

**First Amendment of
Dixon Public Schools District #170
Health Care Benefits Plan**

WHEREAS, the Dixon Public Schools District #170 (the "District") maintains the Dixon Public Schools District #170 Health Care Benefits Plan effective January 1, 2006 (the "Plan"); and,

WHEREAS, amendment of the Plan is now considered desirable;

NOW, THEREFORE IT IS RESOLVED that, by virtue and in exercise of the power reserved to the Company, the Plan is amended in the following Particulars:

1. Effective June 1, 2006: by replacing the section *Payment for COBRA Coverage* beginning on page 24, as follows:

"Payment for COBRA Coverage

If COBRA continuation coverage is elected in a timely manner, a letter of confirmation and payment coupons will be forwarded to the Qualified Beneficiary reflecting the coverage election and applicable payments. 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 (or prescription filled through the Plan's Prescription Drug Program) 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.

Premium coupons will be issued upon COBRA enrollment. A Qualified Beneficiary must make their payment by the due date or within the grace period. 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 (or prescription filled through the Plan's Prescription Drug Program) 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."

2. Effective January 1, 2006: by renumbering and restating the "Organ Transplants" benefit under the section *Eligible Health Care Expenses* beginning on page 41 as follows:

“31. Organ Transplants -

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

- a. bone marrow transplant, stem cell transplantation and cord blood transplants;
- 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 procedures must be (1) approved for Medicare coverage on the date the transplant is performed; and, (2) not be 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 transplant;
- 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 and cornea 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.”

3. Effective January 1, 2006: by restating item No. 25 under the section *Health Care Exclusions* beginning on page 51 as follows:

“25. Not Otherwise Eligible -

any service or supply not specifically listed under the section “Eligible Expenses” or in excess of the Plan’s limits;”

4. Effective January 1, 2006: by adding the following at the end of the section *Health Care Exclusions* beginning on page 51 as follows:

“44. Gene Therapies;

45. Xenographs; and

46. Cloning.”

5. Effective April 20, 2006: by adding the following at the end of the *Miscellaneous Administrative Provisions* beginning on page 64:

“HIPAA Security Rule Compliance

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the “Security Regulations”).

Definitions

Electronic Protected Health Information has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

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

Plan Documents means 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 Benefits Plan Document.

Plan Sponsor means the Dixon Public Schools District #170.

Security Incidents has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.”

I hereby certify that the foregoing is a correct copy of the 1st amendment to the Dixon Public Schools District #170 Health Care Benefits, duly adopted by the Plan Sponsor and that the amendment has not been changed or repealed.

Dated this _____ day of _____, 2007.

Signature

Title