jejunal or gastric shunt operations performed for the treatment of obesity or weight reduction.

Health Care Exclusions

Except as specifically included in the previous section, charges for the following are not eligible:

1. Abortions -

services or supplies in connection with an elective abortion unless the life of the mother will be endangered if the fetus is carried to term. This exclusion does not apply to expenses incurred for treatment of complications arising from an elective abortion;

2. Act of War –

expenses incurred for any illness or injury due to, or aggravated by, war or an act of war, whether declared or undeclared.

3. Acupuncture Services;

4. Behavioral, Social Maladjustment Confinements –

services or supplies received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of a mental illness;

5. Claim Submission Deadline -

   charges for services or supplies for which you do not file a claim by the last day of the 12-month period following the date on which the service was rendered or the supply received or within 90 days if the Plan is terminated;

6. Cloning;

7. Completion of Claim Forms/Missed Visits -

   charges for failure to keep a scheduled visit or charges for completion of a claim form;

8. Cosmetic Services -

   charges for cosmetic surgery and related services and supplies;

9. Coverage Not in Effect –

   any care or supplies received prior to the individual's effective date under the Plan or after coverage terminates;

10. Custodial Care -

    custodial care services. "Custodial care" means non-medical care, wherever furnished or by whatever name called, which is designed primarily to assist the individual in meeting his activities of daily living;

11. Dental Care –

    charges for dental services or supplies for the treatment of teeth, gums or alveolar processes;

12. Experimental or Investigational Treatment –

    expenses for any experimental or investigational treatment, or for any hospital confinement or treatment that results from experimental or investigational treatment. An expense will be considered 'experimental or investigational treatment' if:

    a. the treatment has not been approved by the US Food and Drug Administration at the time the treatment is provided;
    b. the treatment is the subject of on-going Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared with the standard means of treatment or diagnosis;

c. the treatment is governed by a written protocol that references determinations of safety, toxicity and/or efficacy in comparison to conventional alternatives and/or has been approved or is subject to the approval by an Institutional Review Board (IRB) or the appropriate committee of the provider institution;
d. the treatment is being provided subject to the patient's execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternative; or,
e. a three member board of certified specialists practicing in the same or a related specialty as the specialist and facility providing the treatment or course of treatment selected by the claims administrator for the plan, determines that the treatment, procedure, service, device or drug is experimental or investigational.

13. Eyeglasses, Contact Lenses and Examinations -

eyeglasses or contact lenses and the examination for prescribing or fitting of eyeglasses or contact lenses or for determining the refractive state of the eye and surgery to correct the refractive state of the eye;

14. Family Members -

services rendered by a provider who is a member of your family;

15. Foot Care –

treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care. Any treatment of corns, calluses or the trimming, cutting or partial removal of toenails;

16. Free of Charge –

services or supplies for which you or your dependent do not have to pay, or services or supplies for which you would have no legal obligation to pay if you did not have this or similar coverage;

17. Gene Therapies;

18. Government Care -

services or supplies furnished by a hospital owned or operated by the United States Government or agency thereof, or furnished by a physician employed by the United States Government or agency thereof, except that services provided and billed by a Veteran's Administration facility for non-service related disabilities or by a Military Hospital will be eligible;

19. Hearing Aids or Examinations -

    hearing aids or examinations for the prescription or fitting of hearing aids;

20. Health Maintenance Organizations -

    medical care which is provided while a person is covered under a Health Maintenance Organization or similar organization;

21. Infertility –

    services and supplies rendered or provided for the treatment of infertility including, but not limited to, hospital services, medical care, therapeutic injections, fertility and other drugs, surgery, artificial insemination, all forms of in-vitro fertilization and embryo transfer procedures except as listed under covered expenses;

22. Marital or Family Counseling –

    marital or family counseling, except that interviews with the patient's family to obtain information necessary in the patient's treatment will be eligible;

23. Milieu Therapy -

    any confinement in an institution to primarily change or control ones environment;

24. Not Medically Necessary –

    services or supplies not medically necessary for the treatment of an illness or injury;

25. Not Recognized by the American Medical Association -

    charges for procedures which have not been recognized by the American Medical Association as accepted standards of medical practice, or which are not considered legal in the United States;

26. Not Otherwise Eligible -

    any service or supply not specifically listed under the section "Eligible Expenses" or in excess of the Plan's limits.

27. Organ or Tissue Transplants, except as specifically included;

28. Outside the United States –

    expenses for any treatment administered outside the United States if the Covered Person traveled to the location where the treatment was received for the purpose of obtaining the treatment;

29. Personal, Comfort or Convenience Items -

    personal hygiene, comfort or convenience items commonly used for other than medical purposes including, but not limited to, air conditioners, humidifiers, physical fitness equipment, televisions and telephones, hypo allergenic pillows or mattresses, air purifiers, exercise equipment, saunas, steam baths, swimming pools;

30. Pregnancy -

    charges related to a dependent daughter's pregnancy;

31. Premarital Examinations, or pre-employment examinations;

32. Prescription Drugs -

    prescription drugs or medicines which are not approved by the Food and Drug Administration or are not prescribed by a physician for treatment of an illness or injury. Eligible expenses do not include, dietary drugs and vitamins;

33. Prosthetic Devices for Cosmetic Purposes –

    procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes (other than following a mastectomy), the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury;

34. Reasonable and Customary -

    charges in excess of the reasonable and customary amount;

35. Sexual Dysfunctions -

    services related to sex transformations or sexual dysfunctions or inadequacies which includes implants;

36. Speech Therapy –

    speech therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation;

37. Sterilizations -

    expenses incurred for the reversal of elective sterilizations procedures;

38. Surveys, Casefinding, Research Studies or Similar Procedures and Studies;

39. Travel -

    charges by a physician for time spent traveling or by telephone communications or charges for travel for health examinations;

40. Vitamins;

41. Weekend Admissions -

    charges incurred for a Friday or Saturday admission unless the Utilization Review firm receives satisfactory evidence that the confinement is necessary for the treatment of a specific illness or injury or surgery is to be done the next day;

42. Weight Reduction -

    treatment for obesity or weight reduction unless specifically listed as an eligible expense;

43. Work Related –

    a. expenses relating to an injury or illness arising out of, or occurring during the course of, a Covered Person performing any occupation for wage or profit;
    b. services or supplies for an injury or illness arising out of or in the course of employment for which benefits are available under any Worker's Compensation or similar law;

44. Xenographs

Limitations of Benefits for Pre-Existing Conditions

A ‘pre-existing condition’ is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 90-day period immediately prior to your enrollment date. A pre-existing condition includes any condition identified as a result of information that is obtained relating to an individual’s health status before the individual’s enrollment date, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period, but does not include pregnancy. For a new employee (and his/her dependents), the enrollment date means the first day of employment. For a Special Enrollee, the enrollment date means the day you or your dependent become covered as the result of your marriage, or the acquisition of a new dependent child, or the day after the date your other group health plan or health insurance coverage ends. For a Late Enrollee, the enrollment date means the first day of coverage.

No benefits will be provided for expenses related to the treatment of a pre-existing condition until the covered person completes one of the following:

1. the last day of the 12-month period immediately following the enrollment date; or,

2. for a Late Enrollee, the last day of the 18-month period immediately following the enrollment date.

If you or your dependent had health insurance coverage prior to becoming covered under the Plan, the pre-existing condition limitation waiting period may be reduced by the amount of time you or your dependent were covered under another health insurance plan (this is referred to as “creditable coverage”). Creditable coverage will not be applied, however, if you and/or your dependent had a break in coverage of 63 days or more. The determination of the amount of creditable coverage, if any, will be based on the Health Insurance Portability Act of 1996 (HIPAA) as then constituted or later amended. In order to determine if you or your dependents qualify for creditable coverage, please contact the claims administrator, IPMG Employee Benefits Services.

This benefit restriction only applies to conditions existing on the enrollment date and will not apply to new conditions. The restriction will also not apply to pregnancy, or to conditions based solely on genetic information, or to a newborn child or a child adopted or placed with you for adoption before obtaining age 18, who had creditable coverage within 30 days of the date the child was acquired.

The Pre-Existing Condition does not apply to Pregnancy or to a Covered Person under the age of 19.

Hospital Pre-admission Certification/Continued Stay Review Program

The Plan includes a Hospital Pre-Admission Certification/Continued Stay Review program. The program is designed to reduce health costs and help you and your family avoid unnecessary hospital confinements and to assure appropriate, quality medical care. The District has contracted with Hines & Associates, an independent firm which includes medical professionals, to administer the program. It is the intention of this program to assure appropriate care, not to dictate or direct medical care***. If you (or your dependent) do not contact Hines & Associates, a separate $200 deductible per hospital confinement will be applied before any benefits are paid under the Plan.*** This deductible is in addition to the calendar year deductible and does not apply to the Out-of-Pocket limit.

The Notification Procedure

Prior to any scheduled hospital admission, you, your attending physician, or a member of your family needs to contact Hines & Associates. If you or your covered dependent are admitted to the hospital on an emergency basis or for maternity, Hines & Associates must be contacted within 48 hours following admission. The information you will need to provide is as follows:

1. the employee's name, address and Social Security number;
2. the patient's name, address, telephone number, date of birth and sex;
3. the name, address and telephone number of the attending physician and the hospital;
4. the reason for the hospital confinement and expected (or, if an emergency, the actual) date of admission; and,
5. Dixon Public School District #170 Health Care Plan.

Hines & Associates can be contacted by phoning 1-800-944-9401.

How the Program Works

After the Medical Review Specialist has obtained the above information, he or she will contact the attending physician to obtain additional information concerning the confinement and the planned course of treatment. Once the Medical Review Specialist has all of the necessary information, he or she will evaluate the request for hospital admission against established medical criteria to determine the medical need for an inpatient stay, and whether the proposed treatment plan is customary for the diagnosis. The purpose of this evaluation is to assure that you or your dependent are only in the hospital when you need to be, and are receiving appropriate quality care.

Following this evaluation the Medical Review Specialist will “pre-certify” a designated length of stay for the confinement and establish a date when discharge is expected. Prior to the end of the approved length of stay, the Medical Review Specialist will contact the attending physician to determine if discharge is taking place when planned. If not, an

extension of the length of stay will be approved if medically appropriate. This process continues until discharge takes place.

The Impact on Benefits

Your only requirement is to contact Hines & Associates prior to any scheduled hospital admission (or within 48 hours following an emergency or maternity admission). ***If you or your dependent do not contact Hines & Associates as stated above, a $200 deductible will be applied to the hospital confinement before any benefits are paid under the Plan.***

The Preferred Provider Organization Network

When you or a covered dependent obtain services from a Preferred Provider Organization network (PPO) provider for services and supplies covered under the Plan, the charges will be discounted and you will receive the maximum benefit payable under the Plan. There may be changes in the providers participating in the network from time to time. Therefore, you are urged to check with your hospital, physician or other service provider before undergoing treatment to make certain of its participation status.

The Plan has contracted with the following Preferred Provider Networks:

1. HFN/Employer's Coalition on Health (ECOH),
2. HFN/Employer's Coalition on Health-River Valley and
3. Private Healthcare Systems (PHCS).

HFN merged with Employer's Coalition on Health in July 2012.

You will be required to choose which PPO Network you and your covered dependents will access when you enroll. Changes to your network selection can be made during the annual open enrollment and will then be effective for the next 12 months.

HFN/Employer's Coalition on Health (ECOH) and HFN/Employer's Coalition on Health-River Valley:

If you have selected HFN/ECOH or HFN/ECOH-River Valley - to find a hospital, physician or other service provider participating in these PPO networks, please contact them directly at: 1-800-990-3204 or through their website at www.ecoh.com. Be sure to indicate if you are in the HFN/ECOH or HFN/ECOH/River Valley Network.

When traveling or attending school out-of-the state of Illinois, call 1-800-678-7427 and ask for a referral to a participating **PHCS Healthy Directions** provider. Network benefits are payable for a PHCS Healthy Directions provider only when you are outside of the state of Illinois

Private Health Care Systems (PHCS)

If you have selected Private Health Care Systems (PHCS) as your network – to find a hospital, physician or other service provider participating in PHCS PPO networks, please contact them directly at: 1-800-240-1940 or through their website at www.multiplan.com.

Where to file a claim:

If you are in the HFN/ECOH PPO Network and HFN/ECOH River Valley PPO Network:

HFN, Inc.
P O Box 3428
Oak Brook, IL 60522-3428
1-800-990-3204
www.ecoh.com

If you are in the Private Health care Systems (PHCS) PPO

IPMG Employee Benefits Services
225 Smith Road
St. Charles, IL 60174
1-800-423-1841
www.ipmg.com

Large Case Management

If you or a dependent suffer a catastrophic illness or injury, a "Large Case Management Specialist" may consult with the patient's attending physician. If you agree to accept the assistance that can be provided by the Large Case Management Specialist, he or she will develop a written plan of treatment outlining all medical services and supplies to be utilized, as well as the most appropriate setting. The treatment plan will be discussed with the patient's attending physician and modified as the patient's condition changes. Examples of illnesses or injuries defined as "catastrophic" are:

- AIDS;
- Amputations;
- Amyotrophic Lateral Sclerosis (ALS);
- Cerebral Vascular Accident (CVA);
- Leukemia;
- Major Head Trauma and Brain Injury;
- Multiple Fractures;
- Multiple Sclerosis;
- Severe Burns;

- Spinal Cord Injuries;
- Transplants.

You may be contacted by the claims administrator, IPMG Employee Benefits Services if you or your dependent suffers one of the above conditions.

Miscellaneous Administrative Provisions

Amendment, Alteration or Termination of the Plan

This Plan may be amended, changed or discontinued by the employer at any time without the consent of any covered person.

Assignment

No covered person shall have the right, except as specified in this Plan, to assign, alienate, anticipate or commute any payments under the Plan. Except as prescribed by law, no payments shall be subject to the debts, contracts or engagements of any covered person, nor to any judicial process to levy upon or attach the same for payment. Any covered person, however, may with the employer's approval, authorize the employer to pay benefits under the Plan directly to the person or organization on whose charges a claim is based. The employer shall be discharged from all liability to the extent of any payment made in accordance with any such authorization.

Examination

The employer shall have the right and opportunity during pendency of a claim hereunder to have the covered person whose injury or illness is the basis of such claim examined when or as often as it may reasonably require. Where it is not forbidden by law, the employer shall have the right and opportunity to order an autopsy in the case of a death.

Claim Procedure

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual

acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)

Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits or pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the	15 days

Plan	
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This

timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office."

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Voluntary appeals

In addition to the Claims and Appeals Procedures described above, the Plan permits voluntary dispute resolution procedures. If a claimant agrees in writing to use these procedures, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan will not assert that a claimant has failed to exhaust administrative remedies merely because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after receipt of a Final Adverse Benefit Determination.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this

information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

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Legal Proceedings

Pursuant to the following section, no action at law or in equity shall be brought by the employee to recover benefits under the Plan prior to the expiration of sixty days after proof of loss has been filed. No action by the employee shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required.

Proof of Claim

Written proof covering the occurrence, character and extent of the loss of which a claim is made must be given to the claims administrator within twelve months following the date on which the claim is incurred. Failure to furnish proof will not reduce any claim if it shall be shown that it was not reasonably possible to furnish such proof on time and that it was furnished as soon as was reasonably possible. Upon termination of the Plan, final claims must be received within ninety days of the effective date of the termination.

Payment of Benefits

Benefits payable under the Plan for any claim shall be paid as soon as practicable after receipt of written proof of loss from the covered person whose injury or illness is the basis of such claim. Subject to the written direction of the covered employee or the employer all or a portion of the benefits provided under the Plan regarding hospital, nursing, medical, surgical or dental services may be paid directly to the hospital or person rendering such services. The services do not have to be rendered by any particular organization or person. The employer may, at its discretion, have eligible expenses incurred reviewed by a professional audit firm.

Workers Compensation Not Affected

This Plan is not in lieu of and does not affect any requirements for coverage under Worker's Compensation insurance.

Severability

In case any provision of the Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan, and the Plan shall be construed and enforced as if such illegal and invalid provisions were never set forth in the Plan.

Pronouns

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

Change in Benefits

If a covered person is totally disabled on the effective date of any increase or decrease in benefits payable under the Plan, the increase or decrease in the amount of benefits payable will only apply to eligible expenses which are incurred after the covered employee has been actively-at-work for one full day or a covered dependent is no longer disabled. “Totally disabled” means a physical state resulting from an illness or injury which prevents you from performing each and every duty pertaining to your occupation, or the complete inability of a dependent to engage in the normal activities of a person of like age and sex in good health.

Mistake of Fact

Any mistake of fact or misstatement of fact shall be corrected when it becomes known and proper adjustment made by reason thereof.

Indemnity

To the extent permitted by law, any person who is, was or becomes a board member or an employee of the employer shall be indemnified and saved harmless by the employer (to the extent not indemnified or saved harmless by the employer under any liability insurance contracts) from and against any and all liability to which he may be subjected by reason of any act or conduct taken under the Plan in good faith, including all expenses reasonably incurred in his defense in case the employer fails to provide such defense.

Employment Rights

The employment rights of a covered employee shall not be deemed to be enlarged or diminished by reason of the establishment of the Plan, nor shall establishment of the Plan confer any right upon any covered employee to be retained in the service of the employer.

Controlling Law

Except to the extent superseded by the laws of the United States, the laws of the State of Illinois shall be controlling in all matters relating to the Plan.

Plan Year

The Plan year is September 1 through August 31.

Medical Case Management

The claims administrator, on behalf of the District, will notify the Medical Case Management Review firm of the occurrence of a major medical condition so that the covered person's medical condition may be assessed and, if appropriate, the Employer may, at its discretion, designate additional benefits for expenses which may be recommended by the Medical Case Management Review firm as alternative care. ‘Alternative Care’ means a plan of treatment which may not otherwise be eligible but which is determined to be cost-effective and medically necessary and appropriate for the care of an illness or injury. In addition, Alternative Care must be in lieu of treatment that would be eligible under the Plan and may not exceed the Plan’s allowed maximum benefit. A ‘major medical condition’ as used in this subsection means any injury or illness which the Medical Case Management Review firm has identified as being catastrophic or traumatic.

Special Transplant Program

In addition to the standard benefits payable under the Plan, when a covered person participates in a Special Transplant Program, the individual will be eligible for the following:

a. access to over forty transplant Centers of Excellence across the United States;
b. travel and lodging expenses incurred immediately prior to and after the transplant will be reimbursed up to $5,000 for the covered person and his or her companion. Travel and lodging discounts may also be available through preferred airlines and hotels;
c. credit of the covered person's deductible and out-of-pocket limit in an amount equal to $1,500 for all related expenses; and,
d. services of a Transplant Coordinator to facilitate the entire process.

To participate in the Special Transplant Program, the covered person must meet all of the requirements and guidelines stated below:

a. pre-notification must be made to Special Transplant Program by the covered person or the covered person's physician as soon as the individual is identified as a potential transplant candidate;
b. pre-certification must be obtained from the utilization review firm by calling Hines & Associates at 1-800-423-1841; and,
c. all transplant services must be rendered at a transplant facility through the Special Transplant Program.

Failure to meet the above requirements may result in the covered person's inability to access the Program and to qualify for the additional benefits.

Free Choice of Physician

The employee shall have the choice of any legally qualified physician or surgeon and the physician-patient relationship shall be maintained.

Unclaimed Payments

Any benefit payment issued under the Plan that is not executed by the payee within the twelve-month period immediately following its date of issue will be considered void and will only become a plan liability upon receipt of the employee's written request for re-issuance.

Qualified Medical Child Support Orders

Definitions

As used in this section, the following terms have these meanings:

- "Alternate Recipient" means any child of an employee who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan with respect to such employee.

- "Medical Child Support Order" means any court judgment, decree or order (including approval of settlement agreement) which:

    1. provides for child support for a child of an employee under the Plan or
    2. provides for health coverage to such a child under state domestic relations law (including a community property law); and
    3. relates to benefits under this Plan.

- "Qualified Medical Child Support Order" (QMCSO) means a Medical Child Support Order which:

    1. creates or recognizes an Alternate Recipient's right to receive benefits for which an employee or his/her dependent is eligible under the Plan; and
    2. meets the following requirements:
        a. clearly specifies the name and last known mailing address (if any) of the employee and the name and mailing address of each Alternate Recipient covered by the order;
        b. clearly specifies a reasonable description of the type of coverage to be provided by the Plan to each Alternative Recipient, or the manner in which such type of coverage is to be determined;
        c. clearly specifies the period to which such order applies;
        d. clearly specifies each plan to which such order applies; and
        e. does not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

Procedures

Except in the case of a National Medical Support Notice as described later in this section, if the Plan receives a Medical Child Support Order, the Plan Administrator will:

1. promptly notify, in writing, the employee, each Alternate Recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and these QMCSO procedures for determining whether such order is a QMCSO;

2. permit the Alternate Recipient to designate a representative to receive copies of notices sent to the Alternate Recipient regarding the Medical Child Support Order;
3. within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the employee, each Alternate Recipient covered by the order, and each representative for these parties of such determination; and,
4. ensure the Alternate Recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes.

Effect of Determination

If the Plan Administrator determines that a Medical Child Support Order is a QMCSO, then:

1. the Alternate Recipient shall be considered a dependent child of the employee under the Plan;
2. any payment for benefits in reimbursement of expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian (or the provider, with the approval of the custodial parent or guardian). A payment of benefits to an official of a State or political subdivision thereof whose address has been substituted for the address of the Alternate Recipient, shall be treated as payment of benefits to the Alternate Recipient for purposes hereof;
3. the Alternate Recipient shall be considered a participant of the Plan for purposes of the reporting and disclosure requirements of Part 1 of ERISA;
4. if any QMCSO requires an employee who is enrolled in the Plan under Single coverage to provide health coverage for an Alternate Recipient, such child shall be added to the Plan and the appropriate contributions for Family coverage will be withheld from the employee's compensation;
5. if any Qualified Medical Child Support Order requires an employee who is not enrolled in the Plan to provide health coverage for an Alternate Recipient, the employee and child shall be enrolled in the Plan, and the appropriate contributions for Family coverage will be withheld from the employee's compensation;
6. except as provided under the section "National Medical Support Notice", coverage of the Alternate Recipient shall be effective as of the latest of:
    a. the first day of the month specified in the Order;
    b. the first day of the month following the determination by the Plan Administrator; or
    c. the earlier of (1) the first day of the month following the receipt by the Plan of the first premium payment required for coverage, if any, or (2) the effective date of a court or administrative order requiring the Employer to withhold from the participant's compensation, the participant's share, if any, of premiums for health coverage and to pay such share of premiums to the Plan;
7. if the Plan and any fiduciary under the Plan acts in accordance with the provisions of these procedures in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, the Plan's obligation to the employee and

each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

Special Eligibility Rules for Qualified Medical Child Support Orders

Solely for purposes of determining if an Order is a QMCSO under these procedures, the definition of dependent children in the Plan shall not be deemed to exclude from health coverage under the Plan a child born out of wedlock, a child not claimed as a dependent on the employee's Federal income tax return, or a child that does not reside with the employee.

Termination of Coverage

Except to the extent required by law (e.g. COBRA), coverage for an Alternate Recipient will terminate on the earliest of the following dates:

1. the date the Qualified Medical Child Support Order is no longer in effect;
2. the date the Alternate Recipient's age exceeds the maximum age under which a dependent child may participate under the Plan;
3. the date the Plan Administrator is provided written evidence that the Alternate Recipient is or will be enrolled in comparable health coverage which will take effect not later than the effective date of such disenrollment; or
4. the Plan Administrator eliminates family health coverage for all of its employees.

National Medical Support Notice

If the Plan Administrator receives an appropriately completed National Medical Support Notice pursuant to section 401(b) of the Child Support Performance and Incentive Act of 1998 with respect to a child of a non-custodial parent, and the notice meets the requirements of a QMCSO as described under "Definitions", the notice shall be deemed to be a QMCSO in the case of such child.

In any case in which an appropriately completed National Medical Support Notice is issued with respect to a child of an employee who is such child's non-custodial parent, and the notice is deemed to be a QMCSO, the Plan Administrator, within 40 days after the date of the notice, shall:

1. notify the State agency issuing the notice with respect to such child, whether coverage for the child is available under the terms of the Plan and, if so, whether such child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child) to effectuate the coverage; and

2. provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

A non-custodial parent shall be liable to the Plan for employee contributions required under the Plan for enrollment of the child, unless such non-custodial parent properly contests such enforcement based on a mistake of fact.

HIPAA Privacy Rule Compliance

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Dixon Public School District #170. Employee Benefit Plan is the benefit plan of Dixon Public School District #170., the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Dixon Public School District #170 to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Dixon Public School District #170 shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

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

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Dixon Public School District #170 workforce are designated as authorized to receive Protected Health Information from Dixon Public School District #170 Employee Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Dixon Public School District #170 Human Resource Department.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance

With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and payroll deductions made by the covered Employees.

The Plan Administrator will set the level of any Employee payroll deductions for plan participation or premium rates required to continue coverage when not actively at work. These premiums payments and Employee deductions are retained in the general assets after they have been received from the Employee or withheld from the Employee's pay through payroll deductions. They are used as needed in funding the total cost of the Plan.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount for paid claims, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants

shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME
Dixon Public School District #170 Non-DESPA Support Staff Employee Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 36-6007311

PLAN EFFECTIVE DATE: July 1, 2013

PLAN YEAR ENDS: August 31

EMPLOYER INFORMATION
Dixon Public School District #170
1335 Franklin Grove Rd.
Dixon, IL 61021

PLAN ADMINISTRATOR
Dixon Public School District #170
1335 Franklin Grove Rd.
Dixon, IL 61021

NAMED FIDUCIARY
Dixon Public School District #170
1335 Franklin Grove Rd.
Dixon, IL 61021

AGENT FOR SERVICE OF LEGAL PROCESS
Dixon Public School District #170
1335 Franklin Grove Rd.
Dixon, IL 61021

CLAIMS ADMINISTRATOR
IPMG Employee Benefits Services
225 Smith Rd.
St. Charles, Illinois 60174
(800) 423-1841

Certificate of Adoption

I certify that the Dixon Public Schools District #170 Non DESPA Support Staff Health Care Plan Benefit Booklet/Plan Document restated as of July 1, 2013, is adopted by the Board of Education.

Signature

Business Manager

Title

Oct 1, 2013

Date

Attested