HEALTH BENEFIT PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
PEORIA PUBLIC SCHOOL DISTRICT #150 GROUP HEALTH CARE PLAN
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INTRODUCTION

This document is a description of Peoria Public School District #150 Group Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are not covered.


Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.
Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.
SCHEDULE OF BENEFITS

Verification of Eligibility 800-798-2422

Call this number to verify eligibility for Plan benefits before the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Reasonable and Customary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

Note: The following services must be precertified through AIMM at (877) 217-7695 or reimbursement from the Plan may be reduced:

PET Scans
All Hospitalizations
Transplant Services (including transplant evaluation)
Inpatient Rehabilitation Facility Stays (both medical and mental health)
All Substance Abuse Treatment
All Mental Disorder Treatment
Skilled Nursing Facility Stays
Home Health Care
Hospice Care
Physical Therapy (PT)
Dialysis
Speech Therapy (ST)
Occupational Therapy (OT)
Cardiac Rehabilitation Therapy
Outpatient Surgery
Chemotherapy & Radiation Therapy
Durable Medical Equipment Costing Over $500
Pre-natal and Maternity Care
MRI & CT Scans
High Cost Medications (especially those being funded under major medical and not the PBM)

The patient or family member must call the above number to receive certification at least 72 hours in advance of services being rendered or within 72 hours after an emergency admission.

For dialysis treatments, please contact Ethicare Advisors at 877-218-1955 before treatment begins.

Dialysis Treatment Cost Management Program:

The dialysis treatment cost management program is a special cost containment program designed for patients requiring dialysis treatments. The Plan has entered into an agreement with Ethicare Advisors, Inc., a specialized cost management company, to manage dialysis costs. Ethicare Advisors must be contacted by your nephrologist and/or the dialysis treatment clinic providing services before the onset of treatment. Unless your nephrologist and/or dialysis treatment clinic has entered into an agreement with Ethicare Advisors, the payment for all drugs and dialysis treatment will be strictly limited to the reasonable and customary reimbursement rate as defined by the Plan and all other Plan Limitations and Exclusions.
Please see the Cost Management section in this booklet for details.

The Plan is a plan which contains a Network Provider Organization. This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Preferred Providers or Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

- If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within 45 miles of the Covered Person's residence.
- If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. The current Network providers are:

OSF Direct Access Network (find provider 888-209-3761 or www.osfdirectaccessnetwork.com)

OR

Methodist First Choice (find provider 866-510-2922 or www.mymethodist.net) and Proctor Health Plus network (find provider 309-689-8623 or www.healthpluspeoria.org).

Network selection can be made at the time a Plan Participant family member is initially enrolled in the Plan, enrolled during a special enrollment period, or during an open enrollment period. A selection may not be made or changed at any other time and must be identical for all family members. Effective as of January 1, 2017, the selection need not be identical for all family members. In addition, Covered Persons shall be permitted to change their Network selection from OSF Direct Access Network to the Methodist First Choice and Proctor Health Plus Network from May 1, 2017, to May 19, 2017, effective as of July 1, 2017.

Notwithstanding the above, the only Network Hospital providers for organ and tissue transplants are the Centers for Excellence network of transplant Hospitals that the Plan Administrator has contracted with to provide transplant services.

Plan Selection

The Plan provides four benefit packages named "Plan A," "Plan B," the "Maxi Medical Plan – Plan C," and the "MRP – Medical Reimbursement Plan – Plan D." The benefit packages are identical except as described in the Medical Schedule of Benefits below. Each Covered Employee can choose the benefit package for the covered Employee and the Employee's Dependents at the time the Employee commences participation in the Plan or during the Plan annual enrollment period. A Covered Employee cannot change benefit packages at any other time, except that changes on or off of the Maxi Medical Plan – Plan C or the MRP Medical Reimbursement Plan – Plan D can be made at any time. The Covered Employee must select the same benefit package for himself and his Dependents, except as otherwise allowed under the Maxi Medical Plan or the MRP-Medical Reimbursement Plan.

Deductibles payable by Plan Participants

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. Deductibles do not apply towards the 100% maximum out-of-pocket payment.
### MEDICAL SCHEDULE OF BENEFITS – PLAN A

<table>
<thead>
<tr>
<th>Deductible and Maximums</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (calendar year)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$350</td>
<td>$1,050</td>
</tr>
<tr>
<td>Family</td>
<td>$700</td>
<td>$2,100</td>
</tr>
</tbody>
</table>

All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount. The In-Network Deductible and Out-of-Network Deductible are separate and do not accumulate toward one another.

<table>
<thead>
<tr>
<th>Maximum Out-of-Pocket Amount (calendar year)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$9,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$18,000</td>
</tr>
</tbody>
</table>

All individual Maximum Out-of-Pocket amounts will count toward the family Maximum Out-of-Pocket amount, but an individual will not have to pay more than the individual Maximum Out-of-Pocket amount. Copayments do not accumulate to the Maximum Out-of-Pocket amount, except to the extent required by the Affordable Care Act. The In-Network Maximum Out-of-Pocket amount and Out-of-Network Maximum Out-of-Pocket amount are separate and do not accumulate toward one another.

| Lifetime Benefit Maximum | Unlimited | Plan pays a maximum benefit which includes both In-Network and Out-of-Network. |

### Benefits for Covered Services

<table>
<thead>
<tr>
<th>Preventive Care Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Exams/Well-Child Care</strong></td>
<td>$0 PCP/$0 Specialist Copayment per visit. Deductible does not apply.</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>$0 Copayment. Deductible does not apply</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Laboratory and X-ray</td>
<td>$0 Copayment. Deductible does not apply</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>(for mammograms, see Mammography section below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physician Office Services

| Office Visits | $20 PCP/$40 Specialist Copayment per visit. Deductible does not apply. | 40% after Deductible |
| Office Surgery | $20 PCP/$40 Specialist Copayment per visit. Deductible does not apply. | 40% after Deductible |
| Allergy Testing | $40 Copayment per visit. Deductible does not apply | 40% after Deductible |
| Allergy Injections | $10 Copayment per injection. Deductible does not apply | 40% after Deductible |
| Other Injections | $10 Copayment per injection. Deductible does not apply | 40% after Deductible |
| Maternity Physician Services | $100 Copayment per pregnancy. Deductible does not apply | 40% after Deductible |

### Newborn Services

**Inpatient**

**Outpatient**

See "Physician Services at a Facility other than the Office" and "Facility Services."

### Physician Services at a Facility other than the Office

<table>
<thead>
<tr>
<th></th>
<th>$20 PCP/$40 Specialist Copayment per visit. Deductible does not apply.</th>
<th>40% after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Facility Visits</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility Visits</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Inpatient Surgery</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Benefits for Covered Services</td>
<td>In-Network Covered Person Pays</td>
<td>Out-of-Network Covered Person Pays</td>
</tr>
<tr>
<td>------------------------------</td>
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</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Follow-up care obtained in the emergency room is not covered.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Physician</td>
<td>20% after Deductible</td>
<td>20% after Deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 Copayment per visit after Deductible</td>
<td>$150 Copayment per visit after Deductible</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
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<td></td>
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<tr>
<td></td>
<td>20% after Deductible</td>
<td>20% after Deductible</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>$20 Copayment per visit. Deductible does not apply.</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Laboratory and X-ray Services</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Renal Dialysis Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Mammography</td>
<td>0% Deductible does not apply.</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility - (Covered Person is limited to 100 days per calendar year) (The In-Network and Out-of-Network days are combined.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Medical Equipment</strong></td>
<td></td>
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<tr>
<td>Durable Medical Equipment</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
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<tr>
<td>Prosthetic Devices</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Hearing Aid Devices</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>(Plan pays a maximum benefit of $5,000 per calendar year.)</td>
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<tr>
<td><strong>Outpatient Rehabilitative Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation. (Covered Person is limited to 60 outpatient treatment visits per calendar year) (The In-Network and Out-of-Network visits are combined.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Preventative Physical Therapy for Multiple Sclerosis (Covered Person is limited to 60 outpatient treatment visits per calendar year) (The In-Network and Out-of-Network visits are combined.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Habilitative Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Speech Therapy (for Pervasive Developmental Disorders) (Covered Person is limited to 20 visits per calendar year) (The In-Network and Out-of-Network visits are combined.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Benefits for Covered Services</td>
<td>In-Network Covered Person Pays</td>
<td>Out-of-Network Covered Person Pays</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td><strong>Home Health Services</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>(Covered Person is limited to 60 visits per calendar year) (The In-Network and Out-of-Network visits are combined.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Services</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Respite Care</strong></td>
<td>Covered as any other medical condition. See &quot;Physician Office Services,&quot; &quot;Physician Services at a Facility other than the Office,&quot; and &quot;Facility Services.&quot;</td>
<td>Not covered</td>
</tr>
<tr>
<td>(Limited to 10 Respite Care days per calendar year) (The In-Network and Out-of-Network days are combined.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organ and Tissue Transplants</strong></td>
<td>Covered as any other medical condition. See &quot;Physician Office Services,&quot; &quot;Physician Services at a Facility other than the Office,&quot; and &quot;Facility Services.&quot;</td>
<td>Covered as any other medical condition. See &quot;Physician Office Services,&quot; &quot;Physician Services at a Facility other than the Office,&quot; and &quot;Facility Services.&quot;</td>
</tr>
<tr>
<td><strong>Cornea Transplants</strong></td>
<td>Covered as any other medical condition. See &quot;Physician Office Services,&quot; &quot;Physician Services at a Facility other than the Office,&quot; and &quot;Facility Services.&quot;</td>
<td>Covered as any other medical condition. See &quot;Physician Office Services,&quot; &quot;Physician Services at a Facility other than the Office,&quot; and &quot;Facility Services.&quot;</td>
</tr>
<tr>
<td><strong>Autism Spectrum Disorders</strong></td>
<td>Covered as any other medical condition. See &quot;Physician Office Services,&quot; &quot;Physician Services at a Facility other than the Office,&quot; and &quot;Facility Services.&quot;</td>
<td>Covered as any other medical condition. See &quot;Physician Office Services,&quot; &quot;Physician Services at a Facility other than the Office,&quot; and &quot;Facility Services.&quot;</td>
</tr>
<tr>
<td><strong>Infertility</strong></td>
<td>$40 Copayment per visit. Deductible does not apply.</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Office visits/services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Physician Visits</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 PCP/$40 Specialist Copayment per visit. Deductible does not apply.</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Physician Visits</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 PCP/$40 Specialist Copayment per visit. Deductible does not apply.</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Sexual Assault or Abuse – Exams and Treatment</td>
<td>$0 Copayment for examination and treatment of injuries or trauma of a Covered Person who is the victim of an offense defined in the Illinois Criminal Code of 1961, Sections 12-13 through 12-16.</td>
<td>$0 Copayment for examination and treatment of injuries or trauma of a Covered Person who is the victim of an offense defined in the Illinois Criminal Code of 1961, Sections 12-13 through 12-16.</td>
</tr>
<tr>
<td>Service</td>
<td>Copayment</td>
<td>Deductible</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Spinal Manipulation/Chiropractic</td>
<td>$20</td>
<td>does not apply</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Plan pays a maximum benefit of $1,000 per calendar year.) (The in-Network and Out-of-Network dollar amounts are combined.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Covered Services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>after Deductible</td>
<td>after Deductible</td>
</tr>
</tbody>
</table>
PRESCRIPTION DRUG BENEFIT – PLAN A

31-Day Pharmacy Option (Copayments apply per prescription)

Generic drugs
Copayment ...........................................$10

Formulary Brand Name drugs
Copayment ...........................................$40

Non-Formulary Brand Name drugs
Copayment ...........................................$70

Specialty Drugs .......................................$100

90-Day Pharmacy Option (Copayments apply per prescription)

Generic drugs
Copayment ...........................................$20

Formulary Brand Name drugs
Copayment ...........................................$80

Non-Formulary Brand Name drugs
Copayment ...........................................$140

Note: Special copayment rules apply for participation in the MedTrak Script Choice, E-Script, and Copay Waiver programs. See the Prescription Drug Benefits Section for a description of the Step Therapy Program and the Co-Payment Assistance Program.
MEDICAL SCHEDULE OF BENEFITS – PLAN B  
(Effective January 1, 2017)

<table>
<thead>
<tr>
<th>Deductible and Maximums</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (calendar year)</strong></td>
<td><strong>$2,400</strong></td>
<td><strong>$4,800</strong></td>
</tr>
<tr>
<td>Individual</td>
<td><strong>$4,800</strong></td>
<td><strong>$9,600</strong></td>
</tr>
<tr>
<td>Family</td>
<td><strong>$4,800</strong></td>
<td><strong>$9,600</strong></td>
</tr>
</tbody>
</table>

All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount. The In-Network Deductible and Out-of-Network Deductible are separate and do not accumulate toward one another.

| Maximum Out-of-Pocket Amount (calendar year) | **$2,400** | **$4,800** |
| Individual                                 | **$4,800** | **$9,600** |

All individual Maximum out-of-pocket amounts will count toward the family Maximum Out-of-Pocket amount, but an individual will not have to pay more than the individual Maximum Out-of-Pocket amount. Copayments do not accumulate to the Maximum Out-of-Pocket amount, except to the extent required by the Affordable Care Act. The In-Network Maximum Out-of-Pocket amount and Out-of-Network Maximum Out-of-Pocket amount are separate and do not accumulate toward one another.

**Lifetime Benefit Maximum**
(Plan pays a maximum benefit which includes both In-Network and Out-of-Network.)

**Unlimited**

<table>
<thead>
<tr>
<th>Benefits for Covered Services</th>
<th>In-Network Covered Person Pays</th>
<th>Out-of-Network Covered Person Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td><strong>$0 Copayment per visit. Deductible does not apply.</strong></td>
<td><strong>0% after Deductible</strong></td>
</tr>
<tr>
<td>Physical Exams/Well-Child Care</td>
<td>$0 of Allowed Charge. Deductible does not apply.</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>$0 of Allowed Charge. Deductible does not apply.</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Laboratory and X-ray (for mammograms, see Mammography section below)</td>
<td>$0 of Allowed Charge. Deductible does not apply.</td>
<td>0% after Deductible</td>
</tr>
</tbody>
</table>

| **Physician Office Services** | **0% after Deductible** | **0% after Deductible** |
| Office Visits                | **0% after Deductible** | **0% after Deductible** |
| Office Surgery               | **0% after Deductible** | **0% after Deductible** |
| Allergy Testing              | **0% after Deductible** | **0% after Deductible** |
| Allergy Injections           | **0% after Deductible** | **0% after Deductible** |
| Other Injections             | **0% after Deductible** | **0% after Deductible** |

| Maternity Physician Services | **0% after Deductible** | **0% after Deductible** |

<table>
<thead>
<tr>
<th>Newborn Services</th>
<th><strong>See &quot;Physician Services at a Facility other than the Office&quot; and &quot;Facility Services.&quot;</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>See &quot;Physician Services at a Facility other than the Office.&quot;</td>
</tr>
<tr>
<td>Outpatient</td>
<td>See &quot;Physician Services at a Facility other than the Office.&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Services at a Facility other than the Office</th>
<th><strong>0% after Deductible</strong></th>
<th><strong>0% after Deductible</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visits</td>
<td><strong>0% after Deductible</strong></td>
<td><strong>0% after Deductible</strong></td>
</tr>
<tr>
<td>Inpatient Facility Visits</td>
<td><strong>0% after Deductible</strong></td>
<td><strong>0% after Deductible</strong></td>
</tr>
<tr>
<td>Outpatient Facility Visits</td>
<td><strong>0% after Deductible</strong></td>
<td><strong>0% after Deductible</strong></td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td><strong>0% after Deductible</strong></td>
<td><strong>0% after Deductible</strong></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td><strong>0% after Deductible</strong></td>
<td><strong>0% after Deductible</strong></td>
</tr>
<tr>
<td>Benefits for Covered Services</td>
<td>In-Network Covered Person Pays</td>
<td>Out-of-Network Covered Person Pays</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Follow-up care obtained in the emergency room is not covered.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Physician</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Laboratory and X-ray Services</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Renal Dialysis Services</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td><strong>Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility - <em>(Covered Person is limited to 100 days per calendar year.)</em></td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td><em>(The In-Network and Out-of-Network days are combined.)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Hearing Aid Devices <em>(Plan pays a maximum benefit of $2,500 per calendar year.)</em></td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitative Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(Covered Person is limited to 60 outpatient treatment visits per calendar year.)</em></td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td><em>(The In-Network and Out-of-Network visits are combined.)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative Physical Therapy for Multiple Sclerosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(Covered Person is limited to 60 outpatient treatment visits per calendar year.)</em></td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td><em>(The In-Network and Out-of-Network visits are combined.)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Habilitation Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Speech Therapy (for Pervasive Developmental Disorders)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(Covered Person is limited to 20 visits per calendar year.)</em></td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Benefits for Covered Services</td>
<td>In-Network Covered Person Pays</td>
<td>Out-of-Network Covered Person Pays</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>(Covered Person is limited to 60 visits per calendar year) (The In-Network and Out-of-Network visits are combined.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Respite Care</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>(Limited to 10 Respite Care days per calendar year) (The In-Network and Out-of-Network days are combined.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ and Tissue Transplants</td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
<td>Not covered</td>
</tr>
<tr>
<td>Cornea Transplants</td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
</tr>
<tr>
<td>Autism Spectrum Disorders</td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
</tr>
<tr>
<td>Manipulative Services</td>
<td>0% after In-Network Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>(Limited to 20 visits per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Inpatient Physician Visits</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Inpatient Physician Visits</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>Sexual Assault or Abuse – Exams and Treatment</td>
<td>$0 Copayment for examination and treatment of injuries or trauma of a Covered Person who is the victim of an offense defined in the Illinois Criminal Code of 1981, Sections 12-13 through 12-16.</td>
<td>$0 Copayment for examination and treatment of injuries or trauma of a Covered Person who is the victim of an offense defined in the Illinois Criminal Code of 1981, Sections 12-13 through 12-16.</td>
</tr>
<tr>
<td>Spinal Manipulation/Chiropractic Services</td>
<td>0% after Deductible</td>
<td>0% after In-Network Deductible</td>
</tr>
<tr>
<td>Benefits for Covered Services</td>
<td>In-Network Covered Person Pays</td>
<td>Out-of-Network Covered Person Pays</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Prescription Drug Benefit</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
<tr>
<td>All Other Covered Services</td>
<td>0% after Deductible</td>
<td>0% after Deductible</td>
</tr>
</tbody>
</table>
### MEDICAL SCHEDULE OF BENEFITS – PLAN B
(Effective January 1, 2018)

#### Deductible and Maximums

<table>
<thead>
<tr>
<th>Deductible (calendar year)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,600</td>
<td>$5,200</td>
</tr>
<tr>
<td>Family</td>
<td>$5,200</td>
<td>$10,400</td>
</tr>
</tbody>
</table>

All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount. The In-Network Deductible and Out-of-Network Deductible are separate and do not accumulate toward one another.

#### Maximum Out-of-Pocket Amount (calendar year)

| Individual | $5,000 | $10,000 |
| Family     | $10,000 | $20,000 |

All individual Maximum Out-of-Pocket amounts will count toward the family Maximum Out-of-Pocket amount, but an individual will not have to pay more than the individual Maximum Out-of-Pocket amount. Copayments do not accumulate to the Maximum Out-of-Pocket amount, except to the extent required by the Affordable Care Act. The In-Network Maximum Out-of-Pocket amount and Out-of-Network Maximum Out-of-Pocket amount are separate and do not accumulate toward one another.

#### Lifetime Benefit Maximum
(Plan pays a maximum benefit which includes both In-Network and Out-of-Network.)

#### Benefits for Covered Services

<table>
<thead>
<tr>
<th>Preventive Care Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exams/Well-Child Care</td>
<td>$0 Copayment per visit. Deductible does not apply.</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>$0 of Allowed Charge. Deductible does not apply</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Laboratory and X-ray</td>
<td>$0 of Allowed Charge. Deductible does not apply</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

(for mammograms, see Mammography section below)

<table>
<thead>
<tr>
<th>Physician Office Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>20% after Deductible, then $20 copayment</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Office Surgery</td>
<td>20% after Deductible, then $40 copayment</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Other Injections</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternity Physician Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Newborn Services</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>See &quot;Physician Services at a Facility other than the Office&quot; and &quot;Facility Services.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See &quot;Physician Services at a Facility other than the Office.&quot;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Services at a Facility other than the Office</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visits</td>
<td>20% after Deductible, then $20 PCP/$40 specialist copayment per visit</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Facility Visits</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility Visits</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Benefits for Covered Services</td>
<td>In-Network Covered Person Pays</td>
<td>Out-of-Network Covered Person Pays</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Emergency Services</strong> (Follow-up care obtained in the emergency room is not covered.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Physician</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>20% after Deductible, then $150 Copayment per visit</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>20% after Deductible, then $20 Copayment per visit</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Laboratory and X-ray Services</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Radiation Therapy and Chemotherapy</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Renal Dialysis Services</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Mammography</strong></td>
<td>0% of Allowed Charge. Deductible does not apply.</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility - (Covered Person is limited to 100 days per calendar year) (The In-Network and Out-of-Network days are combined.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Medical Equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Hearing Aid Devices (Plan pays a maximum benefit of $2,500 per calendar year.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitative Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation. (Covered Person is limited to 60 outpatient treatment visits per calendar year) (The In-Network and Out-of-Network visits are combined.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Preventative Physical Therapy for Multiple Sclerosis (Covered Person is limited to 60 outpatient treatment visits per calendar year) (The In-Network and Out-of-Network visits are combined.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Habilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Speech Therapy (for Pervasive Developmental Disorders) (Covered Person is limited to 20 visits per calendar year) (The In-Network and Out-of-Network visits are combined.)</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Benefits for Covered Services</td>
<td>In-Network Covered Person Pays</td>
<td>Out-of-Network Covered Person Pays</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Home Health Services</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><em>(Covered Person is limited to 60 visits per calendar year)</em> <em>(The In-Network and Out-of-Network visits are combined.)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Respite Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(Limited to 10 Respite Care days per calendar year)</em> <em>(The In-Network and Out-of-Network days are combined.)</em></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Organ and Tissue Transplants</strong></td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Cornea Transplants</strong></td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
</tr>
<tr>
<td><strong>Autism Spectrum Disorders</strong></td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
<td>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” and “Facility Services.”</td>
</tr>
<tr>
<td><strong>Infertility</strong></td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Physician Visits</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>20% after Deductible, then $20 PCP/ $40 specialist Copayment per visit</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Inpatient Physician Visits</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>20% after Deductible, then $20 PCP/ $40 specialist Copayment per visit</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Sexual Assault or Abuse – Exams and Treatment</strong></td>
<td>$0 Copayment for examination and treatment of injuries or trauma of a Covered Person who is the victim of an offense defined in the Illinois Criminal Code of 1961, Sections 12-13 through 12-16.</td>
<td>$0 Copayment for examination and treatment of injuries or trauma of a Covered Person who is the victim of an offense defined in the Illinois Criminal Code of 1961, Sections 12-13 through 12-16.</td>
</tr>
</tbody>
</table>
Spinal Manipulation/Chiropractic Services
(Plan pays a maximum benefit of $1,000 or 20 visits per calendar year.) (The In-Network and Out-of-Network dollar and visit amounts are combined.)

<table>
<thead>
<tr>
<th>Benefits for Covered Services</th>
<th>In-Network Covered Person Pays</th>
<th>Out-of-Network Covered Person Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug Benefit</td>
<td>See Next Page</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>All Other Covered Services</td>
<td>20% after Deductible</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

20% after Deductible, then $20 Copayment per visit
20% after Deductible, then $20 Copayment per visit
PRESRIPTION DRUG BENEFIT – PLAN B

31-Day Pharmacy Option (Copayments apply per prescription)

Generic drugs

Copayment ................................................................. $10 (Copayment applies after Deductible is satisfied)

Formulary Brand Name drugs

Copayment ................................................................. $40 (Copayment applies after Deductible is satisfied)

Non-Formulary Brand Name drugs

Copayment ................................................................. $70 (Copayment applies after Deductible is satisfied)

Specialty Drugs .......................................................... Subject to Plan Deductible and Coinsurance

90-Day Pharmacy Option (Copayments apply per prescription)

Generic drugs

Copayment ................................................................. $20 (Copayment applies after Deductible is satisfied)

Formulary Brand Name drugs

Copayment ................................................................. $80 (Copayment applies after Deductible is satisfied)

Non-Formulary Brand Name drugs

Copayment ................................................................. $140 (Copayment applies after Deductible is satisfied)

Note: Special copayment rules apply for participation in the MedTrak Script Choice, E-Script, and Copay Waiver programs. See the Prescription Drug Benefits Section for a description of the Step Therapy Program and the Co-Payment Assistance Program.
MAXI MEDICAL PLAN – PLAN C

The Maxi Medical Plan covers the same scope of benefits as Plan A or Plan B, plus 100% of drug plan deductibles or copayments. The Maxi Medical Plan does not apply a deductible, copayment, or co-insurance. Covered expenses are payable at 100% with no deductible, copayment, or dollar limit except on inpatient hospital bills, which are covered for the first calendar day of admission only (subsequent admissions are part of original admission if for related diagnosis). Covered Employees may elect the Maxi Medical Plan separately for themselves or their Dependents in lieu of the major medical coverage otherwise provided by the Plan at any time. An individual covered under the Maxi Medical Plan may elect to change to Plan A or Plan B benefits at any time. All other Plan A and Plan B benefits limits also apply.

MRP – MEDICAL REIMBURSEMENT PLAN – PLAN D

Covered Employees may elect the MRP separately for themselves or their Dependents in lieu of the major medical coverage otherwise provided by the Plan at any time. A Covered Person is covered under the major medical coverage provisions of the Plan unless an MRP election has specifically been made. A Covered Person in the MRP may elect to be covered under the major medical coverage provisions of the Plan during the Plan’s open enrollment period or if the Covered Person loses other group health coverage. The MRP will reimburse the Covered Person for all deductible, copayments, and coinsurance amounts payable under the Covered Person’s other group medical or prescription drug coverage. The MRP will also provide all preventive health services and emergency treatment required under the Affordable Care Act that are not payable by the other group health coverage. Benefits under the MRP are payable upon receipt of a copy of the other plan’s explanation of benefits or a copy of the prescription drug receipt showing the copayment amount.
ELIGIBILITY, FUNDING, EFFECTIVE DATE
AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer who meet the Eligibility Requirements for Employee Coverage.

Eligible Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she is a (1) an Employee who is not a member of a collective bargaining unit who is scheduled to work at least 30 hours per week and who is on the regular payroll of the Employer, (2) an Employee who is a member of a collective bargaining unit who has satisfied the eligibility requirements as set forth in the collective bargaining agreement covering that Employee, (3) a part-time Employee who works more than 60% of a full-time equivalent and who is covered by the teachers collective bargaining agreement. Temporary, seasonal, or other part-time employees are not eligible for coverage, or (4) a full-time Employee as defined by 26 USC 4980H(c)(4) during the Stability Period applicable to such Employee's full-time status.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse and children from birth to the limiting age of 26 years old; or less than 30 years old if a United States military veteran who (i) is an Illinois resident, (ii) has received a release or discharge other than a dishonorable discharge, and (iii) submits to the Claims Administrator a copy of a properly completed form DD2-14 “Certificate of release or Discharge from Active Duty.”

The term "Spouse" shall mean a party to a Marriage. A Marriage is either (i) a legal marriage union, or (ii) a legal relationship between 2 persons, of either the same or opposite sex, established or recognized as such by the Illinois Religious Freedom Protection and Civil Unions Act. The Plan Administrator may require documentation proving a Marriage.

The term "children" shall include natural children, stepchildren, adopted children, children placed with a covered Employee in anticipation of adoption, or children for whom the Employee or Spouse is responsible for health insurance pursuant to a court order or decree.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.
After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined, the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

**FUNDING**

**Cost of the Plan.** The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

**ENROLLMENT**

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application. A covered Employee must specifically enroll each Dependent.

**Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

**TIMELY OR LATE ENROLLMENT**

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.
If two Employees (who are Spouses) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late enrollments are not allowed unless made during an open enrollment period.

**SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

**SPECIAL ENROLLMENT PERIODS**

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in writing in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin on the date of the event described above.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to
individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual’s failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the date of marriage;

(b) in the case of a Dependent’s birth, as of the date of birth; or

(c) in the case of a Dependent’s adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Medicaid and CHIP. An eligible Employee and/or his eligible Dependents whose coverage under a Medicaid Plan under title XIX of the Social Security Act or under a state Child Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, may be eligible for coverage under this Plan. A request for enrollment must be made within 60 days of the date coverage ends.

Should an eligible Employee and/or his or her eligible Dependent become eligible for state premium assistance through Medicaid or a state Child Health Insurance Program (CHIP), he or she may have a right to enroll in this Plan. A request for enrollment must be made within 60 days of the date the Employee or Dependent is determined eligible for such assistance. Contact the Plan Administrator if you have questions regarding application of this provision.

Coverage will begin the date of the event described above.

(4) Employee Transfer Between Union and Non-Union Divisions. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll within 30 days of a transfer of the Employee to either the union or non-union division from the other division. Coverage will begin on the date of the transfer.
EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.
(2) The Active Employee Requirement.
(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent’s coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.
(2) The date the covered Employee’s Eligible Class is eliminated.
(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes or the last day of the Employee’s contract year if the Employee completes his service with the Employer. This includes death or termination of Active Employment of the covered Employee except as noted below. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or layoff, unless the Plan specifically provides for continuation during these periods.
(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
(5) The date of the covered Employee’s or former Employee’s death.

Leave of Absence.

(1) If the covered Employee is not actively working due to an approved leave of absence, the Employee will be eligible for continuation of coverage under the Plan by making the required contribution for the duration of the approved leave of absence.
(2) If the covered Employee is not actively working due to a “parental leave” as defined in the personnel administrative procedures of the Employer, the Employee will be eligible for continuation of coverage under the Plan by making the required contributions for the period of approved parental leave.
If the covered Employee is not actively working due to a "sabbatical leave" as defined in the personnel administrative procedures of the Employer, the Employee will be eligible for continuation of coverage under the Plan by making the required contributions for the period of approved sabbatical leave.

If the covered Employee is not actively working due to a leave of absence without pay as defined in the personnel administrative procedures of the Employer, the Employee will be eligible for continuation of coverage under the Plan by making the required contributions for the period of approved leave of absence.

Notwithstanding the Continuation Coverage Rights Under COBRA Sections, the commencement of COBRA shall begin following the approved absence in (1) through (4) above unless the next sentence applies. Notwithstanding the above, an Employee on a paid leave of absence shall be considered an Active Employee during the paid portion of the leave and the 90-day period thereafter, and the COBRA period shall commence at the conclusion of the 90-day period.

Rescission. The Plan has the right to rescind any coverage of the Employee and/or Eligible Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Plan may either void coverage for the Employee and/or Eligible Retirees and/or Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Eligible Retiree's and/or Dependent's paid contributions.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work and continues his COBRA coverage until he again becomes eligible for coverage as an Employee, any Pre-Existing Conditions Limitations provision will apply only to the extent it was in effect on the last day of COBRA coverage.

Retired Certified Employees. Employees whose employment with the Employer terminates due to retirement may continue coverage under the Plan until the date such Employees are eligible for Medicare, provided they pay any contributions required for coverage.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
A person who elects to continue health plan coverage is not required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

**Continuation During Illinois Municipal Retirement Fund Payments.** The following covered Employees and covered Dependents will have the right to continue coverage at the contribution level set by the Employer when an Employee's eligibility under this Plan ends:

1. a full-time Employee who is removed from the Employer's payroll due to retirement or disability, and who immediately becomes entitled to receive an Illinois Municipal Retirement Fund ("IMRF") pension or disability benefit;

2. the covered Dependents of such a retired or disabled Employee who are covered under the Plan on the day before such Employee is removed from the Employer's payroll; and

3. the surviving Spouse of such a retired or disabled Employee, but only if the Spouse:
   1. is covered under the Plan on the day before such Employee's death;
   2. is eligible for IMRF benefits; and
   3. elects to receive an IMRF surviving spouse pension (rather than a lump-sum death benefit).

Coverage under this Section may be continued until the earliest of:

1. the date the retired or disabled Employee:
   1. again becomes an active participant in IMRF;
   2. is convicted of an IMRF job-related in IMRF;
   3. dies; or
   4. fails to pay any required contribution for coverage;

2. the date a disabled Employee is no longer entitled to IMRF benefit payments or takes a separation refund;

3. the date a Spouse or child ceases to be an eligible Dependent;

4. the date the surviving spouse:
   1. remarries prior to age 55;
   2. dies; or
   3. fails to pay any required contribution for coverage; or

5. the date the Employer terminates medical coverage for all Employees.
Coverage for such retirees, disabled Employees and surviving spouses will be the same as for other Covered Persons and will be subject to any benefit changes or cost increases which take effect after the Employee is removed from the Employer's payroll. The retiree, disabled Employee or surviving spouse will be required to pay the required cost of Plan coverage by each due date.

Within 15 days after a full-time Employee retires, is removed from the Employer's payroll due to disability or dies, the Employer will:

(1) verify the Employee's or surviving spouse's eligibility for IMRF benefits; and
(2) send the Employee or surviving spouse a notice of this continuation privilege (including the cost for continued Plan coverage).

For a disabled Employee, this continuation right will apply only if, after reviewing his or her medical information, the IMRF determines that IMRF disability benefits are payable. For a surviving Spouse of a disabled Employee, this continuation right will apply only if the Spouse elects a monthly annuity (rather than a lump sum death benefit).

To continue Plan coverage, the retiree, disabled Employee or surviving Spouse must send the Employer written election and first payment within 31 days after receipt of notice or as otherwise required by the Employer. In some cases, the individual may sign written authorization for IMRF to deduct future monthly payments for the cost of Plan coverage from his or her recurring IMRF benefit payments. Coverage provided pursuant to this Section will run concurrent with any other continuation coverage offered or available under the Plan.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.
(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
(4) On the last day of the calendar month in which a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

OPEN ENROLLMENT

Dependents who are Late Enrollees will be able to enroll in the Plan during the open enrollment period. The open enrollment period is the 2-week period in November as determined by the Plan Administrator with any resultant change in coverage becoming effective on January 1st of the next year. If an employee does not submit a complete application for coverage under this Plan during the open enrollment period stated, such Dependent will not be able to enroll until the next annual open enrollment period unless the Dependent qualifies under this Plan's Special Enrollment Periods provision.
MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable by the Covered Person at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable by the Plan at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable by the Plan at 100% (except for the charges excluded) for the rest of the Calendar Year.

COVERED CHARGES

Covered charges are the Reasonable and Customary Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

2. **Coverage of Pregnancy.** The Reasonable and Customary Charges for the care and treatment of Pregnancy are covered the same as any other Sickness, except as described in the Schedule of Benefits.

3. **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

   (a) the patient is confined as a bed patient in the facility; and

   (b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

   (c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

4. **Physician Care.** The professional services of a Physician for surgical or medical services.
Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Reasonable and Customary Charge that is allowed for the primary procedures; 50% of the Reasonable and Customary Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered “incidental” and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Reasonable and Customary Charge for each surgeon’s primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Reasonable and Customary percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon’s covered charge will not exceed 20% of the surgeon’s Reasonable and Customary allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital’s Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person’s condition as being terminal, determined that the person is not expected to live more than 6 months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

(8) **Infertility.** Care, supplies, services and treatment which would correct malformation, disease or dysfunction resulting in infertility, of a Covered Person between the ages of 21 and 44. The infertility must not be caused by voluntary sterilization of either partner or hysterectomy. Covered charges include but are not limited to the following services or supplies:

- Ovulation Induction
- Artificial Insemination
- Ultrasound
- Post-Coital Test
- Semen Analysis
In-Vitro Fertilization (IVF)

Services not covered are the purchase of donor sperm or storage, purchase of donor eggs or any services associated with, cloning, gestational carrier programs, gamete intrafallopian tube transfers (GIFT), zygote intrafallopian tube transfers (ZIFT) and intracytoplasmic sperm injection, frozen embryo transfers, including transfers or any services and supplies obtained without pre-certification.

Infertility services must be precertified through AIMM.

(9) Other Medical Services and Supplies. These services and supplies not otherwise included in the items above are covered as follows:

(a) Allergy shots and allergy surveys.

(b) Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(c) Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(d) Cardiac Rehabilitation Services — Benefits will be provided for cardiac rehabilitation services only in approved programs when these services are rendered to you within a six month period following an eligible Inpatient Hospital admission for either myocardial infarction, coronary artery bypass Surgery or percutaneous transluminal coronary angioplasty.

(e) Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.

(f) Initial contact lenses or glasses required following cataract surgery.

(g) Rental of durable medical or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(h) Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint Syndrome (TMJ), except for ostectomy surgery.

(i) Laboratory studies.

(j) Treatment of Mental Disorders and Substance Abuse. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.), MSW, LCPC, or tax supported regional mental health center may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(k) Injury to or care of mouth, teeth and gums. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(l) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness, and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(m) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

- evaluating the organ or tissue;
- removing the organ or tissue from the donor; and
- transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Transplant benefits also include direct transportation costs of the Covered Person to receive transplant services.

(n) **Prosthetic Devices.** Coverage for prosthetic devices/customized orthotic devices includes (a) initial placement of a prosthetic or customized orthotic device and its supportive device, (b) maintenance and repair required for the successful use of the device, (c) replacement of a device when required by growth or change in medical condition, and (d) replacement of a device due either to wear and tear or to technological improvement and determined to be medically necessary.

(o) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function.

(p) **Prescription Drugs** (as defined).

(q) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(r) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.
This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

(s) Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning disorder.

(t) Spinal Manipulation/Chiropractic services by a licensed M.D., D.O. or D.C.

(u) Sterilization procedures.

(v) Surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations.

(w) Coverage of Well Newborn Nursery/Physician Care.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Reasonable and Customary Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery be cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Plan Administrator or AIMM.

Charges for Routine Physician Care. The benefit is limited to the Reasonable and Customary Charges made by a Physician for the first pediatric visit to the newborn child after birth while Hospital confined and charges for circumcision.
Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

\( x \) Charges associated with the purchase of wigs or artificial hairpieces needed as a result of chemotherapy or radiation when prescribed by a physician, limited to $250 per calendar year.

\( y \) Diagnostic x-rays.

(10) Out-Patient Self-Management Training and Education, equipment, supplies and foot care for the treatment of Type I diabetes, Type II diabetes, and gestational diabetes mellitus as follows:

\( a \) Covered medical supplies:

(i) blood glucose monitors;

(ii) blood glucose monitors for the legally blind;

(iii) cartridges for the legally blind; and

(iv) lancets and lancing devices.

\( b \) Covered pharmaceuticals and supplies:

(i) insulin;

(ii) syringes and needles;

(iii) test strips for glucose monitors;

(iv) FDA approval oral agents used to control blood sugar; and

(v) glucagon emergency kits.

Notwithstanding the foregoing, any item listed herein that is an eligible expense under the prescription drug card plan shall not be considered an eligible expense under this Section (EE).

\( c \) Regular foot care exams by a Physician and office visits to a Physician or certified, registered, or licensed health care professional with expertise in diabetes management.

(11) Additional Mandated Benefits. The following services and supplies:

\( a \) Mammograms.

(i) one baseline mammogram for women age 35 to 39; and (ii) one mammogram each year for women age 40 and older. For women under age 40 with a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors, screenings are covered at intervals considered Medically Necessary by the woman’s health care Provider. A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue is covered when Medically Necessary as determined by a Physician. When received from any provider, except a Non-Network Hospital, such services are reimbursed at 100% without application of the deductible. Expenses incurred for services rendered by a Non-Network Hospital are subject to the limitations listed on the Schedule of Benefits;

\( b \) Clinical breast examinations.

(i) at least once every 3 years for women ages 20 through 39; and
(ii) annually for women age 40 and over.

(c) An annual cervical smear or Pap smear test.

(d) An annual digital rectal examination and a prostate-specific antigen test, for males upon the recommendation of a Physician for:

(i) asymptomatic men age 50 and over;

(ii) African-American men age 40 and over; and

(iii) men age 40 and over with a family history of prostate cancer.

(e) Surveillance tests for ovarian cancer who are at risk for ovarian cancer.

(f) Coverage for all colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

(g) Coverage for shingles vaccines for Covered Persons age 50 and over.

(h) Coverage for diagnosis and treatment of autism spectrum disorders as required by Illinois law, for Covered Persons under age 21.

(i) Coverage for habilitative services for Covered Persons under age 19 with a congenital, genetic, or early acquired disorder as required by Illinois law. No coverage is available under the Plan for those services that are solely educational in nature or otherwise paid under State or federal law for purely educational services.

(j) Medically Necessary bone mass measurement and the diagnosis and treatment of osteoporosis.


(l) Human Papillomavirus vaccine (HPV).

(m) Amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary.

(n) Medically necessary preventative physical therapy for covered persons diagnosed with multiple sclerosis.

(o) Preventive Health Services.

(12) Genetic testing when Medically Necessary. Services must be precertified in accordance with the Cost Management Services Section.

(13) Treatment of gastric restrictive procedures for Morbid Obesity when Medically Necessary.
COST MANAGEMENT SERVICES

Cost Management Services Phone Number

AIMM
(877) 217-7695

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 72 hours in advance of services being rendered or within 72 hours after an emergency admission.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for inpatient hospitalizations.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card at least 72 hours before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator within 72 hours of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the penalty will be 10% of the covered charges up to $1,000 which will not apply to the deductible or out-of-pocket maximum.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

**CASE MANAGEMENT**

**Case Management.** The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital or Skilled Nursing Facility;
-- determining alternative care options; and
-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, and patient or patient's family must all agree to the alternate treatment plan.
Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

- Appendectomy
- Cataract surgery
- Cholecystectomy (gall bladder removal)
- Deviated septum (nose surgery)
- Hemorrhoidectomy
- Hernia surgery
- Hysterectomy
- Mastectomy surgery
- Prostate surgery
- Salpingo-oophorectomy (removal of tubes/ovaries)
- Spinal surgery
- Surgery to knee, shoulder, elbow or toe
- Tonsillectomy and adenoidectomy
- Tympanotomy (inner ear)
- Varicose vein ligation

Dialysis Treatment Cost Management Program

The dialysis treatment cost management program is a special cost containment program designed for patients requiring dialysis treatments. The Plan has entered into an agreement with Ethicare Advisors, Inc., a specialized cost management company, to manage dialysis costs. Ethicare Advisors must be contacted by your nephrologist and/or the dialysis treatment clinic providing services before the onset of treatment. Unless your nephrologist and/or dialysis treatment clinic has entered into an agreement with Ethicare Advisors, the payment for all drugs and dialysis treatment will be strictly limited to the reasonable and customary reimbursement rate as defined by the Plan and all other Plan limitations and exclusions.

For dialysis treatments, please contact Ethicare Advisors at (877) 218-1955 before treatment begins.
DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis, but excluding substitute workers regardless of number of hours worked.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

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

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, former Employee, or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is the Board of Education of Peoria Public School District #150.
Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

4. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.
Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.
Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. Where the most appropriate level of services is not available within 40 miles of the patient's residence for adolescent Mental Disorders and Substance Abuse, the next higher level of available services within that service area shall be considered Medically Necessary.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity means morbid obesity as defined by current medical based criteria as maintained by AIMM.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Out-Patient Self-Management Training and Education means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications and instruction in understanding nutrient needs relative to medically prescribed diets, including tube feedings, specialized intravenous solutions, and specialized oral feedings, and food and prescription drug interactions. Diabetes Self-Management Training and Education shall include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist,
Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Peoria Public School District #150 Group Health Care Plan, which is a benefits plan for certain Employees of the City of Peoria Public School District #150 and is described in this document.

Plan Participant is any Employee, former Employee, or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the next December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Health Services mean the following services when required to be provided by applicable law:

(1) Evidence based items or preventive services that have an "A" or "B" rating from the United States Preventive Services Task Force;
(2) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
(3) Evidence-informed preventive care services and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents;
(4) Additional Preventive care and screenings not described above as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for women; and
(5) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention, other than those issued in or around November 2009.

Preventative Physical Therapy is physical therapy that is prescribed by a Physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

Reasonable and Customary Charge means with respect to an in-network provider the in-network negotiated maximum charge amount. The Reasonable and Customary Charge means with respect to a non-network provider for non-emergency department treatment the lesser of the provider's billed charge or a reasonable compensation amount. The reasonable compensation amount is determined by Data iSight in accordance with its standard practices and procedures and based on one or more of the following:

(1) Using current publicly-available data reflecting fees typically reimbursed to providers for professional services, adjusted for geographical differences;
(2) Using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences plus a margin factor; or
(3) Using an amount negotiated with the provider for the specific services provided.

For emergency department treatment, the Reasonable and Customary Charge with respect to a non-network provider shall mean the greater of:

(1) The amount calculated using the above methodology;
(2) The median rate negotiated with in-network providers; or
(3) The fee paid by Medicare for the same services.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if: (i) the cancellation or discontinuance has only a prospective effect; or (ii) the cancellation or discontinuance is attributable to the failure to timely pay required contributions.

Sickness is a person's illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Stability Period means the applicable period of the Employer for purposes of 26 CFR 54.4980H-3.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.
PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Benefits.

For all Medical Benefits, a charge for the following is not covered:

(1) Abortion. Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

(2) Acupuncture. Services, care or treatment for acupuncture or hypnosis.

(3) Antisocial Actions. Expenses Incurred for behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness;

(4) Chelation therapy.

(5) Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(6) Cosmetic Surgery. Charges incurred in connection with cosmetic surgery, except to correct a condition resulting from accidental bodily injury or to correct a congenital anomaly in an eligible dependent born while one of the parents was covered under the Plan, except as stated herein with regard to breast reconstruction in connection mastectomy.

(7) Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(8) Educational or vocational testing. Services for educational or vocational testing or training, except as specifically stated herein.

(9) Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Reasonable and Customary Charge.

(10) Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(11) Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(12) Eye care. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations and examinations for astigmatism, myopia, and hyperopia, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(13) Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(14) Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(15) Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(16) HMO. Expenses denied by another health care plan or HMO for lack of pre-treatment approval, improper claim filing procedures or lack of additional Physician opinions.
(17) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs or artificial hairpieces needed as a result of chemotherapy or radiation when prescribed by a Physician.

(18) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(19) **Illegal act or crime.** Care or treatment sustained during the voluntary commission of an illegal act or crime.

(20) **Immunizations.** Immunizations, except as specifically provided herein.

(21) **IQ testing or educational training.**

(22) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(23) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(24) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(25) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(26) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(27) **Obesity.** Care and treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as specifically provided herein.

(28) **Occupational.** Care and treatment of an Injury or Sickness for which the Covered Person is entitled to benefits under any worker's compensation law or similar law.

(29) **Orphan drugs.**

(30) **Orthotics, including custom molded foot orthotics.**

(31) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(32) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(33) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(34) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
(35) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(36) **Self-Inflicted.** Any loss due to an intentionally self-inflicted injury. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(37) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(38) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(39) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(40) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, except as specifically provided herein.

(41) **Special Education.** Expenses Incurred for special education or training for learning disabilities.

(42) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(43) **Taxes.** Any taxes or other assessments owed with respect to Expense Incurred for medical services (other than sales tax).

(44) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance or transplant charges as defined as a Covered Charge.

(45) **Vitamins or dietary supplements, except for prenatal vitamins and vitamin D & K supplements when prescribed by a Physician.**

(46) **War.** Any loss that is due to a declared or undeclared act of war.

**PRESCRIPTION DRUG BENEFITS**

**Pharmacy Drug Charge**

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. MedTrak is the administrator of the pharmacy drug plan.

**Copayments**

The copayment is applied to each covered pharmacy drug charge and is shown in the schedule of benefits. The copayment amount is not a covered charge under the medical Plan. Any one pharmacy prescription is limited to a 31-day supply or, where requested, to a 90-day supply for retail or mail order maintenance medications.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.
Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Smoking deterrents as provided by MedTrak.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to refills only up to the number of times specified by a Physician but not to exceed 12 months.

Step Therapy Program

Prescription drug program benefits for certain expensive drugs are subject to the step therapy program in order to be covered by the Plan. In the step therapy program, drugs are grouped in categories, based on cost effectiveness:

Front-line drugs – the first step – are generic drugs proven safe, effective and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

Back-up drugs – Step 2 and Step 3 drugs – are brand name drugs. These are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs always cost more than front-line drugs.

Step Therapy means that certain prescriptions require the use (and treatment failure) of front-line drugs before coverage may be allowed for a prescription of a back-up drug. If you are taking a back up drug on May 1, 2017, and are compliant on your medication, you will not be required to try a front line drug.

When a prescription is submitted that is not for a front-line drug, your pharmacist will let you know, and your cost will be higher. If you prefer not to pay the full price for the drug prescribed, you or your pharmacist should contact your physician. Only your physician can approve and change your prescription to a first-step drug. Call MedTrak Services at 800-771-4648 to get examples of effective first-step drugs on your Plan to discuss with your physician. If your physician decides you need a different drug for medical reasons, he or she must call 800-771-4648 to request a Prior Authorization. A MedTrak representative will check your Plan’s guidelines to see if a Step 2 drug can be covered. If it can, you may pay a higher copayment than for a front-line drug. If it cannot be covered, you may need to pay the full price for the drug. Additional program details are available from MedTrak and the Claims Administrator.

Co-Payment Assistance Program

For certain classes of Specialty Drugs (e.g., medications treating conditions such as multiple sclerosis, rheumatoid arthritis, hepatitis c and antiretrovirals), if dispensed through a pharmacy in MedTrak’s Best-In-Class Specialty Pharmacy Network, and where the drug manufacturer offers one or more co-payment assistance programs to help pay for the cost of the prescription, a higher co-payment than the amounts listed on the previous page may be charged; but, any such excess amounts will be billed to the drug manufacturer for payment under the applicable co-payment assistance program, and you will not have to pay out-of-pocket any more than the previously stated co-payment amount set forth.

Expenses Not Covered

This benefit will not cover a charge for any of the following, except as required by law or the Affordable Care Act:

(1) Administration. Any charge for the administration of a covered Prescription Drug.
Appetite suppressants. A charge for appetite suppressants, dietary supplements or vitamin supplements, except as provided herein.

Consumed on premises. Any drug or medicine that is consumed or administered at the place where it is dispensed.

Devices. Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

Drugs used for cosmetic purposes. Charges for drugs used for cosmetic purposes, such as anabolic steroids, or medications for hair growth or removal.

Experimental. Experimental drugs and medicines, even though a charge is made to the Covered Person.

FDA. Any drug not approved by the Food and Drug Administration.

Growth hormones. Charges for drugs to enhance physical growth or athletic performance or appearance.

Injectable supplies. A charge for hypodermic syringes and/or needles (other than for insulin).

Inpatient medication. A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

Investigational. A drug or medicine labeled: "Caution - limited by federal law to investigational use".

Medical exclusions. A charge excluded under Medical Plan Exclusions.

No charge. A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

No prescription. A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or as required by the Affordable Care Act.

Orphan drugs.

Performance. Drugs to enhance physical or mental performance (e.g., anabolic steroids) without a defined underlying pathological cause.

Refills. Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

Sexual Dysfunction or impotence. A drug used for sexual dysfunction or impotence or to improve sexual performance or functioning.

Superstatins. Charges for PCSK9 inhibitors (superstatins).

Prior Authorization. Drugs for which MedTrak required preauthorization and that authorization is not obtained.

Lesser Charge. Drugs available from a provider at a cost less than available from MedTrak are covered only at the lesser cost.

Miscellaneous Drugs. Fluoride, homeopathic drugs, serum, toxoids and allergens.
HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must submit itemized statements to:

Consolciate, Inc.
2828 N. Monroe
P.O. Box 1088
Decatur, Illinois 62525-1088
217-423-7788
800-798-2422

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and
(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any Rescission or request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

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

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:
<table>
<thead>
<tr>
<th>Notification to claimant of benefit determination</th>
<th>72 hours</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Notification to claimant, orally or in writing</th>
<th>24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response by claimant, orally or in writing</td>
<td>48 hours</td>
</tr>
<tr>
<td>Benefit determination, orally or in writing</td>
<td>48 hours</td>
</tr>
</tbody>
</table>

**Ongoing courses of treatment, notification of:**

<table>
<thead>
<tr>
<th>Reduction or termination before the end of treatment</th>
<th>72 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determination as to extending course of treatment</td>
<td>24 hours</td>
</tr>
</tbody>
</table>

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

**Pre-Service Claim**

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

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

<table>
<thead>
<tr>
<th>Notification to claimant of benefit determination</th>
<th>15 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extension due to matters beyond the control of the Plan</td>
<td>15 days</td>
</tr>
</tbody>
</table>

**Insufficient information on the Claim:**

<table>
<thead>
<tr>
<th>Notification of</th>
<th>15 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response by claimant</td>
<td>45 days</td>
</tr>
<tr>
<td>Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim</td>
<td>5 days</td>
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</table>

**Ongoing courses of treatment:**

<table>
<thead>
<tr>
<th>Reduction or termination before the end of the treatment</th>
<th>15 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request to extend course of treatment</td>
<td>15 days</td>
</tr>
</tbody>
</table>

**Review of adverse benefit determination**

<table>
<thead>
<tr>
<th>15 days per benefit appeal</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reduction or termination before the end of the treatment</th>
<th>15 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request to extend course of treatment</td>
<td>15 days</td>
</tr>
</tbody>
</table>
Post-Service Claim

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

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

- Notification to claimant of benefit determination: 30 days
- Extension due to matters beyond the control of the Plan: 15 days
- Extension due to insufficient information on the Claim: 15 days
- Response by claimant following notice of insufficient information: 45 days
- Review of adverse benefit determination: 30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The Claim involved including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis code and the treatment code and their corresponding meanings; the Plan’s applicable standards; and, if an appeal, a discussion of the Plan’s decision.

2. The specific reason or reasons for the adverse determination.

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

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

5. A description of the Plan’s review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures.

6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan will provide the claimant, as soon as practicable, upon request, the diagnosis code and treatment code and their corresponding meanings. A request for these codes will not, in themselves, be considered an appeal.

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

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

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision to the Claims Administrator for consideration by the Plan Administrator. A claimant may submit written comments, documents, records, and other information relating to the Claim and if desired may present evidence and testimony regarding the Claim to the Plan Administrator. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The Plan will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim as soon as possible and sufficiently in advance of the date the appeal must be decided. Before the Plan can issue a final adverse benefit determination based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date the appeal must be decided.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

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

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination, nor the subordinate of any such professional. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be appropriately identified to the claimant.

The Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, personnel decisions, or other similar decisions, will not be based upon the likelihood that an individual will support the denial of benefits.

The Plan will further ensure that:

1. Any notice of adverse benefit determination or decision on appeal include information sufficient to identify the Claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code, and the treatment code and their corresponding meanings. A request for this information will not, in itself, be considered an appeal.
(2) In the case of a decision on appeal, the notice shall include a discussion of the decision.

(3) The Plan will provide a description of available internal appeals and external review processes, including how to initiate an appeal and the availability of and contact information for any assistance or ombudsman to assist individuals with internal claims and appeals and external review processes.

External Appeals

When a claimant receives an adverse benefit determination on appeal for a claim involving a medical judgment or for a Rescission, the claimant has 4 months after the date of receipt of a notice of the notice of denial of the appeal in which to file a request for an external review of the adverse benefit determination. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the 5th month following the receipt of the notice.

Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

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

(2) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(3) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process applicable law; and

(4) The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Plan must allow the claimant to perfect the request for external review within the 4-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan will take action against bias and to ensure independence. The Plan will contract with at least 3 IROs for assignments under the Plan and rotate claims assignments among them. In addition, the IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO must provide the following:

(1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(2) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

(3) Within 5 business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final
internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

(4) Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

(5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the Claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(a) The claimant's medical records;
(b) The attending health care professional's recommendation;
(c) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;
(d) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
(e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(f) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
(g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(6) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

(7) The assigned IRO's decision notice will contain:

(a) A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the Claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

A statement that judicial review may be available to the claimant; and

Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

**Expedited External Appeals**

The Plan shall allow a claimant to request an expedited external review of an adverse benefit determination if:

1. The adverse benefit determination involves an Urgent Care Claim of the claimant for which the timeframe for completion of an expedited internal appeal under the external review procedures would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

2. If the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan will complete the preliminary review of the request as for a standard external review and immediately notify the claimant of the claimant’s right to an expedited review.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements applicable to a standard external review above. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers the appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the Claim de novo and is not bound by any decisions or conclusion reached during the Plan’s internal claims and appeals process.

The Plan’s contract with the assigned IRO must require the IRO to provide notice of the final external review decisions, in accordance with the requirements applicable to a standard external review above, as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.
ASSIGNMENT NOT PERMITTED

Notwithstanding anything in the Plan to the contrary, except for the assignment to a service provider of the right to receive direct payment from the Plan for covered charges properly payable under the Plan for services or supplies rendered by the service provider, no assignment of the Plan or any rights or benefits thereunder by a Plan Participant shall be allowed, recognized, or effective against the Plan. The Plan Administrator may refuse to accept an assignment to a provider of the right to receive direct payment from the Plan if the Plan Administrator believes, in its discretion, that doing so would be helpful or advantageous to the Plan Participant, to the efficient administration of the Plan, or for litigation purposes.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes Medicare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Reasonable and Customary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child’s parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(f) For parents who were never married to each other, the rules apply as set out in subsection (e) above as long as paternity has been established.
If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Participant(s)” or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.
In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan’s discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan’s behalf and function as a trustee as it applies to those funds until the Plan’s rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

(1) The responsible party, its insurer, or any other source on behalf of that party.

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

(3) Any policy of insurance from any insurance company or guarantor of a third party.

(4) Workers’ compensation or other liability insurance company.

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)’ and/or the Plan’s name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien
which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interfere with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

2. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.
Excess Insurance

If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant(s)/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Victims' Economic Security and Safety Act

An Employee who takes a leave of absence that qualifies under the Victim's Economic Security and Safety Act (820 ILCS 180/1) ("VESSA") shall be entitled to maintain coverage under the Plan for the employee and all Dependents covered by
the Plan on the day before the leave of absence for the duration of the VESSA leave, provided that the Employee pays any contributions to the employer required by the Employer for continuation of such coverage. All other Plan provisions apply to Covered Persons on VESSA leave.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Peoria Public School District #150 Group Health Care Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Board of Education City of Peoria Public School District #150 Group Health Care Plan, 3202 N. Wisconsin Ave., Peoria, Illinois 61603. COBRA continuation coverage for the Plan is administered by Consociate, Inc., 2828 N. Monroe, P.O. Box 1068, Decatur, Illinois 62525-1068, 217-423-7788 or 800-798-2422. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

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

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

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

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

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.
An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

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

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

1. The death of a covered Employee.

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

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

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

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

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

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

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

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

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

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

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

(1) the end of employment or reduction of hours of employment,
(2) death of the employee,
(3) commencement of a proceeding in bankruptcy with respect to the employer, or
(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

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

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

Consociate, Inc.
2828 N. Monroe
P.O. Box 1068
Decatur, Illinois 62525-1068
217-423-7788
800-798-2422

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

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

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

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

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

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

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

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

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

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 16- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

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

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a qualified Beneficiary’s COBRA continuation coverage as of the first day of any period for which timely payment is not made.

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

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

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

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

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBOA beneficiaries.
under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Peoria Public School District #150 Group Health Care Plan is the benefit plan of the Board of Education City of Peoria Public School District #150, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of applicable law. An individual may be appointed by the Board of Education City of Peoria Public School District #150 to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Board of Education City of Peoria Public School District #150 shall appoint a new Plan Administrator as soon as reasonably possible.

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

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

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.
(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
(3) To decide disputes which may arise relative to a Plan Participant's rights.
(4) To prescribe procedures for filing a claim for benefits and to review claim denials.
(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
(6) To appoint a Claims Administrator to pay claims.
(7) To perform all necessary reporting as required by applicable law.
(8) To establish and communicate procedures to determine whether a medical child support order is qualified.
(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

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

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

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

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

3. in accordance with the Plan documents to the extent that they agree with applicable law.

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

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

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

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

2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

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

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The members of Employer's workforce with Plan responsibilities are designated as authorized to receive Protected Health Information from Peoria Public School District #150 Group Health Care Plan ("the Plan") in order to perform their duties with respect to the Plan.

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

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

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

3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

**FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

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

The level of any Employee contributions will be set by the Plan Administrator. The current contributions required of Employees are based on the contract schedule referenced in the applicable collective bargaining agreement or other Employer notice. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

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

**PLAN IS NOT AN EMPLOYMENT CONTRACT**

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

**CLERICAL ERROR**

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

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.
AMENDING AND TERMINATING THE PLAN

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

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

PLAN NAME

Peoria Public School District #150 Group Health Care Plan

PLAN NUMBER: 150

TAX ID NUMBER: 37-6001759

PLAN EFFECTIVE DATE: October 1, 2003

EFFECTIVE DATE OF PLAN RESTATEMENT: May 1, 2017

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Board of Education City of Peoria Public School
District #150
3202 N. Wisconsin Avenue
Peoria, Illinois 61603
(309) 672-6770

PLAN ADMINISTRATOR

Board of Education City of Peoria Public School
District #150
3202 N. Wisconsin Avenue
Peoria, Illinois 61603
(309) 672-6770

AGENT FOR SERVICE OF LEGAL PROCESS

David N. Schellenberg
Elias, Megginnes, Riffle & Seghetti, P.C.
416 Main Street
Suite 1400
Peoria, Illinois 61602
(309) 372-6376

Note: Service of process may also be made upon the Plan Administrator or Claims Administrator.
CLAIMS ADMINISTRATOR
Consociate, Inc.
2828 N. Monroe
P.O. Box 1068
Decatur, Illinois 62526-1068
271-423-7788
800-798-2422

BY THIS AGREEMENT, Peoria Public School District #150 Group Health Care Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Board of Education, City of Peoria Public School District #150 on or as of the day and year first below written.

By

[Signature]
Board of Education City of Peoria Public School District #150

Its, Chief Financial Officer

Date 8-25-17

517-106.1
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekdsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebba.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA - Medicaid</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447</td>
<td>Website: <a href="http://filmcaidigiphrecovery.com/hipp/">http://filmcaidigiphrecovery.com/hipp/</a> Phone: 1-877-357-3268</td>
<td></td>
</tr>
<tr>
<td>ALASKA - Medicaid</td>
<td>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</td>
<td></td>
</tr>
<tr>
<td>ARKANSAS - Medicaid</td>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-655-MyARHIPP (655-692-7447)</td>
<td></td>
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</tr>
<tr>
<td>IOWA - Medicaid</td>
<td></td>
<td>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> Phone: 1-888-346-6562</td>
<td></td>
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<tr>
<td>State</td>
<td>Medicaid Services</td>
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</tbody>
</table>
| Kansas | Website: http://www.kcheks.gov/hcf/  
        Phone: 1-785-296-3612 |
| Kentucky | Website: http://chfs.ky.gov/dms/default.htm  
            Phone: 1-800-635-2670 |
| Louisiana | Website: http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331  
            Phone: 1-888-695-2447 |
| Maine | Website: http://www.maine.gov/dhhs/sofi/public-assistance/index.html  
        Phone: 1-800-442-6003  
        TTY: Maine relay 711 |
| Massachusetts | Website: http://www.mass.gov/eoghs/gov/departments/masshealth/  
               Phone: 1-800-462-1120 |
| Minnesota | Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp  
             Phone: 1-800-657-3739 |
| Missouri | Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm  
            Phone: 573-751-2005 |
| Montana | Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP  
          Phone: 1-800-694-3084 |
| Nebraska | Website: http://dhns.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx  
           Phone: 1-855-632-7633 |
| Nevada | Medicaid Website: https://cwss.nv.gov/  
         Medicaid Phone: 1-800-992-0900 |
               Phone: 603-271-5218 |
| New Jersey | Medicaid Website: http://www.state.nj.us/humanservices/dmhs/ clients/medicaid/  
              Medicaid Phone: 609-631-2302  
              CHIP Website: http://www.njfamilycare.org/index.html  
              CHIP Phone: 1-800-701-0710 |
| New York | Website: https://www.health.ny.gov/health_care/medicaid/  
            Phone: 1-800-541-2831 |
| North Carolina | Website: https://nccdmhncdhhs.gov/  
                Phone: 919-855-4100 |
| North Dakota | Website: http://www.nd.gov/dhs/services/medicaidsv/medicaid/  
               Phone: 1-844-854-4825 |
| Oklahoma | Website: http://www.insureoklahoma.org  
           Phone: 1-888-365-3742 |
| Oregon | Website: http://healthcare.oregon.gov/Pages/index.aspx  
         http://www.oregonhealthcare.gov/index-es.html  
         Phone: 1-800-699-5075 |
| Pennsylvania | Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm  
              Phone: 1-800-692-7432 |
| Rhode Island | Website: http://www.esohhs.ri.gov/  
                Phone: 401-462-5300 |
| South Carolina | Website: https://www.scdhhs.gov  
                 Phone: 1-888-549-0820 |
### SOUTH DAKOTA - Medicaid
- Website: [http://dss.sd.gov](http://dss.sd.gov)
- Phone: 1-866-828-0059

### WASHINGTON - Medicaid
- Website: [http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program](http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program)
- Phone: 1-800-562-3022 ext. 15473

### TEXAS - Medicaid
- Website: [http://gethealthtexas.com/](http://gethealthtexas.com/)
- Phone: 1-800-440-0483

### WEST VIRGINIA - Medicaid
- Website: [http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx](http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx)
- Phone: 1-877-596-5620, HMS Third Party Liability

### UTAH - Medicaid and CHIP
- Medicaid Website: [https://medicaid.utah.gov/](https://medicaid.utah.gov/)
- CHIP Website: [http://health.utah.gov/chip](http://health.utah.gov/chip)
- Phone: 1-877-543-7689

### WISCONSIN - Medicaid and CHIP
- Website: [https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf](https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf)
- Phone: 1-800-362-3002

### VERMONT - Medicaid
- Website: [http://www.greenmountaincare.org/](http://www.greenmountaincare.org/)
- Phone: 1-800-250-8427

### WYOMING - Medicaid
- Website: [https://wyequalitycare.acs-inc.com/](https://wyequalitycare.acs-inc.com/)
- Phone: 307-777-7531

### VIRGINIA - Medicaid and CHIP
- Medicaid Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)
- Medicaid Phone: 1-800-432-5924
- CHIP Website: [http://www.coverva.org/programs_premium_assistance.cfm](http://www.coverva.org/programs_premium_assistance.cfm)
- CHIP Phone: 1-855-242-6282

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To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
www.dol.gov/agencies/ebsa  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
www.cms.hhs.gov  
1-877-267-2323, Menu Option 4, Ext. 61565