Second Amendment of
Community Unit School District #200
Health Care Plan

WHEREAS, Community Unit School District #200 (the "District") maintains the Community Consolidated School District #200 Health Care Plan (the "Plan"); and,

WHEREAS, amendment of the Plan is now considered desirable;

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

1. Effective September 1, 2004: by adding the following limitations under the section "Schedule of Health Care Benefits – Maximum Benefits Payable by the Plan":

"Chiropractic Care	Benefits are limited to a maximum of $2,000 per person per calendar year.
Naprapathic Care	Benefits are limited to a maximum of $2,000 per person per calendar year."

2. By modifying the following provisions under the section "Eligible Health Care Expenses":

   a. effective September 1, 2002 - restate the first paragraph on page 12 as follows to remove references to the requirement that the expense be Medicare eligible:

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

b. effective September 1, 2002 – restate item 16 on page 16 as follows:

"16. Durable Medical Equipment –

rental of durable medical equipment. Benefits will also be provided for the purchase of durable medical equipment if it can be shown that long-term use is planned and purchase is likely to cost less than monthly rental, or that the equipment cannot be rented. 'Durable Medical Equipment' means equipment that is (a) prescribed by a physician in conjunction with an illness or injury for use in your home; (b) can withstand repeated use; and, (c) is eligible under Medicare;"

3. By modifying the section "Health Care Exclusions" as follows:

a. effective September 1, 2002 – restate items 17, 33, 38 and 40 as follows –

"17 Illegal Acts –

services or supplies rendered to treat an illness or injury sustained as the result of engaging in an illegal act or occupation, or by committing or attempting to commit any crime, felonious act or aggravated assault, or actively participating in a violent disorder or riot. "Actively participating" does not include being at the scene of a violent disorder or riot while performing his or her official duties. However, this exclusion will not apply if injuries are sustained during an act of domestic violence or as a result of a diagnosed illness, including Mental or Nervous Disorder or an Alcohol or Drug Dependency;

33. Self-Inflicted –

services or supplies rendered in conjunction with the treatment of an intentionally self-inflicted injury or injury committed while sane or insane, including an injury or illness resulting from an assisted suicide. However, this exclusion will not apply if injuries are sustained during an act of domestic violence or as a result of a diagnosed illness, including Mental or Nervous Disorder or Alcohol or Drug Dependence;

38. War -

services and supplies received for any illness or injury occurring as a result of war or an act of war or caused during service in the armed forces of any country. 'War' means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature;

40. Work Related –

services or supplies for an injury or illness arising out of, any occupation for wage or profit, or for which the individual is eligible for benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law, whether or not such policy is actually in force and whether or not such benefits are received by the covered person."

b. effective September 1, 2002 – by adding the following –

"41. Court Ordered Confinement –

expenses incurred during any period a covered person is confined for any reason in a jail, prison, correctional institution, or in the covered person's home if such confinement is ordered by a court of competent jurisdiction and the covered person's behavior during this period is constantly being monitored by the court. However, a covered person will not be considered 'confined' during a court ordered period of probation following confinement in a jail, prison, correctional institutional or his/her home;"

4. Effective September 1, 2002: by restating item 3 under the section "Coordination With Other Plans" as follows:

"3. if a child is covered under more than one plan and the parents are not separated or divorced, the father's plan is the primary plan. If an irresolvable conflict should arise between the two plans because the other plan has a rule based on the birthday of the parents, the claims administrator, acting on behalf of the Plan Sponsor, shall have the authority to resolve such dispute by superseding the gender rule and using the other plan's rule in determining the order of benefits;"

5. Effective September 1, 2002: by restating the section "The Preferred Provider Organization Network" as follows:

"**The Preferred Provider Organization Network**

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

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

- Dreyer Medical Clinic and
  Dreyer Ambulatory Surgery Center – Aurora, Illinois
- University of Chicago Hospital and Health System.

When you or a covered dependent receive treatment from a PPO provider for services and supplies covered under the Plan you will receive a discount from the provider for charges incurred and will also be eligible to receive the maximum benefit payable under the Plan. There will likely be changes in the providers participating in the network from time to time. Therefore, you are urged to check with your hospital, physician or other service provider before undergoing treatment to make certain of their current participation status."

6. Effective September 1, 2002: by restating the following provisions under the section "When Coverage Terminates":

   a. restate the second paragraph of the subsection "Effective Date of Termination for Employees" as follows:

      "If your active employment ends because you begin a family, medical or military leave of absence, your coverage may be continued as follows:

      - Family or Medical Leave -

        If you are eligible for continued coverage based on the provisions of the Family and Medical Leave Act of 1993 (FMLA), coverage will continue as so required provided you agree to make the required contributions. An FMLA leave will be integrated with any other continuation to which you may otherwise be eligible, other than COBRA. Termination of the coverage continuation provided under FMLA or your failure to return from leave will be considered a 'qualifying event' under COBRA. If you waive coverage continuation during an FMLA leave, coverage for you (and any dependent covered prior to your leave) will be reinstated at 12:00 A.M. on the first day you return to the District as an eligible employee. The pre-existing condition limitation of coverage will apply to the extent that you (or your dependent) satisfied the limitation-waiting period prior to beginning the leave. If the pre-existing condition limitation-waiting period was satisfied prior to your leave, you (or your dependent) will not have to meet a new waiting period. However, if the pre-existing condition waiting period was not satisfied prior to your leave, the remaining portion of the waiting period will need to be satisfied by that individual upon reinstatement of coverage. The limitation will only apply to conditions that were considered to be pre-existing prior to the FMLA leave.

- Military Leave -

  If you begin a military leave and are eligible for continued coverage based on the provisions of the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) or Chapter 105 of the Illinois Compiled Statutes section 5/10-20.7b, coverage will continue as so required provided you agree to make the required contributions. A military leave will be integrated with any other continuation to which you may otherwise be eligible. If you waive coverage continuation during a qualified military leave, coverage for you (and any dependent covered prior to your leave) will be reinstated at 12:00 A.M. on the first day you return to the District as an eligible employee. The pre-existing condition limitation waiting period, and any other plan exclusion or waiting period, will be applied to you (or your dependent) as if your coverage has not terminated as a result of the military leave. Therefore, if the pre-existing condition limitation-waiting period was satisfied prior to your leave, you (or your dependent) will not have to meet a new waiting period. If the pre-existing condition waiting period was not satisfied prior to your leave, the remaining waiting period will continue to be reduced while on a protected military leave as if your coverage had continued during the leave."

b. restate the subsection "Effective Date of Termination for Dependents" as follows:

"**Effective Date of Termination for Dependents**.

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

1. <u>if you should die while enrolled for Family coverage, the last day of the calendar month in which your death occurs;</u>
2. for a spouse –
   a. the last day of the calendar month in which you become legally separated or divorced; or,
   b. if you are an active employee, the day on which your spouse makes a written election to be covered by Medicare for Health coverage instead of the Plan;
3. for a child:
   a. who is not a full-time student at an accredited school or college, the last day of the calendar month in which he or she attains age 19; or,

b. who is a full-time student at an accredited school or college, the last day of the calendar month in which he or she –

(1) attains age 25;

(2) graduates or is no longer enrolled and in attendance as a full-time student in an accredited school, college or university. A child will be considered a full-time student through any scheduled breaks between academic quarters or semesters prior to graduation including summer vacation, except that if the child does not return to an accredited school or college after the break, his or her student status will be considered terminated as of 11:59 P.M. on the last day of the academic quarter or semester that ended prior to the break; or,

c. the day on which he or she marries; or,

d. the last day of the calendar month in which he or she ceases to be financially dependent upon you for support and maintenance (unless you are required to provide coverage for the child through a court order or divorce decree); or,

e. the last day of the calendar month in which you are relieved of a court-order obligation to furnish health care coverage for the child;

4. if you request that your contributions for Family coverage be stopped, the last day of the period for which your contribution for Family coverage has been made; or,

5. the day on which your spouse or child begins active duty in the Armed Forces of any country.

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

You and/or your dependents may have the opportunity to continue coverage under the Plan for a period of time beyond the normal termination date. More information about extension of coverage is provided in the sections "Continuation of Coverage for Dependents of Active Employees", "Continuation of Coverage for Employees Participating in the Illinois Municipal Retirement Fund" and "Extension of Coverage Under COBRA".

7. Effective January 1, 2004: by restating the subsection "Continuation of Coverage for a Handicapped Child" as follows:

"Continuation of Coverage for a Handicapped Child

As stated under the section 'Who is Eligible for Coverage', the Plan's age/student status requirement will be waived for a child who is unable to support himself or herself because of a physical or mental handicap. The dependent child must meet all of the eligibility requirements other than age to continue to be eligible. For example, if the dependent marries, he or she will no longer have coverage under the Plan. Also, you must continue to make any required contributions. If your coverage terminates, if you stop your contributions for Family coverage, or if the Plan is ended, coverage for the dependent will end.

Proof of incapacity must be submitted to the Business Office within 60 days following the date the child will no longer be eligible because of age, and at reasonable intervals thereafter. You will have a period of 60 days to provide any information requested to support your dependent's eligibility under this provision. If you fail to provide the requested information within the 60-day period, coverage for your dependent will terminate."

8. Effective January 1, 2004: by restating item 1.,b. under the section "Extension of Coverage Under COBRA – When COBRA Continuation Coverage Will End" as follows:

"b. if, while continuing coverage during the initial 18- or 29-month periods defined above, a former employee dies or divorces or a child ceases to meet the eligibility requirement (referred to as a 'second Qualifying Event'), the affected dependent Qualified Beneficiary may be eligible to extend COBRA continuation coverage from 18 to 36 months. The affected dependent must notify the Business Office and/or claims administrator within 60 days following the occurrence of the second Qualifying Event and make their written election to extend COBRA continuation coverage within 60 days of the date he or she is formally notified of their right. This second Qualifying Event provision does not include a former employee's entitlement to Medicare. In the event a former employee becomes entitled to Medicare after the date COBRA continuation coverage is elected, the former employee will no longer be eligible for COBRA continuation coverage. However, this event will not end or extend a dependent Qualified Beneficiary's eligibility for the remaining duration of the 18-month continuation; or,"

9. Effective September 1, 2002: by adding the following section under the "Miscellaneous Administrative Provisions":

"Unclaimed Payments

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

I, _____, hereby certify that the foregoing is a correct copy of the amendment duly adopted by Community Unit School District #200 and that the amendment has not been changed or repealed.

Dated this _____ day of _____, 2004.

_____
Signature and Title

First Amendment of
Community Unit School District #200
Health Care Plan

WHEREAS, Community Unit School District #200 (the "District") maintains the Community Consolidated School District #200 Health Care Plan (the "Plan"); and,

WHEREAS, amendment of the Plan is now considered desirable;

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

1. Effective January 1, 2004: By adding the following provision under the section "Eligible Health Care Expenses":

   "45. Contraceptive Services –

   outpatient contraceptive services and outpatient drugs and devices approved by the Food and Drug Administration. "Outpatient contraceptive services" mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy, including natural family planning. However, eligible expenses do not include charges incurred in conjunction with an elective abortion."

2. By modifying the section "Health Care Exclusions" as follows:

   a. effective January 1, 2004 - eliminate item 2, Birth Control Pills;

   b. effective March 3, 2004 – by <u>adding the following</u> –

      "42. Surgicore –

      any services received from Surgicore, Inc., 10547 Ewing Avenue, Chicago, IL (TIN 36-3567890)."

3. Effective February 18, 2003: by restating the section "Continuation of Coverage for Employees Participating in the Illinois Municipal Retirement Fund (IMRF)" as follows:

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

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

1. you retire directly from active service with the District with an attained age and accumulated creditable service which qualify for immediate receipt of retirement pension benefits under Article 7 of the Illinois Pension Code; or,
2. you become disabled and are eligible and approved to receive disability benefits under Article 7 of the Illinois Pension Code immediately following completion of the 31-day period following the date of disability.

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

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

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

Pursuant to the Department of Insurance ruling dated February 18, 2003, Medicare entitlement will no longer cease your eligibility for IMRF coverage continuation. However, the Plan will coordinate its benefits with Medicare as described in the section "Benefits for Persons Eligible for Medicare".

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

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

Pursuant to the Department of Insurance ruling dated February 18, 2003, Medicare entitlement will no longer cease your eligibility for IMRF coverage continuation. However, the Plan will coordinate its benefits with Medicare as described in the section "Benefits for Persons Eligible for Medicare".

Continuation of Coverage Following the Death of an IMRF Pension Recipient

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

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

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

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

5. the day the Plan is ended.

Pursuant to the Department of Insurance ruling dated February 18, 2003, Medicare entitlement will no longer cease your dependents' eligibility for IMRF coverage continuation. However, the Plan will coordinate its benefits with Medicare as described in the section "Benefits for Persons Eligible for Medicare".

I, _____, hereby certify that the foregoing is a correct copy of the amendment duly adopted by Community Unit School District #200 and that the amendment has not been changed or repealed.

Dated this _____ day of _____, 2004.

_____
Signature and Title

COMMUNITY UNIT SCHOOL DISTRICT #200

Health Care Plan

Benefit Booklet/Plan Document

Amended and Restated Effective September 1, 2002

Table of Contents

Page

Notice to Plan Participants

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

Please refer to the section, "Hospital Pre-Admission Certification and Continued Stay Review Program" beginning on page 31 for an explanation of this program.

Note: If you (or your dependent) do not contact Hines & Associates prior to a scheduled hospital confinement (or within 48 hours following an emergency admission or maternity admission), benefits payable under the Plan are reduced by 10%, up to a maximum penalty of $1,000 per confinement. This benefit reduction does not apply to the Plan overall out-of-pocket limit.

Introduction

This document describes the coverage provided under the Community Unit School District #200 Health Care Plan (the "Plan) which includes a Preferred Provider Organization (PPO) network and a Prescription Drug Program.

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

This document, and the benefits described within it, is intended to supersede all previously distributed materials. However, any benefit previously paid to a covered person under the Plan maintained prior to September 1, 2002 (including any deductible or out-of-pocket amounts satisfied by that person) will be applied towards the limits described in this document.

Although we expect to continue the coverage described, we necessarily reserve the right to either modify or discontinue the benefits under the Plan at any time. You will be notified in writing of any material changes to the Plan.

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

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

Health Care Benefits

Schedule of Health Care Benefits

Benefits for the Eligible Expenses described beginning on page 12 are provided based on the schedule outlined.

If you obtain services through a Preferred Provider, expenses incurred with the provider will be discounted based on the negotiated agreement with the Preferred Provider Organization (PPO). You will be eligible to receive the maximum co-insurance payable under the Plan only when services or supplies are provided by a PPO network provider. When treatment is rendered at a hospital, facility or physician's office participating in the PPO network, all Out-of-Network services rendered which you or your dependent could not choose will also be reimbursed at the In-PPO Network benefit level. Examples of these services include Emergency Room physician services, radiology, pathology, and anesthesiology charges.

A listing of hospitals, physicians and other service providers participating in the PPO network is available from the Benefits Office, by calling the PPO, or by accessing them through their Website. Please refer to the section Preferred Provider Organization for additional information.

MAXIMUM BENEFITS PAYABLE BY THE PLAN

All Eligible Expenses:

Active Employees and Retirees who Retired after to September 1, 1994	Except as noted below, benefits are unlimited
Retirees who Retired prior to September 1, 1994	Upon attainment of age 65, the maximum benefit payable while covered under the Plan is $10,000 per person.
Alcohol/Substance Abuse	The overall maximum benefit payable while covered under the Plan is $50,000 per person. However, the maximum expense eligible for outpatient treatment limited to 25 visits per person per calendar year.
Infertility	The maximum benefit payable while covered under the Plan is $20,000 per person.
Mental or Nervous Disorders	Eligible expenses are limited to a maximum of: • 20 days per person per calendar year for treatment rendered on an inpatient basis or through a Partial Hospitalization Treatment program. When treatment is rendered through a Partial Hospitalization Treatment program, 2 days of treatment will be counted as 1 day; and, • 25 visits per person per calendar year for outpatient treatment (other than through a Partial Hospitalization Treatment program).

DEDUCTIBLE AND OUT-OF-POCKET LIMIT

Deductible

The deductible is the first $250 of eligible expenses incurred per person per calendar year, limited to an accumulated family maximum deductible of $750 per family per calendar year.

Expenses incurred and applied toward the deductible during the last 3 months of the calendar year (October, November and December) will be carried over and also applied toward the deductible for the following calendar year.

In addition, if 2 or more family members sustain injuries as a result of the same accident, only 1 deductible will need to be satisfied for charges incurred in connection with the accident.

Out-of-Pocket Limit

The "Out-of-Pocket Limit" is the maximum amount you will be required to pay as a result of your deductible and co-insurance for eligible expenses incurred each calendar year. The Out-of-Pocket Limit is $1,500 per person per calendar year, up to a maximum of $3,000 per family per calendar year.

The Out-of-Pocket Limit does **not** include:

- charges which are in excess of the reasonable and customary amount;
- excluded charges;
- charges incurred in excess of any maximum benefit listed in the Plan;
- charges incurred for the treatment of Alcohol/Substance Abuse, Mental or Nervous Disorders and Infertility (unless specifically noted for prescription drugs); and,
- any penalty applied towards hospital expenses incurred in conjunction with a confinement which is not pre-certified under the "Hospital Pre-Admission Certification" program.

BENEFITS FOR ELIGIBLE EXPENSES

Medical and Surgical Expenses

	In-PPO Network	***Out of PPO Network***
Hospital, Physician and All Other Eligible Expenses	After the calendar year deductible is satisfied, 90% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.	After the calendar year deductible is satisfied, 80% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.

The Out-of-Pocket limit does not apply for expenses incurred in conjunction with the treatment of Infertility.

When treatment is rendered at a hospital, clinic or physician office participating in the Network, benefits for services rendered by a Non-Network provider which the patient could not choose will be paid at the PPO benefit. Examples of these services include Emergency Room physician services, radiology, pathology, and anesthesiology charges.

Note: If you or your dependent do not comply with the Hospital Pre-Admission notification procedures described beginning on page 31, benefits payable under the Plan are reduced by 10%, up to a maximum penalty of $1,000 per confinement. Expenses reduced as a result of this penalty do not apply towards the Out-of-Pocket limit.

BENEFITS FOR ELIGIBLE EXPENSES (continued)

Treatment of Alcohol and Substance Abuse

	In-PPO Network	***Out-of-PPO Network***
Inpatient Services/ Partial Hospitalization	After the deductible is satisfied, 90% of eligible expenses incurred. The Out-of-Pocket limit does not apply.	After the deductible is satisfied, 80% of eligible expenses incurred. The Out-of-Pocket limit does not apply.
Outpatient Services:		
Prescription Drugs	After the calendar year deductible is satisfied, 80% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.	
All Other Outpatient Services	After the deductible is satisfied, 50% of eligible expenses incurred, up to a maximum of 25 visits per person per calendar year. The Out-of-Pocket limit does not apply.	
Maximum Benefit	Benefits for both the inpatient and outpatient treatment of Alcohol and Substance Abuse are limited to a maximum of $50,000 per person while covered under the Plan.	

Note: If you or your dependent do not comply with the Hospital Pre-Admission notification procedures described beginning on page 31, benefits payable under the Plan are reduced by 10%, up to a maximum penalty of $1,000 per confinement. Expenses reduced as a result of this penalty do not apply towards the Out-of-Pocket limit.

BENEFITS FOR ELIGIBLE EXPENSES (continued)

Treatment of Mental or Nervous Disorders

	In-PPO Network	***Out-of-PPO Network***
Inpatient Services/ Partial Hospitalization	After the deductible is satisfied, 90% of eligible expenses incurred. The Out-of-Pocket limit does not apply.	After the deductible is satisfied, 80% of eligible expenses incurred. The Out-of-Pocket limit does not apply.
	Eligible expenses are limited to a maximum of 20 days treatment per person per calendar year. Two days of Partial Hospitalization Treatment expenses will be counted as 1 day.	
Outpatient Services:		
Prescription Drugs	After the calendar year deductible is satisfied, 80% of eligible expenses incurred up to the Out-of-Pocket Limit, then 100% for the balance of the same calendar year.	
All Other Outpatient Services	After the deductible is satisfied, 50% of eligible expenses incurred, up to a maximum of 25 visits per person per calendar year. The Out-of-Pocket limit does not apply.	

Note: If you or your dependent do not comply with the Hospital Pre-Admission notification procedures described beginning on page 31, benefits payable under the Plan are reduced by 10%, up to a maximum penalty of $1,000 per confinement. Expenses reduced as a result of this penalty do not apply towards the Out-of-Pocket limit.

Eligible Health Care Expenses

A charge for any of the services or supplies listed below will be considered an eligible expense if: (a) it is prescribed by a physician as necessary in connection with the treatment of the injury or illness involved, (b) it is not excluded under the Plan and (c) it is not in excess of the reasonable and customary charge for similar care. The service or supply cannot be educational in nature, nor provided primarily for the purpose of medical or other research, and must be commonly and customarily recognized as appropriate in the treatment of the patient's diagnosed illness or injury. Unless specifically included, the service or supply must be considered an eligible expense under Medicare. The term "eligible expense" will also include surcharges imposed by the State of New York for health care expenses incurred on behalf of its residents or for expenses incurred at New York facilities. Such surcharges will be reimbursed by the Plan at one hundred percent.

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

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

- an "Injury" means a non-occupational bodily injury that is caused by an event that is sudden and not foreseen, and is exact as to time and place. Any loss which is caused by or contributed to by a hernia of any kind will be considered a loss under the definition of illness and not as a loss resulting from an accidental injury; and,

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

Expenses eligible under the Plan are:

1. Abortions (Medically Necessary) –
   services or supplies in connection with an abortion when the life of the mother will be endangered if the fetus is carried to term;

2. Alcohol and Substance Abuse -
   services rendered by a hospital, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program, or by a Psychiatrist, Psychologist, Licensed Clinical Social Worker or other counselor authorized by his or her state of practice to provide counseling services, up to the maximum benefit specified under the *Schedule of Health Care Benefits.* Eligible expenses include, but are not limited to, counseling, detoxification services and other ancillary services. As used in this provision, the terms noted have the following meaning:
   - "Alcohol/Substance Abuse" means any diagnosis listed under Alcohol and Drug Psychoses, Alcohol and Drug Dependence Syndrome and Nondependent Abuse of Drugs of the current edition of the International Classification of Diseases, except that tobacco and caffeine abuse are not included under this definition;
   - "Substance Abuse Treatment Facility" is a facility, other than a hospital, whose primary function is the treatment of alcoholism, chemical dependency or drug abuse and which is duly licensed by the appropriate state and local authority to provide such services;
   - "Partial Hospitalization Treatment Program" means a program provided through a hospital, mental/nervous treatment facility or alcohol/substance abuse treatment facility which provides psychological therapy on an outpatient basis as an alternative to inpatient confinement or to provide transitional support following inpatient treatment and which meets the following requirements:
     a. it provides care by one or more program therapists who are credentialed by the state in the field;
     b. it is under the full supervision of a physician; and,
     c. it maintains complete medical records on each patient;

3. Allergy Shots and Allergy Surveys;

4. Ambulance Transportation -
   professional ambulance service to take a patient to or from the nearest hospital where necessary care can be given for the treatment of an illness or injury. When specialized care is medically necessary, transportation to the nearest facility equipped to provide such specialized treatment will also be eligible;

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

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

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

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

9. Cardiac Rehabilitation Services –
   outpatient cardiac rehabilitation services prescribed by a physician and under the supervision of a qualified medical individual to the extent that the services are medically necessary;

10. Chemotherapy;

11. Chiropractic Care;

12. Cosmetic Surgery –
    cosmetic surgery to correct -
    a. a congenital anomaly; or,
    b. conditions resulting from accidental injuries, scars, tumors or disease;

13. Dental Care -
    expenses incurred in conjunction with –
    a. an accidental injury to natural teeth provided such treatment is rendered within 6 months of the date the accident occurred. Eligible expenses do not include the repair or replacement of dentures;
    b. an alveolectomy, gingivectomy or removal of impacted teeth. Hospital expenses will also be eligible when treatment must be performed in a hospital due to the patient's medical or mental condition or age;

14. Diabetic Supplies –
    equipment and supplies for the treatment of diabetes, including self-management services prescribed by a physician;

15. Diagnostic X-ray and Laboratory Services –
    x-ray examinations, laboratory tests and their interpretation performed in conjunction with the treatment of an injury or the diagnosis of a suspected illness which is exhibiting symptoms;

16. Durable Medical Equipment -
rental of durable medical equipment. Benefits will also be provided for the purchase of durable medical equipment if it can be shown that long term use is planned and purchase is likely to cost less than monthly rental, or that the equipment cannot be rented;

17. Extended Care/Convalescent Nursing Facility -
charges for the following services and supplies provided by an Extended Care/Convalescent Nursing Facility:
    a. room and board charges, including general nursing services. If private room accommodations are used, eligible expenses will be limited to the facility's average semi-private room rate or, if the facility does not offer semi-private rooms, the an average semi-private room rate of similar institutions in the area;
    b. medical services provided during the confinement; and,
    c. drugs, biologicals, solutions, dressings and casts.

    Eligible expenses do not include private duty or special nursing services and physician fees.

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

18. Glasses or Contact Lenses –
the initial pair of glasses or contact lenses following cataract surgery. Expenses incurred for the replacement of lenses or glasses will also be considered an eligible expense when replacement is required due to a change in the prescription;

19. Home Health Care -

charges by a Home Health Care Agency for services and necessary supplies provided in accordance with a Home Health Care Plan when participation is recommended and supervised by the patient's primary attending physician. Eligible expenses include:

a. part-time or intermittent nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), a vocational nurse or public health nurse who is under the direct supervision of a RN;
b. home health aide services;
c. medical supplies, drugs and medicines prescribed by a physician;
d. diagnostic laboratory services provided by or on behalf of a hospital.

Eligible expenses do not include services of a person who ordinarily resides in the patient's home or who is a close relative, transportation services and any service not recommended by the patient's attending physician or included in the Home Health Care Plan.

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

20. Hospice Care -

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

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

21. Hospital Expenses -

charges by a hospital for semi-private room and board, intensive care or cardiac care unit and all other necessary services and supplies incurred as an inpatient or outpatient. Private room charges will be eligible only if isolation is medically necessary; otherwise, eligible expenses will be limited to 90% of the hospital’s private rate.

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

22. Infertility –

expenses incurred for the diagnosis and treatment of infertility, up to the maximum benefit defined under the “Schedule of Health Care Benefits”. Eligible expenses include, but are not limited to the following procedures:

a. in vitro fertilization;
b. uterine embryo lavage;
c. embryo transfer;
d. gamete intrafallopian tube transfer;
e. zygote intrafallopian tube transfer;
f. low tubal ovum transfer; and,

g. hormonal therapy.

However, coverage for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer will only be provided if:

- the individual has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate fertility treatments covered under the Plan;
- the individual has not undergone 4 completed oocyte retrievals. However, if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals will be covered;
- the procedures which be performed at medical facilities that confirm to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society's minimal standards for programs in vitro fertilization. The responsibility for initiating the pre-approval procedure to ascertain whether the proposed medical facility conforms to these stated guidelines is that of the individual pursuing treatment.

The term "infertility" means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. The term "oocyte" means the early or primitive ovum (egg) before it has developed completely;

23. Mammograms –

routine mammograms performed on the following basis:

a. one baseline mammogram performed for women between age 35 and age 39;
b. one mammogram performed every 1 to 2 years for women between age 40 and age 49; and,
c. one mammogram performed every year for women age 50 and over.

When services are rendered in conjunction with a suspected or diagnosed illness, expenses will not included in the above stated limits;

24. Mastectomy Expenses –

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

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

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

25. Maternity Expenses -
expenses incurred for prenatal care, delivery and postpartum care, including services rendered by a Certified Registered Nurse Midwife.

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

26. Medical and Surgical Dressing, Supplies, Casts, Splints, Trusses, Crutches and Leg, Back, Arm and Neck Braces required in conjunction with an illness or injury;

27. Mental or Nervous Disorders -
services rendered by a hospital, freestanding treatment facility, Partial Hospitalization Treatment Program or by a Psychiatrist, Psychologist, Licensed Clinical Social Worker or other counselor authorized by his or her state of practice to provide counseling services up to the maximum benefit specified under the "Schedule of Health Care Benefits". As used in this provision, the following terms have the defined meaning:

- A "Mental or Nervous Disorder" means any diagnosis listed in the *Mental Disorders* section of the current edition of the International Classification of Diseases, other than diagnoses listed under Alcohol and Drug Psychoses, Alcohol and Drug Dependence Syndrome and Nondependent Abuse of Drugs;
- A "Partial Hospitalization Treatment Program" means a program provided through a hospital, mental/nervous treatment facility or alcohol/substance abuse treatment facility which provides psychological therapy on an outpatient basis as an alternative to inpatient confinement or to provide transitional support following inpatient treatment and which meets the following requirements:
  a. provides care by one or more program therapists who are credentialed by the state in the field;
  b. is under the full supervision of a physician; and,
  c. maintains complete medical records on each patient;

28. Newborn Care -

charges for routine nursery care and all other necessary services and supplies provided for a healthy newborn dependent child while hospital confined immediately following birth, including one routine pediatric examination performed within 7 days following birth and the performance of a circumcision;

Note: Expenses incurred for the above charges or for treatment of an illness of a newborn (for example, premature birth, congenital abnormality) will be eligible on the same basis as any other illness provided you enroll the child for coverage within the 30-day period immediately following the child's birth if you are not already enrolled for Family coverage (see the section "When Coverage Begins" on page 46 for more information on the enrollment procedure);

29. Nursing Services -

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

30. Optometric Services -
services rendered by an Optometrist for treatment of an illness or injury;

31. Organ Transplants -
services and supplies rendered in conjunction with an organ transplant, including procurement of the organ from a cadaver or tissue bank, storage and transportation charges. Eligible "organ transplant procedures" include bone marrow/stem cell rescue, cornea, heart, heart/lung, heart valve, kidney, liver, lung, muscular-skeletal, pancreas or parathyroid organ transplants or tissue transplants from a human to a human.

A second opinion must be obtained prior to undergoing any transplant procedure confirming its medical necessity. Such opinion must be rendered by a physician qualified either through experience, specialist training, education or similar criteria and may not be affiliated with the physician who will be performing the surgical procedure.

Benefits are available to both the recipient and donor of a covered transplant if:

a. both the donor and recipient are covered under the Plan;
b. you or your covered dependent are the recipient of the transplant, and the donor for the transplant has no coverage from any other source; however, the donor benefits will be applied towards your maximum benefit;
c. you are the donor for the transplant and no coverage is available to you from any other source; however, no benefits will be provided for the recipient;

32. Oxygen and its Administration;

33. Physical Therapy -
services of a licensed physical therapist for physical therapy;

34. Physician Services –
a. services rendered by a physician for medical care provided on an inpatient or outpatient basis, including home care. Eligible expenses will also include services rendered by a qualified Physician Assistant;

b. services rendered by a Surgeon and, when medically necessary, an Assistant Surgeon or Certified Surgical Assistant, for surgical procedures covered under the Plan. When the services of a Certified Surgical Assistant are rendered, the combined cost of the surgeon and Assistant's charge will be eligible up to the total usual and customary charge of the surgeon alone. A "surgical procedure" means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, the injection of sclerosing solutions, medically necessary abortions, and elective sterilizations, tubal ligations and circumcision;

c. surgical opinion consultations;

d. diagnostic services;

35. Pre-admission Testing –
x-ray and laboratory services ordered by a physician and rendered on an outpatient basis within 3 days of a scheduled hospital confinement;

36. Prescription Drugs and Medicines -
drugs and medicines prescribed by a physician for the treatment of an illness or injury and which are dispensed on an inpatient basis or an outpatient basis. Drugs and medicines which do not legally require a physician's written prescription are not eligible with the exception of insulin or antigens;

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

38. Radiation Therapy –
radiation therapy by x-ray, radium, radon and radioactive isotopes;

39. Renal Dialysis;

40. Respiratory Therapy –
respiratory therapy rendered by a qualified respiratory therapist;

41. Shock Therapy;

42. Speech Therapy -
services of a qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to an illness or injury or a congenital anomaly for which corrective surgery was performed prior to therapy;

43. Sterilization –
elective sterilization procedures, but not their reversal;

44. Temporomandibular Joint Disorder –
services and supplies provided in the support of a surgical procedure to correct a disorder of the Temporomandibular Joint. Dental treatment is eligible under the District's Dental Care Plan.

Health Care Exclusions

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

1. Abortions -
services or supplies in connection with an elective abortion unless the life of the mother will be endangered if the fetus is carried to term;

2. Birth Control Pills;

3. Claim Submission Deadline -
charges for services or supplies for which you do not file a claim by the 12-month period following the date on which the service was rendered or the supply received or, if sooner,

within 90 days following the date an individual's coverage terminates or within 30 days if the Plan is terminated;

4. Close Relative –
   services rendered by a physician, dentist, nurse or licensed therapist who is a close relative of the patient or who resides in the same household. A "close relative" means the your spouse, brother, sister, child or your spouse's parents or siblings;

5. Completion of Claim Forms/Missed Visits -
   charges for failure to keep a scheduled visit, charges for completion of a claim form or charges assessed for medical records or information necessary to process a claim;

6. Cosmetic Services -
   charges in connection with the care or treatment of, or surgery performed for, a cosmetic procedure;

7. Coverage Not in Effect –
   any care or supplies received prior to the individual's effective date under the Plan or after coverage terminates;

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

9. Dental Care –
   charges for dental services or supplies for the treatment of teeth, nerves or roots of the teeth, gingival tissue, alveolar processes or for the non-surgical treatment of the Temporomandibular Joint;

10. Education or Training;

11. Experimental or Investigational Treatment –
services, supplies, devices, treatments, procedures, or drugs which are not reasonable and necessary or that are investigational or experimental for the diagnosis or treatment of an illness, disease, or injury for which any of such items are prescribed. Charges excluded are those incurred for such items which:
    a. are not accepted as standard medical treatment for the illness, disease or injury being treated by physicians practicing the suitable medical specialty;
    b. are the subject of scientific or medical research or study to determine the item's effectiveness and safety;
    c. have not been granted, at the time services were rendered, any required approval by the federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services Food and Drug Administration, or any comparable state governmental agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII; or,
    d. are performed subject to the patient's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment;

12. Eyeglasses, Contact Lenses and Corrective Surgery -
charges in connection with eye refractions, radial keratotomy, or the purchase of eyeglasses or contact lenses;

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

14. Government Care -
services or supplies furnished by a hospital owned or operated by the United States Government or agency thereof, or furnished by a physician employed by the United States Government or agency thereof, except that services provided and billed by a Veteran's

Administration facility for non-service related disabilities or by a Military Hospital will be eligible;

15. Hearing Aids;

16. Hospital Charges for Therapy or Rest –
hospital charges incurred when confinement occurs primarily for physiotherapy, hydrotherapy, convalescent, custodial or rest care;

17. Illegal Acts –
services or supplies rendered to treat an illness or injury sustained as the result of engaging in an illegal act or occupation, or by committing or attempting to commit any crime, felonious act or aggravated assault, or while incarcerated in a penal institution. However, this exclusion will not apply if injuries are sustained during an act of domestic violence or as a result of a diagnosed illness, including Mental or Nervous Disorder or an Alcohol or Drug Dependency;

18. Immunizations –
immunizations not necessary for treatment of any injury or illness;

19. Not Medically Necessary –
services or supplies not medically necessary for the treatment of an illness or injury or which are not recommended and approved by a physician;

20. Not Recognized by the American Medical Association -
charges for procedures which have not been recognized by the American Medical Association as accepted standards of medical practice or which are listed as having no medical value;

21. Not Rendered by a Physician –
physician fees for any treatment which is not rendered by or in the physical presence of a physician;

22. Not Otherwise Eligible -
    any service or supply not specifically listed under the section “Eligible Expenses”;

23. Nursing Services –
    nursing services if rendered by other than a Registered Nurse or a Licensed Practical Nurse;

24. Nutritional Supplements;

25. Occupational Therapy –
    occupational therapy intended primarily to assess rehabilitation for returning to work;

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

27. Outside of the United States –
    charges incurred outside of the United States if the individual traveled to such location for the sole purpose of obtaining medical services, drugs, supplies or services not customarily rendered within the boundaries of the United States. However, this exclusion will not apply to expenses incurred outside of the United States which are otherwise eligible under the Plan, i.e., the service or supply is recognized by the American Medical Association as accepted standards of medical practice, it is prescribed by a physician as necessary in connection with the treatment of the injury or illness involved, it is not excluded under the Plan and it is not in excess of the reasonable and customary charge for similar care. If you or your dependent incur an expense while traveling abroad, you will need to submit your claim for reimbursement upon your return to the United States;

28. Personal Comfort or Beautification Items –
    services or supplies which constitute personal comfort or beautification items, television or telephone use or expenses actually incurred by other persons;

29. Prescription Drugs -
    prescription drugs or medicines which are not approved by the Food and Drug Administration;

30. Reasonable and Customary -
charges in excess of the reasonable and customary amount;

31. Reversal of a Sterilization Procedure;

32. Routine Care –
routine medical examinations, routine health check-ups, or routine child care;

33. Self-Inflicted –
services or supplies rendered in conjunction with the treatment of an intentionally self-inflicted illness or injury committed while sane or insane. However, this exclusion will not apply if injuries are sustained during an act of domestic violence or as a result of a diagnosed illness, including Mental or Nervous Disorder or an Alcohol or Drug Dependency;

34. Sex Transformations;

35. Sexual Dysfunction;

36. Smoking Cessation Programs;

37. Unbundled Procedures –
charges for unbundled procedures. However, the unbundled procedures will be rebundled for assignment of the proper comprehensive CPT code, and benefits will be paid accordingly. Unbundling occurs when two or more CPT procedures are used to describe procedures performed when a single, more comprehensive CPT code exists that accurately describes the entire procedure performed;

38. War -
services and supplies received for any illness or injury occurring as a result of war or an act of war, whether declared or undeclared, or caused during service in the armed forces of any country;

39. Weight Control Programs/Obesity –
weight control programs or treatment of obesity not caused by organic conditions;

40. Work Related -
services or supplies for an injury or illness arising out of, any occupation for wage or profit, or for which the individual is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law.

Limitations of Benefits for Pre-Existing Conditions

A "pre-existing condition" is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately prior to your enrollment date. A pre-existing condition includes any condition identified as a result of information that is obtained relating to an individual's health status before the individual's enrollment date, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period, but does not include pregnancy. For a new employee (and his/her dependents), the enrollment date means the first day of the employment as an eligible employee. For a Special Enrollee, the enrollment date means the day you or your dependent become covered as the result of your marriage, or the acquisition of a new dependent child, or the day after the date your other group health plan or health insurance coverage ends. For a Late Enrollee, the enrollment date means the first day of coverage.

No benefits will be provided for expenses related to the treatment of a pre-existing condition until:

1. the last day of the 12-month period immediately following the enrollment date; or,
2. for a Late Enrollee, the last day of the 18-month period immediately following the enrollment date.

If you or your dependent had health insurance coverage prior to becoming covered under the Plan, the pre-existing condition limitation waiting period may be reduced by the amount of time

you or your dependent were covered under another health insurance plan (this is referred to as "creditable coverage"). Creditable coverage will not be applied, however, if you and/or your dependent had a break in coverage of 63 days or more. The determination of the amount of creditable coverage, if any, will be based on the Health Insurance Portability Act of 1996 (HIPAA) as then constituted or later amended. In order to determine if you or your dependents qualify for creditable coverage, please contact the claims administrator, Benefit Systems & Services, Inc.

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

Note: If you or your dependent were covered under the group medical benefits plan maintained by the District prior to September 1, 2002, the pre-existing condition limitation will not apply to the extent satisfied under the prior plan.

Hospital Pre-admission Certification/Continued Stay Program

The Plan includes a Hospital Pre-Admission Certification and Continued Stay Review program. The program is designed to reduce health costs and help you and your family avoid unnecessary hospital confinements and to assure appropriate, quality medical care. The District has contracted with Hines & Associates, an independent firm which includes medical professionals, to administer the program. It is the intention of this program to assure appropriate care, not to dictate or direct medical care. **If you (or your dependent) do not contact Hines & Associates, benefits payable under the Plan are reduced by 10%, up to a maximum penalty of $1,000 per confinement.** This penalty does not apply to the Out-of-Pocket limit.

The Notification Procedure

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

1. the employee's name, address and Social Security number;
2. the patient's name, address, telephone number, date of birth and sex;
3. the name, address and telephone number of the attending physician and the hospital;
4. the reason for the hospital confinement and expected (or, if an emergency, the actual) date of admission; and,
5. the name of the Community Unit School District #200 Health Care Plan.

Hines & Associates can be contacted by phoning BSSI at 1-800-423-1841 and selecting Option 7.

How the Program Works

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

Following this evaluation the Medical Review Specialist will "pre-certify" a designated length of stay for the confinement and establish a date when discharge is expected. Prior to the end of the approved length of stay, the Medical Review Specialist will contact the attending physician to determine if discharge is taking place when planned. If not, an extension of the length of stay will be approved if medically appropriate. This process continues until discharge takes place.

The Impact on Benefits

Your only requirement is to contact Hines & Associates prior to any scheduled hospital admission (or within 48 hours following an emergency or maternity admission). If you or your dependent do not contact Hines & Associates as stated above, benefits payable under the Plan are reduced by 10%, up to a maximum penalty of $1,000 per confinement.

The Preferred Provider Organization Network

Through our claims administrator, Benefit Systems & Services, Inc. (BSSI), the District has contracted with the University of Chicago Hospital and Physicians and Private Health Care Systems (PHCS) to access a Preferred Provider Organization network. This network of "preferred providers" render medical care at a cost savings to you and the District. When you or your dependent obtain services from a PPO provider, you and/or your dependent are eligible for the maximum benefit payable under the Plan and will receive a discount from the provider for charges incurred. There may be changes in the providers participating in the network from time to time. Therefore, you are urged to check with your hospital, physician or other service provider before undergoing treatment to make certain of its participation status. PHCS can be contacted at 1-800-240-1940 or through their Website at www.phcs.com.

Prescription Drug Discount Program

The District has contracted with a Prescription Benefit Manager (PBM) to access a Prescription Drug Discount network. When you or your dependent purchase your prescription drugs and medicines through a "preferred pharmacy", you and/or your dependent will receive a discount from the pharmacy. The PBM through which this program is offered is BeneScript. However, beginning on and after October 15, 2002, the program will be offered through Serve you Prescription Management. Serve You's Member Services may be reached at 1-800-759-3203.

Large Case Management

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

- AIDS;
- Amputations;

- Amyotrophic Lateral Sclerosis (ALS);
- Cerebral Vascular Accident (CVA);
- Leukemia
- Major Head Trauma and Brain Injury;
- Multiple Fractures;
- Multiple Sclerosis;
- Severe Burns;
- Spinal Cord Injuries;
- Transplants.

You may be contacted by the claims administrator, Benefit Systems & Services, Inc. (BSSI) if you or your dependent suffers one of the above conditions.

Coordination With Other Plans

The Plan includes a Coordination of Benefits provision to avoid duplicating the benefits of another plan. A "plan" with which these Coordination of Benefits provisions apply include, but is not limited to, any group or blanket policy of insurance providing medical or dental benefits, a group hospital, Health Maintenance Organization, Preferred Provider Organization, or other group prepayment coverage, any coverage under any labor-management trusteed plan or union welfare plan, and any state or federal government program other than Medicaid, or any coverage for students which is sponsored by, or provided through, a school or other educational institution.

When you or your dependent are covered under more than one plan (including an HMO), benefits may be subject to a reduction to the extent necessary to make the benefits payable under all plans equal to the total allowable expense incurred during the calendar year. An "allowable expense" means any necessary, reasonable, and customary item of expense which is covered under at least one plan covering the person for whom a claim is made. When Medicare is considered the primary payor benefits and the provider of service accepts Medicare assignment, the "allowable expense" will be equal to the reasonable and customary amount approved by

Medicare; this limitation will not apply if the provider does not accept Medicare assignment. When a plan provides its benefits in the form of services rather than in cash payments, the reasonable and customary cash value of the service performed is considered to be a benefit paid. For example, if your spouse is covered under a Health Maintenance Organization (HMO), he or she will receive benefits in the form of services. No cash payment is provided to your spouse for reimbursement or cost incurred because an HMO generally reimburses the HMO service provider directly at 100%. If a person covered under an HMO elects to obtain treatment outside of the HMO service provider network and the HMO reimburses that type of treatment at 100% if the service would have been provided by an HMO service provider, the Plan will consider the charges incurred to have been reimbursed by the HMO at 100% and, therefore, no benefits will be paid by the Plan.

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

1. a plan which does not have a coordination of benefits provision is the primary plan;
2. if a person is a covered employee under one plan, and a covered dependent under another plan, the plan that covers the person as an employee is the primary plan;
3. if a child is covered under more than one plan and the parents are not separated or divorced, the father's plan is the primary plan;
4. if a child is covered under more than one plan and the parents are separated or divorced, the primary plan is determined as follows:
    a. the plan of the natural parent having responsibility for the child's health care expenses by court decree pays first. If the court decree splits the responsibility equally between the divorced parents, the primary plan is the plan of the parent whose birthday, excluding year of birth, falls earlier in the calendar year. If both parents have the same birthday, then the plan which has covered the parent the longest will be the primary plan;
    b. in the absence of a court decree, -
        (1) the plan of the natural parent having legal custody pays; then,
        (2) the plan of the spouse (if any) of the natural parent with legal custody pays; then,

(3) the plan of the natural parent without legal custody pays last;

5. if a person is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan;
6. if a person covered under a right of continuation pursuant to federal or state law is also covered under another plan, the plan that covers the person as an employee, member or subscriber is the primary plan before the plan providing continuation coverage;
7. if the order described above fails to establish the order of payment, then the plan under which the person has been covered for the longest period of time is the primary plan.

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

If you or a dependent have a claim for benefits and the Plan is not the primary plan, you should submit a copy of the Explanation of Benefits (EOB) you receive from the other plan to the claims administrator, Benefit Systems & Services, Inc. (BSSI). An EOB is a statement from an insurer or claims processor that shows the action taken on a claim. If you need assistance in determining which plan is primary, you can contact BSSI between 7:30 A.M. and 4:30 P.M., Monday through Friday at (630) 789-2082 or 1-800-423-1841.

Note: The claims administrator on behalf of the District may, without the consent of or notice to any covered person, release or obtain from any insurance company, service provider, benefit administrator or other person any information necessary to administer this Coordination of Benefits provision. In addition, any person claiming benefits under this Plan will be required to furnish to the claims administrator any information that is necessary to administer this Coordination of Benefits provision.

Coordinating Benefits for Persons Eligible for Medicare

(The Health Insurance for Aged and Disabled Program
established by Title XVIII of the Social Security Act of 1965)

The Plan will pay benefits first and Medicare will pay second in the following circumstances:

1. if you are an active employee;
2. if you are in a "current employment status" (as defined by Medicare) and you or your dependent are eligible for Medicare as the result of a disability condition, other than End Stage Renal Disease; or,
3. if you or your dependent are disabled due to End Stage Renal Disease, but only for the period of time defined by current legislation. After this time period, your benefits will be coordinated with Medicare.

If you are age 65 or over and select Medicare as your primary coverage you will not be eligible under this Plan. Also, if your spouse (age 65 or over) selects Medicare as their primary coverage, your spouse will not be eligible under this Plan.

If this Plan is secondary to Medicare (if you are a retiree, for example), the Plan will coordinate its benefits by the amount of Medicare benefits for which you (or your dependent) are entitled even if you have not enrolled. Therefore, you should contact a Social Security office as soon as you or your dependent become eligible for Medicare.

Subrogation/Right of Reimbursement

If you or any of your covered dependents receive benefits arising out of an illness or injury for which you (or your dependent) has or may have any claim or right to recovery:

1. payments under this Plan will be made on the condition that the Plan will be reimbursed out of the proceeds of such claim or right of recovery;
2. payment of benefits under this Plan will be conditioned upon receipt of a signed Subrogation/Right of Reimbursement Agreement; and,
3. payment of benefits may be revoked, and the Plan may seek refunds of payments, where acknowledgement of the Plan's right under this provision is incomplete or impaired.

However, this provision shall not apply to a recovery obtained by you or your covered dependent from an insurance company on a policy under which you or your dependent is entitled to indemnity as a named insured person.

Additional information concerning this provision is provided under the section "Subrogation/Right of Reimbursement" beginning on page 69.

Right of Recovery of Overpayment

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

Reasonable and Customary Expenses

The Plan will consider expenses up to the reasonable and customary charge. The "reasonable and customary charge" means: (a) for a preferred provider, the charge negotiated between that provider and the preferred provider network; or, (b) for a non-preferred provider, only the fee most commonly charged within the same geographical area for equivalent services, based on information provided from insurance companies, governmental payers (e.g., Medicare, Medicaid) and other plan administrators, taking into account the fees and prices generally charged for cases of comparable nature and severity at the time and place received. The firm which will supply these profiles is Medical Data Research, a.k.a., Ingenix. The Plan will not reimburse charges in excess of those considered reasonable and customary, nor will the excess be counted towards satisfying the deductible or Co-insurance limit; you will be responsible for paying the excess. Because of this, whenever possible, you should discuss charges in advance with your doctor, the hospital and others who are to furnish treatment.

How to Apply for Benefits

What Information Is Needed

Our claims administrator, Benefit Systems & Services, Inc., (BSSI), requires the following information be submitted for each claim:

- your name;
- the patient's name;
- the District's name;
- the name and address of the provider of care, including his or her tax identification number;
- the diagnosis;
- the type of service rendered, with diagnosis and/or procedure codes;
- the date(s) of services;
- the amount of charges; and,
- if the claim is for an injury, a description of the accident, including how and when it occurred.

Doctors, hospitals and dentists generally use forms that provide the above information, so you will not be required to use a claim form when submitting your claim.

In addition to the above listed claim detail, the following information must be submitted in the noted circumstance:

- Spouse's Employer -
  on an annual basis BSSI will need to know if your spouse is employed and, if so, the name and address of his/her employer and whether or not they have group coverage through this employer;
- Student Status -
  BSSI will require the name and address of the school at which a child age 19 or over is attending to verify his/her full-time student status each semester or quarter during which your child has a claim;

- Divorce Decree -
  if a child's parents are separated or divorced, BSSI will require information concerning which parent has been assigned responsibility for the child's coverage;
- Coordination of Benefits -
  if you or a dependent have a claim for benefits and the Plan is not the primary plan, BSSI will require a copy of the Explanation of Benefits (EOB) you receive from the other plan. An EOB is a statement from an insurer or claims processor that shows the action taken on a claim.

Where to File the Claim

All claims should be forwarded to:

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

If you have any questions concerning the benefits offered under this Plan or would like to know whether a specific drug, medical test, device or procedure is covered under the Plan, please call BSSI at (630) 789-2082 or 1-800-423-1841.

When to File the Claim

Claims must be submitted for reimbursement under the Plan within one year following the date on which the claim is incurred or, if sooner, within 90 days following the date an individual's coverage terminates. For example, if you are an active employee and incur an expense on June 12, 2003, you must submit the claim no later than June 11, 2004. However, if your employment and coverage terminated on November 1, 2003, you must submit the claim no later than January 29, 2004. If a claim is not submitted within these time periods for reasons beyond your control, the claim may be eligible if you provide evidence of the circumstance which prevented earlier submission.

If the Plan is terminated, all claims must be submitted within 30 days of the termination date.

Review of a Denied Claim

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

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

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

Eligibility and Continuation of Coverage Provisions

Who is Eligible for Coverage

You are eligible for coverage if you are an active full-time employee of the District. Temporary employees and part-time employees working less than the number of hours required your negotiated agreement with the Board of Education are not eligible for coverage under the Plan. In addition, you are not eligible for coverage if you are an active employee age 65 or older and make a written election to be covered by Medicare instead of the Plan or if you are a member of the WWEA who retired after September 1, 1994 (except as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA)).

You may also elect to cover your eligible dependents, provided the dependent resides in the United States and is not on active military duty. Dependents eligible under the Plan are:

- your lawful spouse. Your spouse must meets all the requirements of a valid marriage in the state in which you reside and does not include a spouse from whom you are legally separated or divorced;

- your unmarried, dependent children through age 18 or, through age 24 if enrolled as a full-time student in regular attendance at an accredited school, college or university. A "full-time student" means a student who meets the enrollment requirements defined by the school or college in which the student is enrolled. Proof of a child's full-time student status will be required each semester or quarter during which he or she has a claim. A child must be dependent upon you for his or her maintenance and support unless you are required to provide coverage for the child through a court order or divorce decree and may not be employed by one or more employers on a full-time basis of 30 or more hours per week (exclusive of scheduled vacation period).

Children eligible for coverage under the Plan include your natural child, step child, legally adopted child, a child who has been placed with you for adoption pursuant to an interim court order, a child for whom you have been appointed legal guardian or have legal custody, and a child who is recognized under a Qualified Medical Child Support Order. Foster children or grandchildren (unless you have legal guardianship or legal custody) are not eligible even though you may support them.

The Plan's age/student status requirement will be waived for a child who is unable to support himself or herself because of a physical or mental handicap. Proof of incapacity must be submitted to the Benefits Office within 60 days after the date on which the dependent no longer will be eligible because of age, and at reasonable intervals thereafter. The dependent child must meet all of the eligibility requirements other than age to continue to be eligible. For example, if the dependent marries, he or she will no longer have coverage under the Plan.

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

Note: 1- Each person who was covered under the group plan maintained by the District immediately prior to September 1, 2002, will continue to be covered on and after September 1, 2002, subject to the terms and conditions of this Plan.

2 Coverage will be subject to a limitation of benefits for all pre-existing conditions as described in the section "Limitations of Benefits for Pre-Existing Conditions" beginning on page 30. If you or your dependent had health insurance coverage prior to becoming covered under the Plan, the pre-existing condition limitation waiting period may be reduced by the amount of time you or your dependent were covered under another health insurance plan (this is referred to as "creditable coverage"). Creditable coverage will not be applied, however, if you and/or your dependent had a break in coverage of 63 days or more. The determination of the amount of creditable coverage, if any, will be based on the Health Insurance Portability Act of 1996 (HIPAA) as then constituted or later amended. In order to determine if you or your dependents qualify for creditable coverage, please contact the claims administrator, Benefit Systems & Services, Inc.

3 Benefits payable by the Plan may be reduced as described in the section "Coordination With Other Plans" beginning on page 34 for persons covered under more than one plan.

Who Pays for the Coverage

The cost of coverage for yourself and your dependents will be based on the current policy established by the Board of Education or your negotiated agreement. The Benefits Office will advise you of the amount that will be deducted from your paycheck for coverage when you enroll.

If you elect to make your contribution for coverage on a pre-tax basis under the District's Section 125 Plan, you will only be allowed to change your coverage election during the Open Enrollment period or, if sooner, within the 30-day period following a major life change as defined in the Section 125 Plan. If you elect to make your contributions for coverage on an after tax basis you will not be subject to this Section 125 enrollment limitation.

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

When Coverage Begins

Employee Coverage

Your coverage will begin at 12:00 A.M. on the first day of the calendar month following the day you are employed or first become an eligible employee of the District.

If you are required to contribute towards the cost of coverage, you must complete and submit the enrollment form electing coverage within 30 days of the date you are first eligible to the Benefits Office. If you waive coverage or do not file your written election for coverage with the Benefits Office within this 30-day period, you will not be eligible for coverage until the Open Enrollment period unless you qualify sooner as a "Special Enrollee" (please refer to the following section).

Coverage for Your Dependents

If you are required to contribute towards the cost of your dependent's coverage and have eligible dependent(s) on the day you first become eligible for coverage, you must complete and file your election for Family coverage within the 30-day period and in the manner explained above, coverage for your eligible dependent(s) will begin at 12:00 A.M. on the day you become covered. Once you are enrolled for Family coverage any newly acquired eligible dependent will automatically become covered on the date you acquire him or her. Newborn children are considered acquired at the time of birth; legally adopted children are considered acquired on the date of adoption or placement for adoption.

If you do not have any eligible dependent(s) when you first become covered and acquire an eligible dependent later, that dependent may be enrolled immediately if you complete the enrollment form electing Family coverage within 30 days of the date you acquire the eligible dependent. Coverage for the new dependent will begin at 12:00 A.M. on the date he or she becomes your dependent.

If you are required to contribute towards the cost of coverage for your dependents and you waive coverage or do not file your written election for Family coverage with the Benefits Office within 30 days of the date you are first eligible or, if later, within 30 days of the date you first acquire an eligible dependent, your dependent(s) will not be eligible for coverage until the Open Enrollment period unless they qualify sooner as a "Special Enrollee" (please refer to the following section).

Note: 1 - Whatever type of coverage you select (Single or Family coverage), you will only be allowed to change your Section 125 coverage election during the Open Enrollment period designated by the District or, if sooner, within 30 days following a major life change as defined in the Section 125 Plan.

2 - Please refer to the section "Limitations of Benefits for Pre-Existing Conditions" on page 30 for information on the potential limitation of coverage. If you or your dependent had health insurance coverage prior to becoming covered under the Plan, the pre-existing condition limitation waiting period may be reduced by the amount of time you or your dependent were covered under another health insurance plan (this is referred to as "creditable coverage"). Creditable coverage will not be applied, however, if you and/or your dependent had a break in coverage of 63 days or more. The determination of the amount of creditable coverage, if any, will be based on the Health Insurance Portability Act of 1996 (HIPAA) as then constituted or later amended. In order to determine if you or your dependents qualify for creditable coverage, please contact the claims administrator, Benefit Systems & Services, Inc.

Open Enrollment

The District will designate an Open Enrollment period at the beginning of each school year during the month of September at which time you may:

- file an election to make your contributions for coverage on a pre-tax basis if you have not already done so; or,
- change your coverage election from Single to Family coverage or from Family to Single coverage. Please note, however, that any individual who is enrolled for coverage more than 30 days after the date he or she first becomes eligible will be considered a late enrollee. Please refer to the following section for an explanation of the Plan's coverage requirements for late enrollees; or,

- voluntarily drop your Single or Family coverage, provided you are required to contribute towards the cost of coverage. You will not be permitted to drop your Single or Family coverage if the District pays the full cost of such coverage based on the current policy established by the Board of Education or your negotiated agreement. If you elect to voluntarily terminate your Single or Family coverage and later wish to re-enroll, you and your dependents will be subject to the late enrollee coverage requirements explained in the following section (unless you or your dependents qualify for coverage as a Special Enrollee).

An election or change requested during the Open Enrollment period will become effective at 12:00 A.M. on October 1.

Note: Please refer to the section "Limitations of Benefits for Pre-Existing Conditions" on page 30 for information on the potential limitation of coverage. If you or your dependent had health insurance coverage prior to becoming covered under the Plan, the pre-existing condition limitation waiting period may be reduced by the amount of time you or your dependent were covered under another health insurance plan (this is referred to as "creditable coverage"). Creditable coverage will not be applied, however, if you and/or your dependent had a break in coverage of 63 days or more. The determination of the amount of creditable coverage, if any, will be based on the Health Insurance Portability Act of 1996 (HIPAA) as then constituted or later amended. In order to determine if you or your dependents qualify for creditable coverage, please contact the claims administrator, Benefit Systems & Services, Inc.

Special Enrollees and Late Enrollees

Any employee and/or dependent who is not enrolled for coverage within 30 days following the date he or she first become eligible will be considered either a "Special Enrollee" or a "Late Enrollee" as explained in this section.

Special Enrollees

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

1. you and/or your dependent(s) had coverage under another group health plan or health insurance coverage and that coverage ends as a result of "loss of eligibility" or because employer contributions toward the other coverage stopped. If the other coverage was COBRA continuation coverage, that coverage must have been exhausted. "Loss of eligibility" includes loss of coverage as a result of legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in the number of hours of employment. It does not include a loss due to the failure of you and/or your dependent(s) to pay premiums or make contributions on a timely basis, or termination for cause;
2. you get married; or,
3. you acquire a new dependent child through birth, adoption, or placement for adoption.

If you and/or your dependent(s) qualify for coverage as a Special Enrollee, you must enroll for coverage within 30 days of the loss of the other coverage or within 30 days of the date of marriage, birth, adoption or placement of adoption, whichever is applicable. If you enroll for coverage within this 30-day period, coverage begins at 12:00 A.M. on the day after the other group health plan or health insurance coverage ends or the date you acquire a new dependent or marry.

Late Enrollees

If you and/or your dependent(s) are not a Special Enrollee as explained above or if you and/or your dependent(s) qualify as a Special Enrollee but do not enroll for coverage within 30 days of the occurrence that allows for a "special enrollment", you and/or your dependent(s) are a "Late Enrollee". Late Enrollees may enroll for coverage only during the Open Enrollment period held every September for an October 1 effective date. In addition:

- coverage will be subject to an 18-month pre-existing condition limitation period. If you or your dependent had health insurance coverage prior to becoming covered under the Plan, the pre-existing condition limitation waiting period may be reduced by the amount of time you or your dependent were covered under another health

insurance plan (this is referred to as "creditable coverage"). Creditable coverage will not be applied, however, if you and/or your dependent had a break in coverage of 63 days or more. The determination of the amount of creditable coverage, if any, will be based on the Health Insurance Portability Act of 1996 (HIPAA) as then constituted or later amended. In order to determine if you or your dependents qualify for creditable coverage, please contact the claims administrator, Benefit Systems & Services, Inc.

- the individual must remain covered under the Plan for at least 12 months. This 12-month minimum coverage requirement is waived however, if your active employment ends or if you request termination of coverage within 60 days following the date:
  a. your spouse's employment terminates; or,
  b. you or your spouse change the number of hours worked per week or change positions (for example, switching from full-time to part-time employment); or,
  c. you or your spouse or a dependent child become disabled, die or change marital status.

When Coverage Terminates

Effective Date of Termination for Employees

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

1. if your employment ends –
   a. the last day of the calendar month in which your employment ends (unless you qualify for continued coverage as a retiree based your negotiated agreement with the Board of Education. Please refer to the section "Coverage Following Your Retirement" for additional information); or,
   b. the last day of the school year in which your employment ends if, prior to such termination, you were employed for a school year of less than 12 months (as shown on the District's records);
2. the last day of the calendar month in which you no longer meet the definition of an eligible employee (please refer to the section "Continuation of Coverage for

Active Employees and Their Dependents" for information concerning continued coverage if you take an approved sabbatical or are unable to work because of an illness (including pregnancy) or an injury);

3. if you are an active employee age 65 or older, the day you elect Medicare as your primary Health coverage;
4. if you request that your contributions for coverage be stopped, the last day of the period for which your contributions have been made;
5. the day the Plan is terminated.

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

If both husband and wife are eligible for coverage as employees and one spouse has been considered the covered employee and the other the covered dependent and the spouse carrying the Family coverage no longer qualifies as an employee, the Family coverage may be switched to the remaining employed spouse. In order to do this, the remaining spouse must provide the Benefits Office with his/her written request for Family coverage and agreement to make any required employee contributions within the 30-day period immediately following the date the former employee's coverage would otherwise have terminated. Any person who was covered under the former employee's coverage will

then be covered under the remaining employed spouse as of 12:00 A.M. on the day following the date coverage would otherwise have been terminated.

Likewise, if a child's parents are divorced and are both covered under the Plan and the parent who has been covering the child as his or her dependent no longer qualifies as an employee, at 12:00 A.M. on the day following termination the dependent child will be considered the dependent of the parent remaining under the Plan. However, if the remaining parent is not already enrolled for Family coverage, he or she must provide the Benefits Office with written request for Family coverage and agreement to make any required employee contributions within the 30-day period immediately following the date the former employee's coverage would otherwise have terminated.

Effective Date of Termination for Dependents

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

1. for a spouse –
    a. the last day of the calendar month in which you become legally separated or divorced; or,
    b. if you are an active employee, the day on which your spouse makes a written election to be covered by Medicare for Health coverage instead of the Plan;
2. for a child:
    a. who is not a full-time student at an accredited school or college, the last day of the calendar month in which he or she attains age 19; or,
    b. who is a full-time student at an accredited school or college, the last day of the calendar month in which he or she –
        (1) attains age 25;
        (2) graduates or is no longer enrolled and in attendance as a full-time student in an accredited school, college or university. A child will be considered a full-time student through any scheduled breaks between academic quarters or semesters prior to graduation including summer

vacation, except that if the child does not return to an accredited school or college after the break, his or her student status will be considered terminated as of 11:59 P.M. on the last day of the academic quarter or semester that ended prior to the break; or,

c. the day on which he or she marries; or,

d. the last day of the calendar month in which he or she ceases to be financially dependent upon you for support and maintenance (unless you are required to provide coverage for the child through a court order or divorce decree); or,

e. the last day of the calendar month in which you are relieved of a court-order obligation to furnish health care coverage for the child;

3. if you request that your contributions for Family coverage be stopped, the last day of the period for which your contribution for Family coverage has been made; or,

4. the day on which your spouse or child begins active duty in the Armed Forces of any country.

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

You and/or your dependents may have the opportunity to continue coverage under the Plan for a period of time beyond the normal termination date. More information about extension of coverage is provided in the sections “Continuation of Coverage for Dependents of Active Employees”, “Continuation of Coverage for Employees Participating in the Illinois Municipal Retirement Fund” and “Extension of Coverage Under COBRA”.

Certificate of Creditable Coverage Upon Termination

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

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

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

Continuation of Coverage for Active Employees and Their Dependents

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

Continuation of Coverage During An Approved Sabbatical

If your active employment ends because you take an approved sabbatical, you have the option of continuing coverage until 11:59 P.M. on the earliest of the following dates by making the required contribution for coverage:

1. the last day of the period for which you have paid for the coverage. The Benefits Office will advise you of the cost to continue coverage for you and your dependents;
2. the last day of your approved leave of absence;
3. the last day of the 12-month period immediately following the date your active employment ended;
4. the day the Plan is ended.

You will have to make a choice between continuing coverage under this continuation option and COBRA (see page 59).

Continuation of Coverage During an Illness or Injury

If your active employment ends because an of illness (including pregnancy) or an injury, coverage may be continued until the last day of the period for which you qualify for continued coverage under Board policy or negotiated agreement by making the required employee contribution. If you are unable to return to active full-time work at the end of this period, you may qualify for continuation of coverage under one of the following options:

1. COBRA (see page 59); or,
2. if the District has been making a contribution to the Illinois Municipal Retirement Fund in your behalf, the IMRF disability extension (see page 56).

Continuation of Coverage for a Disabled Student

If a dependent student age 19 or older becomes disabled, coverage will be extended without interruption until the beginning of the next available quarter or semester. If he or she cannot return to student status at the beginning of the next available quarter or semester, he or she will be given the option to extend coverage under COBRA as explained in the section beginning on page 59.

Continuation of Coverage for a Handicapped Child

As stated under the section "Who is Eligible for Coverage", the Plan's age/student status requirement will be waived for a child who is unable to support himself or herself because of a physical or mental handicap. Coverage can continue as long as the child is unmarried and unable to support himself or herself. Coverage for the dependent will end if your coverage terminates, you stop your contributions for dependent coverage, or the Plan is ended.

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

Coverage Following Your Retirement

Your group coverage will end as specified under the section "When Coverage Terminates" when your employment with the District ends. However, based on your negotiated agreement with the Board of Education, you will qualify for continuation of coverage as follows:

- if you have been employed under the Community Unit School District #200 Education Association and retire after September 1, 1994, you (and your covered dependents) will be eligible for COBRA continuation as explained under the section "Extension of Coverage under COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)" beginning on page 59). If you retired prior to September 1, 1994 and elected to continue coverage under the Plan, your coverage is limited to the maximum benefit specified under the "Schedule of Health Care Benefits"; your dependents are not eligible for coverage.
- if the District was making a contribution to the Illinois Municipal Retirement Fund on your behalf prior to retirement, you (and your covered dependents) will be eligible for the IMRF retirement extension as explained under the section "Continuation of Coverage for Employees Participating in the Illinois Municipal Retirement Fund (IMRF)" beginning on page 56); or,
- if you have been employed as an Administrator of Community Unit School District #200 and meet the eligibility requirements established under the administrative retirement plan as of the date you retiree, the District will provide

you (and your covered dependents) with 5 years of continued coverage under either this Plan or the Teachers' Retirement Plan.

Please refer to your negotiated agreement with the Board of Education for confirmation of which continuation option you (and your covered dependents) qualify for.

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

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

1. you retire directly from active service with the District with an attained age and accumulated creditable service which qualify for immediate receipt of retirement pension benefits under Article 7 of the Illinois Pension Code; or,
2. you become disabled and are eligible and approved to receive disability benefits under Article 7 of the Illinois Pension Code immediately following completion of the 31-day period following the date of disability.

You must choose between this continuation option and continuation of coverage under COBRA (see the following section, "Extension of Coverage Under COBRA"). You have 60 days after you are notified of your continuation rights to make your written IMRF election. If you elect to continue coverage, you will be eligible for coverage under the Plan on the same basis as any other active employee. However, you will have to pay the full cost of coverage. Your first premium must be paid within 45 days of the date of your written election and on a timely basis thereafter.

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

1. the day of your reinstatement or re-entry into active service as a participant in the IMRF;
2. the day you are convicted of an IMRF job-related felony which results in a loss of benefits pursuant to Section 7-219 of the Illinois Pension Code;
3. the day you die;

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

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

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

Continuation of Coverage Following the Death of an IMRF Pension Recipient

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

1. the surviving spouse was married to you for at least 365 days prior to the date of your death and for at least 365 days prior to the date of your termination of active employment with the District; and,
2. for a surviving spouse of a retiree, he or she is eligible to receive a surviving spouse's pension from the Illinois Municipal Retirement Fund; or,
3. for a surviving spouse of a disabled employee, he or she was the designated beneficiary and elects to receive a monthly surviving spouse pension from the Illinois Municipal Retirement Fund in lieu of a lump sum death benefit; and,

4. the surviving spouse is not eligible for or, if eligible, does not elect continuation of coverage under COBRA.

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

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

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

As explained in this section, the provisions of COBRA allow covered employees and dependents to temporarily continue coverage by paying the full monthly premium if coverage ends due to a Qualifying Event.

Qualifying Events

A "Qualifying Event" is any one of the following events that causes you or your dependent to lose coverage under the Plan:

For you -

1. because your employment terminates (unless the reason is gross misconduct, in which case continuation coverage will not be available);
2. the number of hours you work is reduced and you, therefore, no longer meet the definition of an eligible employee;

For your dependents -

1. because your employment terminates (unless the reason is gross misconduct, in which case continuation coverage will not be available) or the number of hours you work is reduced and you, therefore, no longer meet the definition of an eligible employee;
2. your death;
3. divorce or legal separation;

Note: If an employee drops dependent coverage in anticipation of a divorce, a former spouse will be eligible for COBRA continuation coverage following the divorce if he or she can establish the dependent coverage was dropped earlier in anticipation of the divorce. The former spouse will be eligible for COBRA continuation coverage from the date of the divorce, not retroactively to the date the employee terminated dependent coverage.

4. your child no longer meets the definition of an eligible dependent; or,
5. you become entitled to Medicare benefits *if* your eligibility for Medicare results in the termination of coverage for your dependents.

Qualified Beneficiary

A "Qualified Beneficiary" is any individual who is covered under the Plan on the date coverage terminates due to a Qualifying Event. In addition, a newborn infant or child placed for adoption with a former employee continuing coverage under COBRA is also considered a Qualified Beneficiary provided the child is enrolled under the continuation within 31 days of his birth or placement for adoption. If the child is enrolled within this 31-day period, he or she will be eligible for COBRA continuation coverage for the remainder of the continuation period available to the former employee or, if later, to his or her dependents if a second Qualifying Event occurred before the child's birth or placement for adoption.

Each Qualified Beneficiary within a family is eligible for COBRA continuation coverage independently of the other family members. In addition, the provisions of COBRA require that a Qualified Beneficiary be treated on the same basis as any other active

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

Notices and Election

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

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

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

Each Qualified Beneficiary within a family is eligible for COBRA continuation coverage independently of the other family members; however, a former covered employee or his/her spouse may elect COBRA continuation coverage on behalf of the family. Information about the cost of the continued coverage and the election form will be

provided to the Qualified Beneficiary's last known home address at the time of eligibility for COBRA continuation coverage.

Type of Coverage and Premium Payments

A Qualified Beneficiary will be offered COBRA continuation coverage based on the same coverage that was in effect on the day before the Qualifying Event. Any change to the coverage provided under this Plan for active employees will also apply to COBRA continuation coverage.

If COBRA continuation is elected, coverage becomes effective retroactive from the date coverage would otherwise have terminated. If a Qualified Beneficiary makes a written waiver of coverage followed by a written election of coverage within the 60-day election period, COBRA continuation coverage will begin at 12:00 A.M. on the date of his or her written election (in other words, there will be a gap in coverage between the date of termination and the date of the written election to continue coverage).

The first premium payment for COBRA continuation coverage must be made within 45 days after the date continuation coverage is elected and will cover premium due from the date coverage would otherwise have terminated through the month in which the election to continue coverage is made. All other premiums are due on the first day of each calendar month for which the premium is payable, subject to a 30-day grace period. A premium payment is considered made on the date the envelope containing the payment is post-marked.

Premium rates are determined for a 12-month period based on the cost of providing coverage under the Plan and as specified under the COBRA regulations. A Qualified Beneficiary's applicable premium will not be increased during the 12-month period unless there is a disability extension, or the Qualified Beneficiary changes his or her coverage, or if the Plan subsidizes a portion of the premium and the Plan discontinues its subsidy.

When COBRA Continuation Coverage Will End

A Qualified Beneficiary (and his or her dependent(s)) who elects COBRA continuation coverage will be eligible until 11:59 P.M. on the first of the following dates:

1. if coverage terminates because your employment ends or if the number of hours you work is reduced to less than the number of hours required to be eligible for coverage, the last day of the 18-month period following the date coverage terminates. However, coverage may be extended beyond this 18-month period in the following circumstances –
    a. if a Qualified Beneficiary is disabled (as defined by the Social Security Administration) at any time during the first 60 days of COBRA continuation coverage, the Qualified Beneficiary and/or his or her dependents are eligible to extend continuation coverage from 18 to 29 months provided notice of the Social Security's determination is given to the Benefits Office or claims administrator both within 60 days of the date the determination was made by the Social Security Administration and within the initial 18-months of COBRA continuation coverage. If, at any time after the Qualified Beneficiary has been on COBRA continuation coverage for at least 18 months, the Social Security Administration determines that the Qualified Beneficiary is no longer totally disabled, coverage will end on the first day of the calendar month immediately following the completion of the 30 calendar day period following the date of the Social Security Administration's determination; or,
    b. if, while continuing coverage during the initial 18- or 29-month periods defined above, a former employee dies, divorces or becomes covered by Medicare, or a child ceases to meet the eligibility requirement, the affected dependent Qualified Beneficiary may be eligible to extend COBRA continuation coverage from 18 to 36 months. The affected dependent must notify the Benefits Office and/or claims administrator within 60 days following the occurrence of the "second" Qualifying Event

and make their written election to extend COBRA continuation coverage within 60 days of the date he or she is formally notified of their right; or,

c. if the Qualifying Event (i.e., termination of employment or reduction in the number of hours you worked) occurs within 18 months after an employee becomes entitled to Medicare (even though this entitlement did not result in a loss of coverage), your covered dependents will be eligible for COBRA until the later of:

(1) 18 months (29 months if there's a disability extension) after the date of the termination of employment or reduction in hours worked; or,

(2) 36 months after you became entitled to Medicare;

2. if a dependent's coverage terminates due to your divorce, your death, a child no longer meeting the eligibility requirements or if your eligibility for Medicare results in the termination of coverage for your dependents, your dependents will be eligible until the last day of the 36-month period following the date coverage terminates;

3. the first day of the period for which a timely payment of the premium for continuation coverage is not paid. Premiums will be considered paid when the envelope is post-marked. If a check is returned for insufficient funds, the premium will not be considered paid;

4. the day prior to the date a person first becomes covered by Medicare, Part A or Part B, whichever is earlier. A Qualified Beneficiary who was covered by Medicare prior to the date he or she elects COBRA continuation coverage will not be prohibited from this coverage continuation;

5. the day prior to the date on which a person becomes covered under another group plan. If the other group plan contains a pre-existing condition exclusion or limitation for a condition the Qualified Beneficiary has, he or she will continue to qualify for COBRA continuation coverage until the pre-existing condition exclusion or limitation no longer applies. The other group plan will be considered the primary payer of benefits. A Qualified Beneficiary who was covered under

another group plan prior to the date he or she elects COBRA continuation coverage will not be prohibited from this coverage continuation; or,

6. the day the Plan is terminated.

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

Miscellaneous Administrative Provisions

Amendment, Alteration or Termination of the Plan

This Plan may be amended, changed or discontinued by the District subject to the terms of the Board's negotiated agreements.

Assignment

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

Examination

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

Claim Procedure

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

Legal Proceedings

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

Proof of Claim

Written proof covering the occurrence, character and extent of the loss of which a claim is made must be given to the claims administrator within the 12-month period following the date on which the claim is incurred or, if sooner, within 90 days following the effective date of an individual's coverage. Failure to furnish proof will not reduce any claim if it shall be shown that it was not reasonably possible to furnish such proof on time and that it was furnished as soon as was reasonably possible. Upon termination of the Plan, final claims must be received within 30 days of the effective date of the termination.

Payment of Benefits

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

Workers Compensation Not Affected

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

Severability

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

Pronouns

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

Mistake of Fact

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

Indemnity

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

Employment Rights

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

Controlling Law

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

Plan Year

The Plan year is September 1 through August 31.

Subrogation/Right of Reimbursement

A. If a Covered Person receives any benefits arising out of an injury or illness (herein, referred to collectively as "Injury") for which the Covered Person has or may have any claim or right to recovery:

1. payments under this Plan shall be made on the condition that this Plan will be reimbursed out of the proceeds of such claim or right to recovery;
2. payment of benefits under this Plan shall be conditioned upon, and no payments under this Plan of benefits shall be made until, acknowledgment in a form specified by the Plan of the agreement of the Covered Person, and his attorney, to the terms of this Section; and,
3. payment of benefits may be revoked, and the Plan may seek refunds of payments, where acknowledgement of the Plan's right under this Section is incomplete or impaired.

B. The Covered Person agrees:

1. to give the Plan notice of intent to pursue a claim against a responsible party, or any decision not to pursue such a claim, as provided in paragraph E. below;
2. to refrain from doing anything to prejudice the Plan's rights to reimbursement or subrogation, or the pursuit of claims directly or indirectly to recover reimbursement of benefits paid;
3. to cooperate fully and exclusively with the Plan and its appointed agents regarding subrogation rights, including executing and delivering all instruments and papers (including the execution of a subrogation form) and do whatever else is necessary to fully protect any and all subrogation or reimbursement of rights;
4. that any such funds received will be held in constructive trust for the reimbursement of the Plan;
5. to direct any attorneys or fiscal intermediaries to hold recovery of all funds related to the Injury in trust for the benefit of the Plan, and to direct that such parties deal exclusively with the cost recovery agent for the Plan;
6. to assign to the Plan and its designees all rights against such agents and attorneys to enforce this direction; and
7. that the Plan will be reimbursed in full before any amounts (including, but not limited to, attorney fees or costs), incurred are deducted from such funds.

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

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

Medical Case Management

The claims administrator, on behalf of the District, will notify the Medical Case Management Review firm of the occurrence of a major medical condition so that the covered person's medical condition may be assessed and, if appropriate, the District may, at its discretion, designate additional benefits for expenses which may be recommended by the Medical Case Management Review firm as alternative care including, but not limited to, home care, therapy, nursing/housekeeping assistance, medical equipment and supplies. A *"major medical condition"* as used in this subsection means any illness or illness which the Medical Case Management Review firm has identified as being catastrophic or traumatic.

Free Choice of Physician

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

Qualified Medical Child Support Orders

Definitions

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

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

- "Medical Child Support Order" means any court judgment, decree or order (including approval of settlement agreement) which:
  1. provides for child support for a child of an employee under the Plan or
  2. provides for health coverage to such a child under state domestic relations law (including a community property law); and
  3. relates to benefits under this Plan.

- "Qualified Medical Child Support Order" (QMCSO) means a Medical Child Support Order which:
  1. creates or recognizes an Alternate Recipient's right to receive benefits for which an employee or his/her dependent is eligible under the Plan; and
  2. meets the following requirements:
     a. clearly specifies the name and last known mailing address (if any) of the employee and the name and mailing address of each Alternate Recipient covered by the order;
     b. clearly specifies a reasonable description of the type of coverage to be provided by the Plan to each Alternative Recipient, or the manner in which such type of coverage is to be determined;

c. clearly specifies the period to which such order applies;
d. clearly specifies each plan to which such order applies; and
e. does not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

Procedures

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

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

2. permit the Alternate Recipient to designate a representative to receive copies of notices sent to the Alternate Recipient regarding the Medical Child Support Order;

3. within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the employee, each Alternate Recipient covered by the order, and each representative for these parties of such determination.

Effect of Determination

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

1. the Alternate Recipient shall be considered a dependent child of the employee under the Plan;

2. any payment for benefits in reimbursement of expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent shall be made to the Alternate Recipient or the

Alternate Recipient's custodial parent or legal guardian (or the provider, with the approval of the custodial parent or guardian). A payment of benefits to an official of a State or political subdivision thereof whose address has been substituted for the address of the Alternate Recipient, shall be treated as payment of benefits to the Alternate Recipient for purposes hereof;

3. if any QMCSO requires an employee who is enrolled in the Plan under Single coverage to provide health coverage for an Alternate Recipient, such child shall be added to the Plan and the appropriate contributions for Family coverage will be withheld from the employee's compensation;

4. if any Qualified Medical Child Support Order requires an employee who is not enrolled in the Plan to provide health coverage for an Alternate Recipient, the employee and child shall be enrolled in the Plan, and the appropriate contributions for Family coverage will be withheld from the employee's compensation;

5. except as provided under the section "National Medical Support Notice", coverage of the Alternate Recipient shall be effective as of the latest of:
   a. the first day of the month specified in the Order;
   b. the first day of the month following the determination by the Plan Administrator; or
   c. the earlier of (1) the first day of the month following the receipt by the Plan of the first premium payment required for coverage, if any, or (2) the effective date of a court or administrative order requiring the District to withhold from the participant's compensation, the participant's share, if any, of premiums for health coverage and to pay such share of premiums to the Plan;

7. if the Plan and any fiduciary under the Plan acts in accordance with the provisions of these procedures in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, the Plan's obligation to the employee and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

Special Eligibility Rules for Qualified Medical Child Support Orders

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

Termination of Coverage

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

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

National Medical Support Notice

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

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

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

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

Certificate of Adoption

I certify that the Community Unit School District #200 Health Care Plan amended and restated effective September 1, 2002, is adopted by the Board of Education.

_____
Signature

_____
Title

_____
Date

_____
Attested