DIXON PUBLIC SCHOOLS DISTRICT #170

Health Care Plan

Benefit Booklet/Plan Document

Amended and Restated Effective January 1, 2006

Table of Contents

Page

Notice to Plan Participants *1*
Introduction *2*
Eligibility and General Plan Provisions *3*
Who is Eligible for Coverage 4
Who Pays for the Coverage 5
When Coverage Begins 5
Employee Coverage 5
Coverage for Your Dependents 6
Open Enrollment 6
Special Enrollees and Late Enrollees 7
When Coverage Terminates 8
Effective Date of Termination for Employees 8
Effective Date of Termination for Dependents 9
Certificate of Creditable Coverage Upon Termination 10
Continuation of Coverage for Active Employees and Their Dependents 10
Continuation of Coverage During An Approved Leave of Absence 11
Continuation of Coverage If You Become Totally Disabled 11
Continuation of Coverage for a Disabled Student 11
Continuation of Coverage for a Handicapped Child 11
Continuation of Coverage for Surviving Dependents 11
Continuation of Coverage for Retirees 12
Continuation of Coverage for Employees Participating in the Illinois Municipal Retirement Fund (IMRF) 12
Continuation of Coverage Following the Death of an IMRF Pension Recipient 13
Continuation of Coverage under COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) 14
Qualifying Events 15
Qualified Beneficiary 16
Your Responsibility to Report a Qualifying Event 17
Electing COBRA Continuation Coverage 17
Special Considerations in Deciding Whether to Elect COBRA Continuation Coverage 18
The Maximum COBRA Continuation Coverage Period 19
Termination Before the End of the Maximum Coverage Continuation Period 20
COBRA Continuation Coverage Premiums 21
Payment for COBRA Coverage 22
Notice Procedures 23
Keep Your Plan Administrator Informed 24
Contact Information 24
Coordination With Other Plans 24
Benefits for Persons Eligible for Medicare 27
Subrogation/Right of Reimbursement 27
Right of Recovery of Overpayment 29

Reasonable and Customary Limit 29
How to Apply for Benefits 30
What Information Is Needed 30
Where to File the Claim 30
When to File the Claim 30
Review of a Denied Claim 31
Health Care Benefits *32*
Schedule of Health Care Benefits 33
Eligible Health Care Expenses 38
Health Care Exclusions 49
Limitations of Benefits for Pre-Existing Conditions 55
Hospital Pre-admission Certification/Continued Stay Review Program 56
The Notification Procedure 56
How the Program Works 56
The Impact on Benefits 57
Second Surgical Opinion Review 57
The Notification Procedure 57
The Preferred Provider Organization Network 59
Large Case Management 59
Miscellaneous Administrative Provisions *61*
Amendment, Alteration or Termination of the Plan 62
Assignment 62
Examination 62
Claim Procedure 62
Legal Proceedings 62
Proof of Claim 62
Payment of Benefits 63
Workers Compensation Not Affected 63
Severability 63
Pronouns 63
Change in Benefits 63
Mistake of Fact 63
Indemnity 64
Employment Rights 64
Controlling Law 64
Plan Year 64
Medical Case Management 64
Sun Excel Special Transplant Program 65
Free Choice of Physician 65
Unclaimed Payments 65
Qualified Medical Child Support Orders 66
Definitions 66
Procedures 66
Effect of Determination 67
Special Eligibility Rules for Qualified Medical Child Support Orders 68

Termination of Coverage 68
National Medical Support Notice 68
HIPAA Privacy Rule Compliance 69
The Plan's Designation of Person/Entity to Act on its Behalf 69
The Plan's Disclosure of Protected Health Information to the Plan Sponsor-Required Certification of Compliance by Plan Sponsor 69
Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor 70
Disclosure of Individuals' Protected Health Information-Disclosure by the Plan Sponsor 70
Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor 71
Required Separation between the Plan and the Plan Sponsor 72
Certificate of Adoption *73*

Notice to Plan Participants

The Plan has a Hospital Pre-Admission Certification, Continued Stay Review Program and a Second Surgical Opinion 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 or surgery 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" on page 56 and "Second Surgical Opinion Review" on page 57 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. If you do not contact Hines for assistance regarding the second surgical opinion program the surgery benefit will be reduced by 50%. This deductible or benefit reduction is in addition to the calendar year deductible.

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.

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 at least 20 hours per week. Temporary employees or employees who work less than 20 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; and,

2. your unmarried, dependent children to age 19 or, to age 23 if enrolled as a full-time student in regular attendance at an accredited school, college or university. A full-time student means a student who is enrolled for at least 12 credit hours of study unless otherwise defined by the school or college in which the student is enrolled. Proof of a child's full-time student status will be required each semester or quarter during which he or she has a claim. A child must be dependent upon you for his or her maintenance and support unless you are required to provide coverage for the child through a court order or divorce decree. 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- Each person who was covered under the group benefits plan maintained by Dixon Public Schools immediately prior to January 1, 2006, will continue to be covered on and after January 1, 2006, subject to the terms and conditions of this plan.

2- 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" beginning on page 55.

3- Benefits payable by the Plan may be reduced as described in the section "Coordination With Other Plans" beginning on page 24 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 on January 1, 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" on page 55 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**" beginning on page 55.

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 on which 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.

2. for a child:

    a. who is not a full-time student at an accredited school or college, he or she attains age 19;
    b. who is a full-time student at an accredited school or college, he or she –
        (1) attains age 23;
        (2) graduates or is no longer enrolled and in attendance as a full-time student in an accredited school, college or university. A child will be considered a full-time student through any scheduled breaks between academic quarters or semesters prior to graduation including summer vacation, except that if the child does not return to an accredited school or college after the break, his or her student status will be considered terminated as of 11:59 P.M. on the last day of the academic quarter or semester that ended prior to the break;
    c. marries; or,
    d. ceases to be financially dependent upon you for support and maintenance (unless you are required to provide coverage for the child through a court order or divorce decree).

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:

Benefit Systems & Services, Inc. (BSSI)
760 Pasquinelli Drive, Suite 320
Westmont, IL 60559
1-800-423-1841

The name and address to which BSSI 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 (see page 14); or,

2. if the District is making a contribution to the Illinois Municipal Retirement Fund in your behalf, the IMRF disability extension (see page 12).

Continuation of Coverage for a Disabled Student

If a dependent student age 19 or older becomes disabled, coverage will be extended without interruption until the beginning of the next available quarter or semester. If he or she cannot return to student status at the beginning of the next available quarter or semester, he or she will be given the option to extend coverage under COBRA as explained in the section beginning on page 14.

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 14 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)

COBRA continuation coverage is an extension of Plan coverage required under the Federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This law requires that most group health plans (including this Plan) give "Qualified Beneficiaries" the opportunity to continue their health care coverage when there is a "Qualifying Event" that results in a loss of coverage.

A Qualified Beneficiary will be offered COBRA continuation coverage based on the same coverage that was in effect on the day before the Qualifying Event. However, if you or your dependent are eligible for Medicare on the date of the Qualifying Event, benefits will be coordinated with Medicare as described in the section "Benefits for Persons Eligible for Medicare". Any change to the coverage provided under this Plan for active employees will also apply to COBRA continuation coverage.

Each Qualified Beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as an active employee or dependent covered under the Plan, including any Open Enrollment or Special Enrollment rights available under this Plan. COBRA continuation coverage does not apply to, and is not available for, life insurance, disability, accidental death or dismemberment benefits, or other non-group health plan benefits offered by the District. The Plan provides no greater rights than what is required under the COBRA legislation – nothing in this document is intended to expand your rights.

Qualifying Events

A "Qualifying Event" is any one of the following events that causes a loss of coverage under the Plan:

- For You -

  1. Your hours of employment (that is, the number of hours you work each week) are reduced; or,
  2. Your employment ends for any reason, other than due to your gross misconduct;

- For Your Covered Spouse -

  1. Your hours of employment (the number of hours you work each week) are reduced or your employment ends for any reason, other than due to your gross misconduct;
  2. Your death;
  3. You become entitled to Medicare (Part A, Part B or both) if entitlement to Medicare causes a loss of coverage under the Plan; or,
  4. You divorce or become legally separated (if legal separation causes a loss of coverage under the Plan). In addition, if you cancel your spouse's coverage under the Plan in anticipation of a divorce or legal separation, the divorce or legal separation may still be considered a Qualifying Event even though your ex-spouse lost coverage earlier. If your ex-spouse notifies the Business Office within 60 days after the divorce or legal separation and can establish that you canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage will be available for the period after the divorce or legal separation.

  Note: You or your dependent are responsible for notifying the Business Office in writing within 60 days following the date a dependent qualifies for continuation because of divorce. If the Business Office is not notified within this 60-day period, the dependent(s) will not qualify for coverage continuation unless the District determines the Qualified Beneficiary did not receive his or her initial notice of COBRA rights and notice of the Qualifying Event was given as soon as was reasonably possible.

- For Your Covered Dependent Child(ren) -

  1. Your hours of employment (the number of hours you work each week) are reduced or your employment ends for any reason, other than due to your gross misconduct;
  2. Your death;
  3. You become entitled to Medicare (Part A, Part B or both) if entitlement to Medicare causes a loss of coverage under the Plan;

4. You divorce or become legally separated (if legal separation causes a loss of coverage under the Plan); or,
5. Your child no longer meets the definition of an eligible dependent under the Plan.

Note: You or your dependent are responsible for notifying the Business Office in writing within 60 days following the date a dependent qualifies for continuation because of divorce or because your child no longer meets the eligibility requirements. If the Business Office is not notified within this 60-day period, the dependent(s) will not qualify for coverage continuation unless the District determines the Qualified Beneficiary did not receive his or her initial notice of COBRA rights and notice of the Qualifying Event was given as soon as was reasonably possible.

Qualified Beneficiary

A "Qualified Beneficiary" is:

- Any individual who is covered under the Plan on the date coverage terminates due to a Qualifying Event listed above.

- A newborn infant or child placed for adoption with a former employee continuing coverage under COBRA provided the child meets the Plan's eligibility requirements (for example, the child has not exceeded the Plan's age limitation). However, the newborn or adopted child must be enrolled for COBRA continuation coverage within 31 days of his or her birth or placement for adoption. The child's COBRA continuation coverage will last as long as it does for other Qualified Beneficiaries within the former employee's family. If the former covered employee or family member fails to notify BSSI in a timely fashion of the child's birth or adoption, the child will not be eligible for COBRA coverage.

- A child of a covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee's period of employment. This child is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

According to the provisions of COBRA, a Qualified Beneficiary must be treated on the same basis as any other active employee. Therefore, a Qualified Beneficiary is eligible to enroll his or her dependent(s) for coverage under the same terms and conditions as an active employee; however, the dependents will only be eligible for COBRA continuation coverage for as long as the Qualified Beneficiary is continuing coverage.

Your Responsibility to Report a Qualifying Event

You or your dependent are responsible for notifying the Business Office in writing within 60 days following the date a dependent qualifies for continuation because of divorce or because your child no longer meets the eligibility requirements. Please refer to the paragraph entitled "Notice Procedures" for details on how to notify the District that a Qualifying Event has occurred. If the Business Office is not notified within this 60-day period, the dependent(s) will not qualify for COBRA continuation coverage unless the District determines the Qualified Beneficiary did not receive his or her initial notice of COBRA rights and notice of the Qualifying Event was given as soon as was reasonably possible.

If you (or a family member) fail to notify the Business Office in writing of a Qualifying Event, and any claims are paid mistakenly for expenses incurred after the Qualifying Event date, then you or your qualifying family member will be required to reimburse the Plan for any such claims paid.

Information about the cost of the continued coverage and the election form will be provided to the Qualified Beneficiary's last known home address at the time of eligibility for COBRA continuation coverage.

Electing COBRA Continuation Coverage

You and your covered dependent(s) will be notified in writing of your right to continue coverage when your employment terminates or you reduce your number of hours worked per week.

Your dependents will be notified in writing of their rights if you die or if your eligibility for Medicare results in the termination of your dependent's coverage.

If your dependent(s) become eligible due to a divorce or a child no longer meeting the eligibility requirements and the District receives timely notice that a Qualifying Event has occurred, your dependent(s) will be notified in writing of their right to COBRA continuation coverage.

Each Qualified Beneficiary who was covered under the Plan on the date coverage terminated is entitled to elect COBRA continuation coverage independently. You may elect COBRA continuation coverage on behalf of your spouse and/or dependent children. If you decline your right to COBRA continuation coverage, your spouse and/or children are still entitled to elect the continuation for themselves. A parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

A Qualified Beneficiary may elect COBRA continuation coverage even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date of their COBRA election. However, COBRA coverage will terminate automatically if, after electing COBRA, the Qualified Beneficiary becomes entitled to Medicare

benefits 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).

Each Qualified Beneficiary will have a period of 60 days to elect COBRA continuation coverage. This 60-day election period will begin on the later of the day coverage would otherwise terminate or the day the Qualified Beneficiary is provided his continuation rights. An election will be deemed made on the date the envelope containing the election is post-marked. If COBRA continuation coverage is not elected during the 60-day election period, each Qualified Beneficiary loses their right to coverage continuation.

To elect COBRA continuation coverage, the Election Form that is part of the Plan's *Notice of Right to COBRA Continuation Coverage* must be completed and mailed within the required 60-day election period (the *Notice* will be provided to Qualified Beneficiaries at the time of a Qualifying Event.) Your Election Form must be sent to:

COBRA Department
Benefit Systems & Services, Inc. (BSSI)
760 Pasquinelli Drive, Suite 320
Westmont, IL 60559-5555

The Qualified Beneficiary's election for COBRA continuation coverage must be in writing (via the Election Form) and must be sent to the address specified above. Verbal notice, including notice by telephone or in-person, is not acceptable.

A Qualified Beneficiary may change a prior refusal of COBRA continuation coverage at any time within their 60-day election period by using the Election Form and following the procedures specified on the Election Form. The Qualified Beneficiary's COBRA continuation coverage will begin on the date he or she rescinds their waiver of coverage (in other words, there will be a gap in coverage between the date of termination and the date of the written election to continue coverage).

Special Considerations in Deciding Whether to Elect COBRA Continuation Coverage

In considering whether to elect COBRA continuation coverage, please bear in mind that failure to elect COBRA will affect the individual's future rights under other Federal laws for which they may be eligible.

First, if a group health plan is required to comply with HIPAA, the individual can avoid having pre-existing condition exclusions apply to them if they do not have more than a 63-day gap in health coverage. An election of COBRA coverage may help avoid such a gap.

Second, if a Qualified Beneficiary does not elect COBRA coverage for the maximum time available to them, they will lose their guaranteed right to purchase an individual health insurance policy that does not impose a pre-existing condition exclusion. Finally, a Qualified Beneficiary may have the right to request special enrollment in another group health plan for which he or she is otherwise eligible (such as a plan sponsored by their spouse's employer) within 30 days after their group health coverage under this Plan ends because of a Qualifying Event. If entitled to this special enrollment, the Qualified Beneficiary will also have the same special enrollment right at the end of the maximum COBRA continuation period available to them.

The Maximum COBRA Continuation Coverage Period

Unless specifically stated elsewhere in this Plan, the maximum continuation periods defined below are measured from the date of the Qualifying Event, even if the Qualifying Event does not result in a loss of coverage under the Plan.

36-Month Qualifying Events. If a spouse or dependent child lose group health coverage because of the employee's: death, divorce, legal separation, or entitlement to Medicare, or because a child no longer meets the definition of an eligible dependent under the Plan, the maximum coverage period for the spouse and dependent child is 36 months from the date of the Qualifying Event.

18-Month Qualifying Events. If the employee, spouse or dependent child loses group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in employment hours, the maximum continuation coverage period is 18 months from the date of the Qualifying Event. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

- Disability Extension

  The 18-month maximum continuation may be extended up to a maximum of 29 months if you or another covered Qualified Beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage *and* you notify BSSI in a timely fashion. This extension is available to all Qualified Beneficiaries within your family who are continuing coverage due to your termination or reduction in hours of employment. During the additional 11-month extension you may be charged up to 150% of the applicable premium. To benefit from this extension, you must notify BSSI **in writing** within 60 days after the date of the Social Security Administration's determination and before the end of the original 18-month period. In addition, your notice must follow the procedures specified in the paragraph entitled "Notice Procedures" and include the name of the disabled Qualified Beneficiary, the date that the Qualified Beneficiary became disabled, and the date that the Social Security Administration made its determination. A copy of the Social Security Administration's determination must accompany your written notice. If these procedures are not followed or if the notice is not provided in writing to BSSI within the required timeframe, the 11-month disability

extension will not be available. If the 11-month disability extension is granted, the affected individual must also notify BSSI within 30 days of any final determination made by the Social Security Administration that the individual is no longer disabled.

- Second Qualifying Event Extension

  If a second Qualifying Event occurs within the 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours. This extension is available to all dependents who are Qualified Beneficiaries due to an employee's termination of employment or reduction in employment hours. "Second Qualifying Events" are the former employee's death, divorce or legal separation from his or her spouse, or if a child no longer meets the definition of an eligible dependent under the Plan. In all of these cases, BSSI must be notified **in writing** of the second Qualifying Event within 60 days of the date the event occurs. The Plan requires you to follow the procedures specified in the paragraph entitled "Notice Procedures". Your notice must include what Second Qualifying Event occurred and the date it happened. If these procedures are not followed or if the notice is not provided in writing to BSSI within the required 60-day period, the additional COBRA continuation coverage extension will not be available.

- Medicare Extension for Spouse and Dependent Children

  As noted earlier, if an employee loses group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in employment hours, the maximum continuation coverage period is 18 months from the date of the Qualifying Event for the employee and his/her covered spouse and children. While this remains true for the former covered employee, COBRA provides an extension of this continuation period for the employee's covered spouse and dependent children if, while still employed and within 18 months prior to the employee's termination of employment or reduction in employment hours, the employee becomes entitled to Medicare. If this occurs, the employee's covered spouse and dependent children will be eligible for COBRA continuation coverage for a maximum of 36 months beginning on the date of the employee's entitlement to Medicare even though this entitlement occurred while the employee and dependents were still covered.

Termination Before the End of the Maximum Coverage Continuation Period

The law provides that COBRA may be terminated before the end of the maximum coverage period stated in the preceding section for any of the following five reasons:

1. The Plan no longer provides group health coverage to any of its employees;

2. The premium for COBRA is not paid on time. Premium will be considered paid when the envelope is postmarked. If a check is returned for insufficient funds, the premium will not be considered paid;

3. After electing COBRA, the Qualified Beneficiary becomes covered under another group health plan. You must notify BSSI in writing within 30 days if, after electing COBRA coverage, a Qualified Beneficiary becomes covered under another group health plan. You must use the notice procedures specified in the paragraph entitled "Notice Procedures". If the other group plan contains a pre-existing condition exclusion or limitation for a condition the Qualified Beneficiary has, he or she will continue to qualify for COBRA continuation coverage until the pre-existing condition exclusion or limitation no longer applies. The other group plan will be considered the primary payer of benefits;

   Note: Under the Federal law, the Health Insurance Portability and Accountability Act of 1996, a group health plan's pre-existing condition exclusion or limitation may be offset by the amount of creditable plan coverage the individual has attained prior to enrolling in the health plan.

4. After electing COBRA, the Qualified Beneficiary becomes entitled to Medicare. You must notify BSSI in writing within 30 days if, after electing COBRA coverage, a Qualified Beneficiary enrolls in Medicare Part A or B. You must use the notice procedures specified in the paragraph entitled "Notice Procedures";

5. The Qualified Beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. The affected individual must notify BSSI within 30 days of any final determination that the individual is no longer disabled.

COBRA Continuation Coverage Premiums

The COBRA regulations dictate how COBRA continuation coverage premiums may be calculated. Under COBRA, a Qualified Beneficiary's premium may not exceed 102% of the cost to the group health plan (this includes both employer and employee contributions) for coverage of an active employee or dependent who is not receiving continuation coverage. In the case of an extension of continuation coverage due to a disability, the Qualified Beneficiary's premium may not exceed 150% of the group health plan's cost for the additional 11-months of COBRA continuation coverage. These rates are reviewed and subject to change once a year at the Plan's anniversary date. A Qualified Beneficiary's applicable premium will not be increased during the plan year unless there is a disability extension, or the Qualified Beneficiary changes his or her coverage, or if the Plan subsidizes a portion of the premium and the Plan discontinues its subsidy.

Payment for COBRA Coverage

If COBRA continuation coverage is elected in a timely manner, an Initial Premium Notice will be forwarded to the Qualified Beneficiary reflecting the total premium due from the Qualifying Event date through the last day of the applicable billing cycle. Payment of the Initial Premium is required within 45 days of the date COBRA continuation coverage is elected. If the full payment is not received (envelope postmarked) within this 45-day grace period, COBRA continuation coverage will be canceled retroactive to the coverage termination date.

All COBRA premiums must be paid by check (personal or certified) or by money order. Cash payments will not be accepted.

Claims will not be processed until a Qualified Beneficiary has both elected COBRA and made their first payment (please refer to the paragraph below entitled "Important Note – Coverage Reinstatement" for additional information). Although not required, if you wish to expedite reinstatement of coverage you may forward a partial premium payment along with your Election Form (for example, one month's premium). The total amount due on the Initial Premium Notice will be adjusted accordingly. However, if the full payment of the Initial Premium is not received (envelope postmarked) within the 45-day grace period required for Initial Premiums, COBRA continuation coverage will be canceled retroactive to the last day for which you have paid premium.

COBRA continuation coverage runs on a month-to-month basis. Therefore, after you make your initial payment for COBRA continuation coverage, premium for each following month of COBRA continuation coverage will be due on the first day of each calendar month with a 30-day grace period. If premiums are not paid (envelope postmarked) by the last day of the premium payment grace period, COBRA continuation coverage will end as of the last day for which premiums were paid on time.

BSSI will send monthly premium notices to the Qualified Beneficiary. A notice is only a reminder that a premium is due. It is not a bill. A Qualified Beneficiary must make their payment by the due date or within the grace period whether or not a notice is received. The Qualified Beneficiary's premium will not be considered paid in full if their check is returned by their bank due to insufficient funds (the check "bounces"). If this occurs, BSSI will notify the Qualified Beneficiary in writing. If the Qualified Beneficiary does not make full payment of the specified premium due by certified check or money order within 15 days from the date of the notice, the Qualified Beneficiary's COBRA continuation coverage will end as of the last date he or she has made sufficient premium payment.

The initial and subsequent monthly payments for COBRA continuation coverage should be sent to BSSI at the following address:

COBRA Department
Benefit Systems & Services, Inc. (BSSI)
760 Pasquinelli Drive, Suite 320
Westmont, IL 60559-5555

Important Note Concerning Coverage Reinstatement: A Qualified Beneficiary's COBRA continuation coverage will be in force as long as payment is made before the end of the grace period for each period of coverage (for example, each month). If a Qualified Beneficiary makes his or her premium payment later than its due date but during the grace period, their coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is received. No claims will be paid until premium is paid for the month in which the charges are incurred. This means that any claim submitted for benefits while coverage is suspended may be denied and will have to be resubmitted once coverage is reinstated.

Notice Procedures

The Plan requires that all notices must be made in writing. Verbal notice, including notice by telephone, is not acceptable and will not meet the Plan's notice requirement. Notices that a Qualified Beneficiary is required to give to the District (i.e., divorce, legal separation, or a dependent child no longer eligible under the Plan) must be made in writing and mailed to:

Dixon Public Schools District #170
Attention: Business Office
1335 Franklin Grove Road
Dixon, IL 61021

Notices that a Qualified Beneficiary is required to give to BSSI (i.e., a Disability Extension or Second Qualifying Event Extension) must be made in writing and mailed to:

Benefit Systems & Services, Inc.
Attention: COBRA Department
760 Pasquinelli Drive, Suite 320
Westmont, IL 60559-5555

Notice must be made no later than the last day of the required notice period. Notice is considered to have been made on the date the envelope mailed to the District or BSSI is postmarked or, if notice is delivered by carrier or in person, the date it is signed as being received by that office.

All notices must include: the name of the Plan, the name and address of the employee covered under the Plan, the name(s) and address(es) of the Qualified Beneficiary(ies), the Qualifying Event and the date the event happened.

There are two forms available to assist an individual with their notice requirement. The *Notice of Qualifying Event* can be utilized to notify the District of a divorce/legal separation or a dependent child no longer eligible under the Plan. The *Notice by Qualified Beneficiary* can be utilized to notify BSSI of a disability extension or a second Qualifying Event. A copy of these forms can be obtained from the Business Office or BSSI's COBRA Department.

Keep Your Plan Administrator Informed

In order to protect your family's rights to COBRA continuation coverage, you should keep the Business Office informed of any changes in your marital status (divorce or legal separation) or the addresses of you or any of your covered family members. All COBRA notices will be sent to the last known address. You should also keep a copy of any notices you send for your records.

Contact Information

If you have questions regarding your COBRA continuation coverage, please contact BSSI's COBRA Department at:

Benefit Systems & Services, Inc.
Attention: COBRA Department
760 Pasquinelli Drive, Suite 320
Westmont, IL 60559-5555
Phone: (630) 789-2082

Additional information regarding COBRA can also be obtained by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Regional and District EBSA office addresses and phone numbers are available through EBSA's website at www.dol.gov/ebsa/.

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, Benefit Systems & Services, Inc. (BSSI). 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 BSSI between 7:30 A.M. and 4:30 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 firm which will supply these profiles is Medical Data Research, a.k.a., Ingenix. 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, Benefit Systems & Services, Inc. (BSSI) 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 BSSI for reimbursement, please be sure the bill includes your name, the patient's name and the District's name. If BSSI needs additional information, they will contact either the provider of services or you for the information.

In addition to the claim detail, BSSI 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, BSSI will request the information directly from you in writing.

Where to File the Claim

All claims should be forwarded to:

Benefit Systems & Services, Inc.
760 Pasquinelli Drive, Suite 320
Westmont, Illinois 60559-5555

When to File the Claim

Claims must be submitted for reimbursement under the Plan within fifteen months following the date on which the claim is incurred. For example, if you incur an expense on June 12, 2006, the claim must be submitted no later than September 12, 2007. 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
Benefit Systems & Services, Inc.
760 Pasquinelli Drive, Suite 320
Westmont, Illinois 60559

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 described beginning on page 38 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 FOR EMPLOYEES AND THEIR DEPENDENTS COVERED UNDER THE TEACHERS' BARGAINING UNIT	
Maximum Benefit	$2,000,000 per person while covered under the Plan. If you are covered for one full calendar year, up to $1,000 of benefits paid during the prior calendar year will be reinstated as partial restoration of this maximum benefit.
Deductible	The deductible is the first $500 of eligible expenses incurred per family per calendar year. However, this deductible will be waived for inpatient hospital confinements other than for Mental Disorders or Substance Abuse confinements. 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	The "Out-of-Pocket Limit" is the maximum amount you will be required to pay as a result of your 10% or 20% co-insurance for eligible expenses incurred. The Out-of-Pocket Limit is $600 per person per calendar year for expenses payable at a benefit of 90% or 80%. 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"; • the non compliance penalty for second surgical opinions; or, • services incurred for mental or nervous disorders and alcohol drug dependency. However, prescription drugs expenses for these conditions will apply to the out of pocket.

BENEFITS FOR ELIGIBLE MEDICAL AND SURGICAL EXPENSES NOT SUBJECT TO THE DEDUCTIBLE

	For Eligible Expenses Incurred Within the PPO Network	***For Eligible Expenses Incurred Outside the PPO Network***
Inpatient Hospital Services	90% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the calendar year.	80% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the calendar year.
Second Surgical Opinion	100% for eligible expenses incurred for a second surgical opinion and, if there is a conflict between the first and second opinion, expenses incurred for an independent third opinion consultation.	

Note: 1 - If you or your dependent do not comply with the Hospital Pre-admission notification procedures described beginning on page 56, a separate $200 deductible per hospital confinement will be applied before any benefits under the Plan are paid.

2 - If you or your dependent do not comply with the Second Surgical Opinion requirement described beginning on page 57, benefits for charges incurred with the surgeon for the performance of the procedure will be reduced to 50% .

BENEFITS FOR ALL OTHER ELIGIBLE MEDICAL AND SURGICAL EXPENSES		
	For Eligible Expenses Incurred Within the PPO Network	***For Eligible Expenses Incurred Outside the PPO Network***
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, 80% 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, 80% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.
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, 80% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.

Note: If you or your dependent do not comply with the Second Surgical Opinion requirement described beginning on page 57, benefits for charges incurred with the surgeon for the performance of the procedure will be reduced to 50% .

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, 80% 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, 80% 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 56, 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. 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;

7. Blood -

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

8. 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;

9. Chemotherapy;

10. Chiropractic Care;

11. 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;

12. 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;

13. Diagnostic X-ray and Laboratory Services –

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

14. 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;

15. 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;

16. 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;

17. 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;

18. 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;

19. 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;

20. 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;

21. Mammograms -

    expenses related to routine mammograms will be eligible based on the following schedule:

    a. a baseline mammogram for females age 35-39 years of age;
    b. a mammogram every two years for females ages 40-49; or,
    c. an annual mammogram for females age 50 and over;

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 services up to the maximum benefit specified under the "Schedule of Health Care Benefits" beginning on page 33. 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" on page 5 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;

33. 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 "SunExcel Transplant Benefit" 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". See the section "Sun Excel Special Transplant Program" on page 65 for additional information.

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. 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;

38. Radiation Therapy –

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

39. Renal Dialysis;

40. Respiratory Therapy –

respiratory therapy rendered by a qualified respiratory therapist;

41. 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);

42. Self-Management of Diabetes –

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

43. Shock Therapy;

44. 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;

45. Sterilization –

elective sterilization procedures, but not their reversal;

46. 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;

47. Temporomandibular Joint Dysfunction –

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

48. 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 15-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. Completion of Claim Forms/Missed Visits -

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

7. Cosmetic Services -

   charges for cosmetic surgery and related services and supplies;

8. Coverage Not in Effect –

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

9. 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;

10. Dental Care –

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

11. 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.

12. 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;

13. Family Members -

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

14. 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;

15. 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;

16. 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;

17. Hearing Aids or Examinations -

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

18. Health Maintenance Organizations -

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

19. Immunizations -

    charges for preventive immunizations;

20. 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;

21. 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;

22. Milieu Therapy -

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

23. Not Medically Necessary –

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

24. 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;

25. Not Otherwise Eligible -

    any service or supply not specifically listed under the section "Eligible Expenses";

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

27. 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;

28. 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;

29. Pregnancy -

    charges related to a dependent daughter's pregnancy;

30. Premarital Examinations, or pre-employment examinations;

31. 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 *contraceptives*, dietary drugs and vitamins;

32. 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;

33. Reasonable and Customary -

    charges in excess of the reasonable and customary amount;

34. Routine Physical Examinations

    charges for routine physical exams unless specifically listed as an eligible expense;

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;

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, Benefit Systems & Services, Inc.

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.

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 BSSI at 1-800-423-1841.

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.***

Second Surgical Opinion Review

The Plan includes a non-emergency Second Surgical Opinion Review program for certain procedures as shown on the list in this section. 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. Dixon Public Schools has contracted with an independent firm that 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 comply with the requirements of this program, benefits in conjunction with the surgical procedure will be reduced by 50%. This benefit reduction is in addition to the calendar year deductible and does not apply to the Out-of-Pocket limit.

The Notification Procedure

If your physician recommends one of the procedures on the following list, you must contact Hines & Associates at 1-800-423-1841 to determine if a second opinion will be required in order to obtain full plan benefits. Some of these procedures do not require a hospital confinement, but may be performed in a freestanding facility or physician's office. If an overnight hospital confinement has also been recommended you will also need to pre-certify the hospital stay once you have complied with the Second Opinion program. Please refer to

Hospital Pre-admission Certification/Continued Stay Review Program section.

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 ;
4. the name, address and telephone number of where the procedure is to be performed, if outside of the attending physician's office;
5. the reason for the proposed surgical procedure; and,
6. Dixon Public School District #170 Health Care Plan.

After the Medical Review Specialist has obtained the above information, he or she will contact the attending physician to obtain additional information concerning the proposed surgical procedure. Once the Medical Review Specialist has all of the necessary information, he or she will evaluate the request for surgery against established medical criteria to determine if there is a need for a second surgical opinion. If the Medical Review Specialist determines a second opinion is necessary, the Plan will pay 100% for the second opinion and, if necessary, third opinion. The second surgical opinion consultation must be rendered by a Board Certified Specialist in the type of surgery to be performed. The purpose of this evaluation is to assure that you or your dependent are receiving appropriate quality care.

The procedures which are subject to this program are:

1. Back Surgery – Laminectomy for exploration or decompression, incision or excision or implantation or a Diskectomy;
2. Mastectomy;
3. Bunion Surgery;
4. Cataract Surgery;
5. Coronary Artery Bypass Surgery;
6. Gall Bladder Surgery – Cholecystostomy, Cholecystectomy, Cholecystoenterostomy;
7. Hemorrhoid Surgery (all types and any method);
8. Hernia Repairs (all types)
9. Hysterectomy;
10. Knee Surgery – Arthrotomy, Arthroscopic Surgery or Capsulotomy;
11. Rhinoplasty (nose surgery);
12. Tonsillectomy or Adenoidectomy;
13. Varicose Vein Surgery (any method)

The initial recommendation for surgery must be provided by a physician. The surgeon providing the second surgical opinion consultation must be a Board Certified Specialist in the type of surgery to be performed. In addition, to qualify for this benefit, the Board Certified Specialist may not be affiliated with the surgeon who initially recommended the surgery.

The Preferred Provider Organization Network

Through our claims administrator, Benefit Systems & Services, Inc. (BSSI), the Company has contracted with Private Healthcare Systems (PHCS) to access a Preferred Provider Organization (PPO) network. To find a hospital, physician or other service provider participating in the PHCS PPO network, please contact them directly at 1-800-240-1940 or through their website at www.phcs.com.

In addition to the providers participating in the PHCS PPO network, BSSI has also contracted with the following organizations that have agreed to participate in the network:

- Dreyer Ambulatory Surgery Center – Aurora, Illinois;
- University of Chicago Hospital and Health System;
- effective August 1, 2005, Mayo Clinic – Rochester, Minnesota; Jacksonville, Florida; and Scottsdale, Arizona. For information on Mayo Clinic, see their website at www.mayoclinic.org or call Rochester at 507-284-2111, Jacksonville at 904-953-2272, or Scottsdale at 480-301-8484.

When you or your dependent obtain services from a PPO provider, you and/or your dependent are eligible for the maximum benefit payable under the Plan and will receive a discount from the provider for charges incurred. 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.

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, Benefit Systems & Services, Inc. (BSSI) 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

Written notice will be provided to any covered person whose claim for benefits under the Plan has been denied, setting forth the reasons for such denial.

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 fifteen month 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.

Sun Excel Special Transplant Program

In addition to the standard benefits payable under the Plan, when a covered person participates in the Sun Excel 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 Sun Excel 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

In order to comply with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the "504" provisions") the provisions of this section will establish the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information.

The Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Dixon Public Schools District #1704 to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts, accepting certification from the Plan Sponsor).

Definitions

All terms defined in the HIPAA Privacy Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions in this section.

Plan means the Dixon Public Schools District #170 Health Care Plan.

Plan Documents mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the Dixon Public Schools District #170 Health Care Plan and Prescription Drug Program Plan Document.

Plan Sponsor means Dixon Public Schools District #170.

The Plan's Disclosure of Protected Health Information to the Plan Sponsor-Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance

issuer or HMO with respect to the Plan, *only if* the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and,
3. the Plan Sponsor agrees to comply with the Plan provisions as contained in this section.

Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor

The Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the Protected Health Information of the Plan's individuals by the Plan's business associate, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.
The Plan (and any business associate acting on behalf of the Plan), may not, and may not permit a health insurance issuer or HMO to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

Disclosure of Individuals' Protected Health Information-Disclosure by the Plan Sponsor

The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.

The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan Sponsor will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:

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

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required Separation between the Plan and the Plan Sponsor

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan:

1. Superintendent
2. Business Manager
3. Staff designated by Business Manager
4. Plan Auditor

This list reflects the employees, classes of employees or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

Certificate of Adoption

I certify that the Dixon Public Schools District #170 Employee Health Care Plan Benefit Booklet/Plan Document restated as of January 1, 2006, is adopted by the Board of Education.

_____

Signature

_____

Title

_____

Date

_____

Attested