PEORIA PUBLIC SCHOOL DISTRICT #150
GROUP HEALTH CARE PLAN

SECOND AMENDMENT

This Second Amendment to the Peoria Public School District #150 Group Health Care Plan ("Plan") is made in duplicate at Peoria, Illinois, on the date noted below, by the Board of Education City of Peoria Public School District #150 ("Employer").

WHEREAS, the Plan grants the Employer the right to amend the provisions of the Plan, and

WHEREAS, the Employer desires to make such amendments;

NOW, THEREFORE, the Plan is hereby amended as follows effective January 1, 2014, except where specifically indicated to the contrary:

1. The fourth to the last paragraph of the MEDICAL BENEFITS Section is hereby revised to read as follows:

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 location.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

2. The Deductibles payable by Plan Participants Section is hereby revised to read as follows:

**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 apply towards the 100% maximum out-of-pocket payment.
3. Effective January 1, 2015, the Deductible and Maximums Sections of the MEDICAL SCHEDULE OF BENEFITS – PLAN A is hereby revised to read as follows:

<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>$2,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
<td>$12,000</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.)

4. Effective January 1, 2015, the Emergency Services Section of the MEDICAL SCHEDULE OF BENEFITS – PLAN A is hereby revised to read as follows:

**Emergency Services**

*(Follow-up care obtained in the emergency room is not covered.)*

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>20% after Deductible</td>
<td>20% after Deductible</td>
</tr>
<tr>
<td>Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 Copayment per visit after Deductible</td>
<td>$150 Copayment per visit after Deductible</td>
</tr>
</tbody>
</table>
5. Effective January 1, 2015, the PRESCRIPTION DRUG BENEFIT – PLAN A Section is hereby revised to read as follows:

**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, Tablet Splitting, and Copay Waiver programs.

6. The Eligibility Requirements for Employee Coverage Section is hereby revised to read as follows:

**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, or (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.

7. The DEDUCTIBLE Section is hereby revised to read as follows:

**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.

8. Subsection (8) of the COVERED CHARGES Section is hereby revised to read as follows:

**(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.
BOARD OF EDUCATION CITY OF PEORIA PUBLIC SCHOOL
DISTRICT #150

By: 

Its: CHIEF FINANCIAL OFFICER