PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
MACOMB COMMUNITY UNIT SCHOOL DISTRICT #185
EMPLOYEE HEALTH CARE PLANS
STANDARD HEALTH PLAN
&
QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)
JANUARY 1, 2017
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NOTICE TO PLAN PARTICIPANTS

Pre-Certification Requirements

The Plan has a Hospital Pre-Admission Certification and Continued Stay Review Program. The District has contracted with Hines and 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, "Cost Management Services" beginning on page 30 in this booklet for an explanation of this program.

Note: If you (or your dependent) do not comply with the Pre-Certification program, an additional $300 deductible will be applied for the hospital confinement. In addition, if any portion of the hospital confinement is not certified by the utilization review firm as being medically necessary, no benefits will be provided for those days. The deductible and/or excluded charges will not apply towards the Out-of-Pocket limit.

Notice of Non-Grandfathered Status effective January 1, 2012

This group health plan believes this plan is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act).
INTRODUCTION

This document is a description of Macomb Community Unit School District #185 Employee Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

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

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

This booklet, and the benefits described within it, is drafted to be compliant with applicable laws, including the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act), and otherwise is intended to replace all previously distributed materials. Although the Plan Administrator hopes and expects to continue the coverage described in this booklet, the Plan Administrator necessarily reserves 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. If benefits are discontinued, benefits will be paid for eligible expenses incurred prior to the date of termination.

A description of the Group Life and Accidental Death and Dismemberment Insurance Plan coverage 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.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

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

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

The Health Care Plan is not a policy of Worker’s Compensation insurance. Please contact the Administrative Office if your illness or injury is work-related.

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

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

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

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

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.
This part should be read carefully since each Plan Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

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

**Plan Exclusions.** Shows what charges are not covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

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

Verification of Eligibility (800) 423-1841

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

MEDICAL BENEFITS

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

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

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

Hospitalizations
MRI/CAT/PET scans
Inpatient Substance Abuse/Mental Disorder treatments
Outpatient surgical procedures
Chemotherapy/radiation oncology
Infusions – high cost injectables
Dialysis
DME – Durable Medical Equipment over $2000
Home Care

Please see the COST MANAGEMENT section in this booklet for details.

The Plan is a plan which contains a Network Provider Organization.

PPO name: HFN
Address: P O Box 3428
          Oak Brook, IL  60522-3428
Telephone: (800) 295-5444
E-mail: www.hfninc.com

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

When a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.
Deductibles/Copayments payable by Plan Participants

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

A deductible is an amount of money paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. Deductibles do not accrue toward the 100% maximum out-of-pocket payment. Effective 01/01/14 Deductibles do accrue towards the PPACA In-Network Maximum Out-of-Pocket.

"QHDHP Family Unit Deductible. As each family member incurs medical expenses, the amount they pay toward these expenses is credited toward the family’s deductible. When these expenses add up to the family deductible, the QHDHP coverage begins. Note: If one family member has high health care expenses, by paying those health care expenses, he reaches the family deductible and coverage begins for the entire family.

A copayment is the amount of money paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment. Effective 01/01/14 Copayments do accrue towards the PPACA In-Network Maximum Out-of-Pocket.
### STANDARD MEDICAL BENEFITS SCHEDULE

<table>
<thead>
<tr>
<th>MAXIMUM BENEFIT AMOUNT: Aggregate Annual Limit</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DEDUCTIBLE, PER CALENDAR YEAR** - Amounts applied to In Network services and amounts applied to Out of Network services will accumulate separately and will not apply to one another.

<table>
<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Covered Person</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>Per Family Unit</td>
<td>$2,250</td>
<td>$4,500</td>
</tr>
</tbody>
</table>

The Calendar Year deductible is waived for the following Covered Charges:
- In Network Preventive Care
- Second Surgical Opinions

**COPAYMENTS**

<table>
<thead>
<tr>
<th>Hospital services</th>
<th>None</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician visits</td>
<td>$30</td>
<td>$60</td>
</tr>
<tr>
<td>Specialist visits</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Emergency room</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, Hines and Associates must be notified at (800) 944-9401 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.

**MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR** - Amounts applied to In Network services and amounts applied to Out of Network services will accumulate separately and will not apply to one another.

<table>
<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Covered Person</td>
<td>$2,250</td>
<td>$4,500</td>
</tr>
<tr>
<td>Per Family Unit</td>
<td>$4,500</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

**PPACA MAXIMUM IN-NETWORK OUT-OF-POCKET** – will be adjusted each January 1st to comply with PPACA regulations.

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.

**Effective 01/01/14 Deductibles and Copayments do accrue towards the PPACA In-Network Maximum Out-of-Pocket.**

- Deductible(s)
- Cost containment penalties
- Copayments
- Amounts over Usual and Reasonable Charges

### COVERED CHARGES

**Hospital Services**

<table>
<thead>
<tr>
<th>Room and Board</th>
<th>80% after deductible the semiprivate room rate</th>
<th>60% after deductible the semiprivate room rate</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Intensive Care Unit</th>
<th>80% after deductible Hospital's ICU Charge</th>
<th>60% after deductible Hospital's ICU Charge</th>
</tr>
</thead>
</table>

**Emergency Room Visit**

<table>
<thead>
<tr>
<th>Medical Emergency</th>
<th>80% after $100 copay and deductible</th>
<th>Payable at the network level</th>
</tr>
</thead>
</table>

<p>| Medical Non-Emergency Care | 80% after $100 copay and deductible | 60% after $100 copay and deductible |</p>
<table>
<thead>
<tr>
<th>SERVICE TYPE</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
</table>
| Skilled Nursing Facility | 80% after deductible  
the facility's semiprivate room rate  
within 14 days of a 3 day stay  
60 days Calendar Year maximum | 60% after deductible  
the facility's semiprivate room rate within 14 days of a 3 day stay  
60 days Calendar Year maximum |
| Physician Services | | |
| Inpatient visits | 80% after deductible | 60% after deductible |
| Office visits | 100% after $30 copayment. All other services performed in the office are payable at 80% after deductible. | 100% after $60 copayment. All other services performed in the office are payable at 60% after deductible. |
| Specialist office visits | 100% after $50 copayment. All other services performed in the office are payable at 80% after deductible. | 100% after $100 copayment. All other services performed in the office are payable at 60% after deductible. |
| Surgery | 80% after deductible | 60% after deductible |
| Allergy testing | 80% after deductible | 60% after deductible |
| Allergy serum and injections | 80% after deductible | 60% after deductible |
| Diagnostic Testing (X-ray & Lab) | 80% after deductible | 60% after deductible |
| Home Health Care | 80% after deductible  
120 visits Calendar Year maximum | 60% after deductible  
120 visits Calendar Year maximum |
| Inpatient Prescription Drugs | 80% after deductible | 60% after deductible |
| Outpatient Private Duty Nursing | 80% after deductible | 60% after deductible |
| Hospice Care | 80% after deductible  
$10,000 inpatient and outpatient  
Lifetime maximum | 60% after deductible  
$10,000 inpatient and outpatient  
Lifetime maximum |
| Bereavement Counseling | 80% after deductible  
6 visits Lifetime maximum | 60% after deductible  
6 visits Lifetime maximum |
| Ambulance Service | 80% after deductible | 80% after deductible |
| Occupational Therapy | 80% after deductible | 60% after deductible |
| Speech Therapy | 80% after deductible | 60% after deductible |
| Physical Therapy | 80% after deductible | 60% after deductible |
| Durable Medical Equipment | 80% after deductible | 60% after deductible |
| Prosthetics | 80% after deductible | 60% after deductible |
| Orthotics | 80% after deductible | 60% after deductible |
| Spinal Manipulation Chiropractic | Visits are payable at 100% after a $50 copay. All other services are payable at 80% after the deductible. Maximum of $2,000 per calendar year. | Visits are payable at 100% after a $100 copay. All other services are payable at 60% after the deductible. Maximum of $2,000 per calendar year. |
| Mental Disorders and Substance Abuse | | |
| Inpatient/Day Hospital | 80% after deductible  
Maximum of 30 days per calendar year.  
Alcohol/Substance Abuse treatment is limited to one course of treatment while covered under the Plan. | 60% after deductible  
Maximum of 30 days per calendar year.  
Alcohol/Substance Abuse treatment is limited to one course of treatment while covered under the Plan. |
<table>
<thead>
<tr>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
</tr>
<tr>
<td>100% after a $50 copay for visits and psychotherapy by a specialist or $30 copay for non specialists. All other services are payable at 80% after deductible.</td>
<td>100% after a $100 copay for visits and psychotherapy by a specialist or $60 copay for non specialists. All other services are payable at 60% after deductible.</td>
</tr>
<tr>
<td>Maximum of 50 visits per calendar year.</td>
<td>Maximum of 50 visits per calendar year.</td>
</tr>
</tbody>
</table>

**Autism Spectrum Disorder** – Maximum Lifetime Benefit $36,000

**PPACA Preventive Care**

**Immunizations**

100% at In-network Pharmacy, Health Dept Clinic, and In-Network Physicians Office.

| Women’s Preventive Act services effective 07/01/13 | 100%, no deductible | Not Covered |

The following women’s preventive services, are covered expenses effective 07/01/13: Breastfeeding support, supplies, and counseling; Screening and counseling for interpersonal and domestic violence; Screening for gestational diabetes; DNA testing for high-risk strains of HPV; Counseling regarding sexually transmitted infections, including HIV; Screening for HIV; Contraceptive methods and counseling; and Well woman visits.

- Preventive Well Adult Care: 100%
- Not covered

Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, preventive physical examination, x-rays, laboratory tests, immunizations/flu shots, colonoscopies, sigmoidoscopies and includes all services as required under the Affordable Care Act.

Frequency limits for preventive services:

- Mammogram
  - one baseline mammogram for women age 34 through 39;
  - one mammogram per calendar year for women age 40 and over;
- Cholesterol testing, limited to once per calendar year;
- Pap smear testing, limited to once per calendar year;
- Colonoscopy – Once during Ages of 50-59; once every 5 years for ages 60 and above.

| Routine Well Newborn Nursery Care | 80% after deductible | 60% after deductible |
| Preventive Well Child Care | 100% | Not covered |

Includes: office visits, preventive physical examination, laboratory tests, x-rays, hearing tests, vision tests, immunizations and other preventive care and services required by applicable law if provided by a Panel/Network/Participating Provider to age 26.

**Organ Transplants**

| Paid same as any other illness | Paid same as any other illness |

**Pregnancy**

| Paid same as any other illness | Paid same as any other illness |

**Infertility Benefits**

| Paid same as any other illness for below services only | Paid same as any other illness for below services only |

**Limited to:** care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of infertility. Does not include services related to assisted reproductive technologies such as but not limited to artificial insemination, egg retrieval, embryo transfers, drug therapy.
# QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP) MEDICAL BENEFITS SCHEDULE

<table>
<thead>
<tr>
<th>MAXIMUM BENEFIT AMOUNT: Aggregate Annual Limit</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unlimited</td>
<td></td>
</tr>
</tbody>
</table>

Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.

**DEDUCTIBLE, PER CALENDAR YEAR** - Amounts applied to In Network services and amounts applied to Out of Network services will accumulate separately and will not apply to one another.

### Prior to 1/1/2013
- Per Covered Person: $1,200
- Per Family Unit: $2,400

### Effective 1/1/2013
- Per Covered Person: $1,250
- Per Family Unit: $2,500

### Effective 1/1/2014 – 12/31/2017
- Per Covered Person: $1,500
- Per Family Unit: $3,000

The Calendar Year deductible is waived for the following Covered Charges:
- In Network Preventive Care
- Second Surgical Opinions

### COPAYMENTS
- Hospital services: None
- Physician visits: None
- Specialist visits: None
- Emergency room: $100

The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, Hines and Associates must be notified at (800) 944-9401 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.

**MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR** - Amounts applied to In Network services and amounts applied to Out of Network services will accumulate separately and will not apply to one another.

### Effective 1/1/2013 – 12/31/13
- Per Covered Person: $1,500
- Per Family Unit: $6,000

### Effective 1/1/2014 – 12/31/17
- Per Covered Person: $3,000
- Per Family Unit: $6,000

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

**IRS MAXIMUM IN-NETWORK OUT-OF-POCKET** – will be adjusted each January 1st to comply with IRS regulations

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.

**Effective 01/01/14 Deductibles and Copayments do accrue towards the PPACA In-Network Maximum Out-of-Pocket.**
- Deductible(s)
- Cost containment penalties
- Copayments
- Amounts over Usual and Reasonable Charges

**COVERED CHARGES**
- Hospital Services
<table>
<thead>
<tr>
<th><strong>NETWORK PROVIDERS</strong></th>
<th><strong>NON-NETWORK PROVIDERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>85% after deductible</td>
</tr>
<tr>
<td></td>
<td>the semiprivate room rate</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>85% after deductible</td>
</tr>
<tr>
<td></td>
<td>Hospital's ICU Charge</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td></td>
</tr>
<tr>
<td>Medical Emergency</td>
<td>85% after $100 copay and</td>
</tr>
<tr>
<td></td>
<td>deductible</td>
</tr>
<tr>
<td>Medical Non-Emergency Care</td>
<td>85% after $100 copay and</td>
</tr>
<tr>
<td></td>
<td>deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>85% after deductible</td>
</tr>
<tr>
<td></td>
<td>the facility's semiprivate room rate within 14 days of a 3 day stay</td>
</tr>
<tr>
<td></td>
<td>60 days Calendar Year maximum</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
</tr>
<tr>
<td>Inpatient visits</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Office visits</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>85% after deductible.</td>
</tr>
<tr>
<td>Surgery</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Allergy serum and injections</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing (X-ray &amp; Lab)</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>85% after deductible</td>
</tr>
<tr>
<td></td>
<td>120 visits Calendar Year maximum</td>
</tr>
<tr>
<td>Inpatient Prescription Drugs</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Outpatient Private Duty Nursing</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>85% after deductible</td>
</tr>
<tr>
<td></td>
<td>$10,000 inpatient and outpatient Lifetime maximum</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>85% after deductible</td>
</tr>
<tr>
<td></td>
<td>6 visits Lifetime maximum</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Orthotics</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Spinal Manipulation</td>
<td>85% after the deductible.</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Maximum of $2,000 per calendar year.</td>
</tr>
<tr>
<td>Mental Disorders and Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Inpatient/Day Hospital</td>
<td>85% after deductible</td>
</tr>
<tr>
<td></td>
<td>Maximum of 30 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Alcohol/Substance Abuse treatment is limited to one course of treatment while covered under the Plan.</td>
</tr>
<tr>
<td></td>
<td>NETWORK PROVIDERS</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Outpatient</td>
<td>85% after deductible.</td>
</tr>
<tr>
<td></td>
<td>Maximum of 50 visits per calendar year</td>
</tr>
<tr>
<td>Autism Spectrum Disorder – Maximum Lifetime Benefit $36,000</td>
<td></td>
</tr>
<tr>
<td>PPACA Preventive Care¹</td>
<td></td>
</tr>
<tr>
<td>Women’s Preventive Act services effective 07/01/13</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Preventive Well Adult Care</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>100% at in-network Pharmacy, Health Dept Clinic, and In- Network Physicians Office.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, preventive physical examination, standard preventive x-rays and laboratory tests, immunizations/flu shots and services required by applicable law. A current listing of required preventive care can be accessed at: <a href="http://www.HealthCare.gov">www.HealthCare.gov</a></td>
</tr>
<tr>
<td></td>
<td>Frequency limits for preventive services:</td>
</tr>
<tr>
<td></td>
<td>Mammogram</td>
</tr>
<tr>
<td></td>
<td>– one baseline mammogram for women age 34 through 39;</td>
</tr>
<tr>
<td></td>
<td>– one mammogram per calendar year for women age 40 and over;</td>
</tr>
<tr>
<td></td>
<td>Cholesterol testing, limited to once per calendar year;</td>
</tr>
<tr>
<td></td>
<td>Pap smear testing, limited to once per calendar year;</td>
</tr>
<tr>
<td></td>
<td>Colonoscopy – Once during Ages of 50-59; once every 5 years for ages 60 and above.</td>
</tr>
<tr>
<td>Routine Well Newborn Nursery Care</td>
<td>85% after deductible</td>
</tr>
<tr>
<td>Preventive Well Child Care</td>
<td>100%, no deductible</td>
</tr>
<tr>
<td>Includes: office visits, preventive physical examination, laboratory tests, x-rays, hearing tests, vision tests, immunizations and other preventive care and services required by applicable law if provided by a Panel/Network/Participating Provider to age 26.</td>
<td></td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>Paid same as any other illness</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Paid same as any other illness</td>
</tr>
<tr>
<td>Infertility Benefits</td>
<td>Paid same as any other illness for below services only</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Limited to:</strong> care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of infertility. Does not include services related to assisted reproductive technologies such as but not limited to artificial insemination, egg retrieval, embryo transfers, drug therapy.</td>
</tr>
</tbody>
</table>
*The QHDHP plan deductible and/or Out-of-Pocket will be adjusted each January 1st to comply with IRS regulations.

Radiology, Pathology, Anesthesiology and Emergency Physician charges are paid at In-Network Benefit Level if services are received at an In-Network facility.

Covered Persons may receive Non-Network Provider services when an In-Network Provider isn’t within a 100-mile radius. With prior approval these charges will be considered at the In-Network Benefit Level.

PPACA defines preventive care services as items or services recommended with an A or B rating by the U.S. Preventive Services Task Force and Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention. A complete listing of recommendations and guidelines can be found at www.HealthCare.gov/center/regulations/prevention.html.

**Preventive versus Diagnostic Services:**
Certain services can be done for preventive or diagnostic reasons. When a service is performed for the purpose of preventive screening and is appropriately reported, it will be adjudicated under the Preventive Care Services benefit.

Preventive Services are those performed on a person who:
1. Has not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities; or
2. Has had screening done within the recommended interval with the findings considered normal; or
3. Has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals.
4. Has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g., polyp removal during a preventive colonoscopy), the therapeutic service would still be considered a preventive service.

Examples include, but are not limited to:
- A woman had an abnormal finding on a preventive screening mammography and the follow up study was found to be normal, and the patient was returned to normal mammography screening protocol, then future mammography would be considered preventive.
- If a polyp is encountered during preventive screening colonoscopy, the colonoscopy, removal of the polyp, and associated facility, lab and anesthesia fees done at the same encounter are covered under the Preventive Care Services benefit.

When a service is done for diagnostic purposes, it will be adjudicated under the applicable non-preventive medical benefit.

Unless otherwise stated above under Preventive Care, Diagnostic services are done on a person who:
1. Had abnormalities found on previous preventive or diagnostic studies that require further diagnostic studies; or
2. Had abnormalities found on previous preventive or diagnostic studies that would recommend a repeat of the same studies within shortened time intervals from the recommended preventive screening time intervals; or
3. Had a symptom(s) that required further diagnosis.

Examples include, but are not limited to:
- A patient had a polyp found and removed at a prior preventive screening colonoscopy. All future colonoscopies are considered diagnostic because the time intervals between future colonoscopies would be shortened.
- A patient had elevated cholesterol on prior preventive screening. Once the diagnosis has been made, further testing is considered diagnostic rather than preventive. This is true whether or not the patient is receiving treatment.
• If a Preventive Service results in a therapeutic service at a later point in time, the Preventive Service would be adjudicated under the Preventive Care Services benefit and the therapeutic service would be adjudicated under the applicable non-preventive medical benefit.

Related Services:
Services directly related to the performance of a preventive service are adjudicated under the Preventive Care Services benefit. For example, all services for a preventive colonoscopy (e.g. associated facility, anesthesia, pathologist and physician fees) are adjudicated under the Preventive Care Services benefit. Note, however, that benefit adjudication is contingent upon accurate claims submission by the provider, including diagnosis, procedure, age and gender.
# Prescription Drug Benefit Schedule

## Standard Plan

<table>
<thead>
<tr>
<th>Prescription Drug Benefit</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy Option (up to a 30 Day Supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$10.00 copayment</td>
<td>Prescriptions are only covered at participating pharmacies</td>
</tr>
<tr>
<td>Brand Name Drugs</td>
<td>$30.00 copayment</td>
<td>Prescriptions are only covered at participating pharmacies</td>
</tr>
<tr>
<td>Brand Equivalent Name Drugs</td>
<td>$60.00 copayment</td>
<td>Prescriptions are only covered at participating pharmacies</td>
</tr>
<tr>
<td>Specialty</td>
<td>$80.00 copayment</td>
<td>Prescriptions are only covered at participating pharmacies</td>
</tr>
<tr>
<td><strong>Mail Order and Retail Option (up to a 90 Day Supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$25.00 copayment</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Brand Name Drugs</td>
<td>$75.00 copayment</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Brand Equivalent Name Drugs</td>
<td>$150.00 copayment</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

## QHDP Plan

<table>
<thead>
<tr>
<th>Prescription Drug Benefit</th>
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<th>Non-Network</th>
</tr>
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<tbody>
<tr>
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<td>$25.00 copayment</td>
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</tr>
<tr>
<td>Brand Equivalent Name Drugs</td>
<td>$40.00 copayment</td>
<td>Prescriptions are only covered at participating pharmacies</td>
</tr>
<tr>
<td>Specialty</td>
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<td>Generic Drugs</td>
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<td>Not Applicable</td>
</tr>
<tr>
<td>Brand Name Drugs</td>
<td>$65.00 copayment</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Brand Equivalent Name Drugs</td>
<td>$100.00 copayment</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

**QHDP Plan** - All eligible Prescriptions are applied to the deductible. After the deductible is met the co-pay will be applied. Once the Out-of-Pocket limit is met no further co-pay will apply.
WHO IS ELIGIBLE FOR COVERAGE

You are eligible for the coverage described in this booklet if you are:

- a permanent full-time employee who works at least 30 hours per week for a regular wage or salary;

- a variable employee who works an average of 30 hours per week per PPACA stability period effective 01/01/15;

- a member of an employee class entitled to coverage through the District; and,

- a permanent resident of the United States.

You are not eligible for coverage if you are a temporary employee, a part-time employee working less than an average of 30 hours per week, an employee who is employed in an employment class not entitled to coverage through the District, or an individual who is retained by the District on a non-wage or salary basis to provide a professional service including, but not limited to, an attorney or accountant.

VARIABLE EMPLOYEES AND ELIGIBLE DEPENDENTS:

As required by Employer Shared Responsibility Provisions of the PPACA, new variable employees and dependents are eligible to apply for enrollment upon meeting the requirements of and completing their Initial Measurement Period. Ongoing variable employees and dependents are eligible to apply for enrollment upon meeting the requirements of and completing their Standard Measurement Period. An employee must make written application for coverage and sign a payroll deduction order form within thirty-one (31) days of becoming eligible.

INITIAL MEASUREMENT PERIOD: Begins on the first day of the next month following completion of one calendar month of continuous employment and ends twelve (12) months later.

REQUIREMENT: During the Initial Measurement Period the employee must average thirty (30) hours per week or average one hundred thirty (130) hours per month, also known as the “minimum hours threshold”.

EFFECTIVE DATE: After meeting the minimum hours threshold requirement during the Initial Measurement Period coverage is effective no later than thirteen (13) months from the employee’s start date plus time remaining until the 1st day of the next calendar month.

INITIAL STABILITY PERIOD: Coverage begins with the Effective Date of coverage as described above and continues for a period of twelve (12) consecutive months, regardless of actual hours worked during this subsequent Stability Period, provided the employee remains employed.

STANDARD MEASUREMENT PERIOD: Begins on November 1st and ends twelve (12) months later on October 31st.

REQUIREMENT: During the Standard Measurement Period the employee must average thirty (30) hours per week or average one hundred thirty (130) hours per month, also known as the “minimum hours threshold”.

EFFECTIVE DATE: After meeting the minimum hours threshold requirement during the Standard Measurement Period coverage is effective the 1st day of January.

STANDARD STABILITY PERIOD: Coverage begins the first 1st day of January and continues for a period of twelve (12) consecutive months, regardless of actual hours worked during this subsequent Stability Period, provided the employee remains employed.
You may also elect to cover your eligible dependents. Dependents eligible under the Plan are:

Spouses and Working Civil Union Partners who have access to employer subsidized (at least 50%) major medical insurance are only allowed on this Plan if they have enrolled thru their employer’s Health Plan.

1. your legal spouse. The term "spouse" means a person of the opposite sex who is legally married to the Plan Participant. However, a spouse from whom you are legally separated is not eligible; and,

2. Civil Unions as required by Illinois Public Act 96-1513

   An eligible Dependent includes a partner, of the opposite sex or same sex, with whom you have entered into a legal civil union. Such civil union must meet all the requirements of a valid civil union in the State of Illinois. A copy of your completed civil union certificate may be required at enrollment. Any newly acquired Civil Union Partner will be eligible to enroll in the Plan within the same time requirements as a newly acquired Spouse.

   Your partner in a same-sex marriage, or an opposite sex or same sex civil union or a similar relationship other than common law marriage, that was legally entered into in another state will also be eligible under this provision. You may be required to provide proof of a valid, legal union in that state, e.g. a copy of your marriage or civil union certificate.

   Your partner must be a resident of the same country as you.

   The value of any benefits provided by this Plan or your partner may be considered “imputed” income for federal income and payroll tax purposes.

   A partner in a legal civil union (as defined above) is entitled to the same benefits provided to a married spouse, including coverage continuation provided under this Plan for a married spouse or a surviving spouse under the COBRA section, even though COBRA is a Federal mandate that applies only to a federally recognized spouse under the Defense of Marriage Act.

3. your dependent child(ren) to age 26, provided the child is not serving in the armed forces of any country.

4. military veteran dependents under age 30 if all of the following are applicable:

   • are Illinois residents;
   • are not married;
   • have served in the active or reserve components of the U.S. Armed Forces (which includes the National Guard); and
   • have received a release discharge other than a dishonorable discharge. Must submit a “Certificate of Release or Discharge from Active Duty”.

Note: Adult Children will be enrolled in the same benefit plans as the employee.

Foster children, grandchildren (unless you have legal guardianship or legal custody) or your parents are not eligible even though you may support them. Proof of a spouse or child’s eligibility, or continued eligibility, may be requested at any time by the District.

If both you and your spouse or Civil Union partner are employees of the District, you may not be covered as both an employee and as your spouse’s or Civil Union’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.

**Working Spouse or Working Civil Union Partner Provision**

Spouses and Working Civil Union Partners who have access to employer subsidized (at least 50%) major medical insurance are only allowed on this Plan if they have enrolled thru their employer’s Health Plan. The District then will become the secondary payer. Please note this provision does not affect children or spouses who are not employed or do not have access to employer subsidized medical insurance.


**Who Pays for the Coverage**

The District and Employee share in the cost of Single coverage for its active, eligible employees.

The cost of Family coverage is based on current Board policy for your employment classification or on the Board’s negotiated agreement with your Association. If you are required to contribute toward the cost of coverage, your contribution will be taken from your pay on a "pre-tax" basis under the District’s Section 125 Plan (or, you may waive in writing at time of completing the enrollment form if post-tax deduction is desired). As such, you will only be allowed to change your Family coverage election during the following:

1. the Open Enrollment period held every November for a January 1 effective date; or
2. within 31 days following a major life change as defined in the District’s Section 125 Plan document.

If you are a retired employee who qualifies for continued coverage under the Illinois Municipal Retirement Fund, you will be responsible for the full cost of coverage for yourself and, if you elect Family continuation, the full cost for coverage for your dependents.

All other (ie: retiree, disabled, leave of absence, etc.) premiums are due to the District by the 10th of each month. Failure to pay within thirty (30) days of the due date will result in immediate termination from the Plan.

If you or your dependent qualify for COBRA continuation as described in the section “Extension of Coverage under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)”, you and/or your dependent will be provided with information regarding the premium amount and payment procedure.

**When Coverage Begins**

**Employee Coverage**

Your coverage will begin at 12:00 A.M. on the first day you are employed as an eligible employee of the District. A completed enrollment / waiver form must be submitted to the Business Office within 31 days of the date you are first eligible. If you waive coverage you will not be eligible for coverage until the Open Enrollment period unless you qualify sooner as a “Special Enrollee”.

**Automatic Enrollment.** Effective 01/01/15. Unless a waiver of coverage or a health insurance enrollment form is received within 31 days of becoming eligible, a full-time employee will be automatically enrolled in the lowest cost health plan available with employee only coverage.
Coverage for Your Dependents

If you have eligible dependent(s) on the day you first become eligible, coverage for your eligible dependent(s) will normally begin at 12:00 A.M. on the day you become covered. However, if you are required to contribute toward the cost of Family coverage, you must file your enrollment/waiver form for Family coverage within 31 days of the date you are first eligible to the District Business Office. If you waive coverage a waiver form is needed and your dependent(s) will not be eligible for coverage until the Open Enrollment period unless they qualify sooner as a “Special Enrollee”.

Once you are enrolled for Family coverage any newly acquired eligible dependent will automatically become covered on the date you acquire him or her. Dependents are considered “acquired” and eligible for coverage on the date of:

- your marriage;
- a newborn child’s birth;
- a child’s adoption, placement for adoption or your legal obligation for total or partial support in anticipation of adoption; or,
- a court order establishing your legal guardianship of a child.

A child’s eligibility under the terms of a Qualified Medical Child Support Order are defined separately.

If you do not have any eligible dependent(s) when you first become covered and acquire an eligible dependent later, coverage for the new dependent will normally begin at 12:00 A.M. on the date he or she is acquired as defined above. However, if you are required to contribute toward the cost of coverage, you must file your election for Family coverage within 31 days of the date you acquire your new spouse or child to the District Business Office.

If you waive coverage or do not file your written election for Family coverage with the Business Office within 31 days of the date you are first eligible or, if later, within 31 days of the date you first acquire an eligible dependent, your dependents will not be eligible unless he or she qualifies sooner as a “Special Enrollee”.

Note: 1 - If you are required to contribute toward the cost of Family coverage, you will only be allowed to change your coverage election during the Open Enrollment period designated by the District in November or, if earlier, within 31 days following a major life change as defined in the Section 125 Plan.
Open Enrollment

The District will designate an Open Enrollment period during the month of November at which time you may:

- change your coverage election;
- change your coverage election from the PPO Plan to the HDHP Plan; or,
- enroll eligible dependent children as defined under Public Act 95-0958.

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

The eligible employee must submit an enrollment/waiver form each calendar year during the Open Enrollment period for themselves and for any eligible dependent children.

Note:

Late Enrollees are not eligible to come on the Plan during Open Enrollment for Calendar Year 2013.

Special Enrollees and Late Enrollees

An employee and/or dependent that is not enrolled for coverage will be considered either a “Special Enrollee” or a “Late Enrollee”.

Special Enrollees

You and/or your dependent(s) will qualify as a “Special Enrollee” if coverage was declined/waived 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 ended as a result of “loss of eligibility”, or incurring a claim that meets or exceeds a lifetime limit on all benefits, or because employer contributions toward the other coverage stopped. If the other coverage was COBRA continuation coverage, that coverage must have been exhausted. “Loss of eligibility” includes loss of coverage as a result of legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in the number of hours of employment, as well as loss of coverage due to the plan no longer offering any benefits to a class of similarly situated individuals (for example, part-time employees). It does not include a loss due to the failure of you and/or your dependent(s) to pay premiums or make contributions on a timely basis, or termination for cause;

2. you get married or;

3. you enter into a Civil Union as defined by Public Act 96-1513;

4. you acquire a new dependent child through birth, adoption, or placement for adoption;

5. Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA): you and/or your dependent(s) had coverage under Medicaid or a state child health plan which you are no longer eligible for; or

6. your dependent returns from Military Service and is now eligible under the Plan as defined under Public Act 95-0958.

If you and/or your dependent(s) qualify for coverage as a Special Enrollee, you must enroll for coverage within 31 days of the loss of the other coverage or within 31 days of the date of marriage, Civil Union, birth, adoption or placement of adoption, whichever is applicable. If you enroll for coverage within this 31-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, marry or enter into a Civil Union.

If you and/or your dependent(s) qualify for coverage as a Special Enrollee due to loss of other coverage that was a result of no longer qualifying for Medicaid or a state child health plan you must enroll for coverage within 60 days of the loss of the other coverage. If you enroll for coverage within this 60-day period, coverage begins at 12:00 A.M. on the day after the other group health plan or health insurance coverage ends.

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

Coverage will begin the first of the month following the date the completed enrollment form is received.

**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 31 days of the occurrence that allows for a “special enrollment”, you and/or your dependent(s) are a “Late Enrollee”.

**Effective Date of Termination for Employees**

Your coverage will end at 11:59 P.M. on the earliest of the following days:

1. the day on which your employment terminates, subject to Board Policy or the Board’s negotiated agreement with your Association;

2. the day on which you no longer meet the definition of an eligible employee. However, if your active work ceases due to a total disability, temporary lay-off or approved leave of absence, you may elect to continue coverage by making any required contribution for coverage and up to:
   a. the last day of the period for which you are considered totally disabled. “Totally disabled” means you are unable to perform each of the main duties of your occupation with the District because of an injury or illness, as certified by your attending physician; or,
   b. the last day of the second month following the date such leave of absence or lay-off began;

3. if you are an active employee age 65 or older, the day on which you elect Medicare as your primary coverage;

4. the day on which you are no longer a resident of the United States;

5. the day the Plan is terminated;

6. individuals retiring from the District: July 1;

7. individuals resigning from the District: when other coverage commences or September 1, whichever is earlier; or,

8. individuals released from service (termination or reduction in force): when other coverage commences or September 1, whichever is earlier.

If 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.

• 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. If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Macomb Community Unit School District #185, 323 W Washington St, Macomb, Illinois, 61455, (309) 833-4161. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

• Victims’ Economic Security and Safety Act -

An Employee who takes a leave of absence that qualifies under the Victim’s Economic Security and Safety Act (820 ILCS 180/1) ("VESAA") shall be entitled to maintain coverage under the Plan for the employee and all Dependents covered by the Plan on the day before the leave of absence for the duration of the VESSA leave, provided that the Employee pays any contributions to the employer required by the Employer for continuation of such coverage. All other Plan provisions apply to Covered Persons on VESSA leave. If both husband and wife or Civil Union Partner are eligible for coverage as employees and one has been considered the covered employee and the other the covered dependent, and the individual carrying the Family coverage no longer qualifies as an employee, the Family coverage may be switched to the remaining spouse or Civil Union Partner. In order to do this, the remaining spouse or Civil Union Partner must provide the Business Office with his/her written request for Family coverage and agreement to make any required employee contributions within the 31-day period immediately following the date the former employee’s coverage would otherwise have terminated. Any person who was covered under the former spouse or Civil Union Partner will then be covered under the remaining spouse or Civil Union Partner as of 12:00 A.M. on the day following the date coverage would otherwise have been terminated.

If more than one parent of a dependent child is covered by the plan as an employee and the parent who has been covering the child as his or her dependent no longer qualifies as an employee, at 12:00 A.M. on the day following termination the dependent child will be considered the dependent of the parent remaining under the Plan. However, if the remaining parent is not already enrolled for Family coverage, he or she must provide the Business Office with written request for Family coverage and agreement to make any required employee contributions within the 31-day period immediately following the date the former employee's coverage would otherwise have terminated.
Effective Date of Termination for Dependents

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

1. for a spouse –
   a. 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 instead of this Plan;
   c. your spouse is eligible for coverage under their employer subsidized (at least 50%) major medical insurance and does not enroll for that coverage.

2. for a civil union –
   a. Dissolution; declaration of invalidity. Any person who enters into a civil union in Illinois consents to the jurisdiction of the courts of Illinois for the purpose of any action relating to a civil union even if one or both parties cease to reside in Illinois. A court shall enter a judgment of dissolution of a civil union if at the time the action is commenced it meets the grounds for dissolution set forth in Section 401 of the Illinois Marriage and Dissolution of Marriage Act. your spouse is eligible for coverage under their employer subsidized (at least 50%) major medical insurance and does not enroll for that coverage.
   b. your civil union partner is eligible for coverage under their employer subsidized (at least 50%) major medical insurance and does not enroll for that coverage.

3. for a child, he or she no longer meets the qualifications of an eligible dependent as defined in the section “Who is Eligible for Coverage”;

4. if you request your contributions for Family coverage be stopped, the last day of the period for which contributions have been paid; or,

5. the date the Plan is terminated or Family coverage is discontinued under the Plan.

Note: In order to be eligible for COBRA coverage continuation, you or your dependent are responsible for notifying the Business Office within 60 days following the date a dependent is no longer eligible for coverage because of divorce, Dissolution of Civil Union or because your child no longer meets the eligibility requirements. If the Business Office is not notified within 60 days following the date your dependent is no longer eligible for coverage, he or she will not qualify for COBRA coverage continuation.

You and/or your dependents may have the opportunity to continue coverage under the Plan for a period of time beyond the normal termination date. More information about extension of coverage is provided in the following sections.

Continuation of Coverage for a Totally and Permanently Disabled Child

Coverage can be continued beyond a child’s attainment of age 26 if he or she is totally and permanently disabled and is unable to support himself or herself because of a mental or physical handicap. The dependent child must be covered under the Plan on his or her 26th birthday and meet all of the eligibility requirements other than age to continue to be eligible. For example, if the dependent marries or ceases to be primarily dependent upon you for support and maintenance, he or she will no longer have coverage under the Plan. Also, you must continue to make
any required contributions for Family coverage. In addition, if your coverage terminates or if the Plan is ended, coverage for the dependent will end.

Proof of a child’s disability must be submitted to the Business Office within 30 days following the date the child will no longer be eligible because of age, i.e., the child’s 26th birthday, and at reasonable intervals thereafter. You will have a period of 60 days to provide the information requested by our claims administrator 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.

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, 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 IMRF retiree, 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 last day of the period for which you have paid a premium by the applicable due date;

5. the day the plan is ended;

6. The date the retired or disabled Employee (or your Dependent) becomes entitled to all Medicare benefits even if the employee (or dependent) has not enrolled in the Medicare benefits. Pursuant to the Department of Insurance ruling dated February 18, 2003, Medicare entitlement no longer ceases your eligibility for IMRF coverage continuation. You are eligible to continue coverage under the Macomb CUSD #185 IMRF Medicare Eligible Retirees Plan. IMRF Medicare Eligible Retirees will automatically be rolled to this Plan in the month they become Medicare Eligible regardless of whether or not they purchase Medicare coverage.

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;

7. **The date the retired or disabled Employee (or your Dependent) becomes entitled to all Medicare benefits even if the employee (or dependent) has not enrolled in the Medicare benefits. Pursuant to the Department of Insurance ruling dated February 18, 2003, Medicare entitlement no longer ceases your eligibility for IMRF coverage continuation. You are eligible to continue coverage under the Macomb CUD #185 IMRF Medicare Eligible Retirees Plan. IMRF Medicare Eligible Retirees will automatically be rolled to this Plan in the month they become Medicare Eligible regardless of whether or not they purchase Medicare coverage.**

**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, they will be eligible to continue 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;

6. **The date the retired or disabled Employee (or your Dependent) becomes entitled to all Medicare benefits even if the employee (or dependent) has not enrolled in the Medicare benefits. Pursuant to the Department of Insurance ruling dated February 18, 2003, Medicare entitlement no longer ceases your eligibility for IMRF coverage continuation. You are eligible to continue coverage under the Macomb**
CUD #185 IMRF Medicare Eligible Retirees Plan. IMRF Medicare Eligible Retirees will automatically be rolled to this Plan in the month they become Medicare Eligible regardless of whether or not they purchase Medicare coverage.

Continuation of Coverage During Periods of Employer-Certified Disability, Workman’s Compensation, Leaves of Absence, or Layoff. If coverage under the Plan would otherwise terminate with respect to a covered person or covered dependent, benefits will continue to be provided for those individuals to the extent required by Illinois law, a collective bargaining agreement in effect with respect to the Employer, a letter of agreement issued pursuant to a collective bargaining agreement in effect with respect to the Employer, a resolution or ordinance of the Employer, or the Employer’s personnel policies. Except to the extent specifically provided in the foregoing, coverage under the Plan will terminate on the date the Covered Person is eligible for Medicare benefits.

Such period of leave, in most instances, will count toward the calculation of maximum extended coverage under COBRA.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Health Insurance Marketplace Options for You and Your Family
There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options available through a Health Insurance Marketplace visit www.healthcare.gov.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.
MEDICAL BENEFITS

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

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. Amounts applied to In Network services and amounts applied to Out of Network services will accumulate separately and will not apply to one another.

This amount will not accrue toward the 100% maximum out-of-pocket payment. Effective 01/01/14 this amount will accrue toward the PPACA In-Network Maximum Out-of-Pocket.

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

"QHDHPlan Family Unit Deductible. As each family member incurs medical expenses, the amount they pay toward these expenses is credited toward the family’s deductible. When these expenses add up to the family deductible, the QHDHIP coverage begins. Note: If one family member has high health care expenses, by paying those health care expenses, he reaches the family deductible and coverage begins for the entire family.

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year. Amounts applied to In Network services and amounts applied to Out of Network services will accumulate separately and will not apply to one another.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.
PPACA IN-NETWORK MAXIMUM OUT-OF-POCKET

$6,350 per Plan Participant and $12,700 per family in calendar year 2014. This limit applies to deductibles, coinsurance, and copays for covered PPACA Essential Health Benefit expenses. This limit does not apply to the drug card program, out-of-network expenses, amounts over reasonable and customary, non-covered expenses, or penalties.

$6,600 per Plan Participant and $13,200 per family in calendar year 2015. This limit applies to deductibles, coinsurance, and copays for covered PPACA Essential Health Benefit expenses including the drug card program. This limit does not apply to out-of-network expenses, amounts over reasonable and customary, non-covered expenses, or penalties.

Beginning with calendar year 2016 and each calendar year thereafter this In-Network Maximum Out-of-Pocket amount shall be adjusted as required under the Patient Protection and Affordable Care Act of 2010 and any regulation issued pursuant thereto.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the Macomb Community Unit School District #185 Employee Health Care Plan, including the ones described in this document.

COVERED CHARGES

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

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits.

Room charges made by a Hospital having only private rooms will be limited to 90% of the hospital’s average private room rate.

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

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans 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 cesarean 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 her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require a provider to obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

(b) the confinement starts within 14 days of a Hospital confinement of at least 3 days or a home confinement for which Home Health Care services were provided; and
(c) the attending Physician certifies the confinement is needed for further care of the condition that caused the Hospital confinement or Home Health Care; and

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

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

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

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

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

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

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

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

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

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

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

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

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within twelve months after the patient's death.

Charges for Bereavement counseling are subject to the limits as described in the Schedule of Benefits.

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

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Claim Administrator finds a longer trip was Medically Necessary. When an individual is being transferred from a Hospital or Skilled Nursing Facility to receive Home Health Care or Hospice Care at Home, transportation by ambulance from the facility to the individual's home will also be eligible if medically necessary.

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

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

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

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

(f) **Rental of durable medical or surgical equipment** if deemed Medically Necessary. Rental of wheelchairs, hospital beds and other durable medical equipment, or the purchase of durable medical equipment if it can be shown that long-term use is planned and that the equipment cannot be rented, or that a purchase is likely to cost less than monthly rental. Deluxe equipment such as electrically-operated beds and wheelchairs are limited to the cost of comparable basic equipment.

(g) Care, supplies and services for the diagnosis, prescription drugs for treatment and charges for surgical correction of physiological abnormalities of **infertility.** Does not includes services related to assisted reproductive technologies such as but not limited to artificial insemination, egg retrieval, embryo transfers, drug therapies.

(h) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(i) Treatment of **Mental Disorders and Substance Abuse.** For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:
All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician’s visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

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

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

Emergency repair due to Injury to sound natural teeth within 12 months of injury.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

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

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted wisdom teeth.

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

(k) Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
Organ transplant charges incurred in conjunction with the direct transplant of the following natural organ(s) from a living person to the covered person or tissue transplant from a human to a human:

a. bone marrow transplant, including stem cell transplantation and reinfusion and cord blood transplant;

b. heart transplant;

c. heart/lung transplant;

d. lung (single or double) transplant;

e. kidney transplant;

f. kidney/pancreas transplant;

g. liver transplant; and,

h. pancreas transplant.

An eligible transplant procedure must be (1) approved for Medicare coverage on the date the transplant is performed; and, (2) not otherwise excluded under the Plan, e.g., the procedure is not experimental or investigational treatment.

A transplant procedure must be performed at a Transplant Facility in order to be considered an eligible expense. A “Transplant Facility” is a hospital or facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations to perform a transplant and:

• for organ transplants, it is an approved member of the United Network for Organ Sharing for such transplant or is approved by Medicare as a transplant facility for such procedure;

• for unrelated allogeneic bone marrow or stem cell transplants, it is a participant in the National Marrow Donor Program;

• for autologous stem cell transplants, it is approved to perform such transplant by (a) the state where the transplant is to be performed; or (b) Medicare; or, (c) the Foundation for the Accreditation of Hemopoietic Cell Therapy. Outpatient facilities must be similarly approved.

Skin and cornea transplants are also eligible but are not subject to the above limitations.

Expenses incurred by a covered individual who is a transplant donor will be eligible. However, if the donor is covered by this Plan but the recipient of the transplant is not, the recipient’s plan will be primary for the donor’s expenses and the Plan will be secondary. The recipient is not eligible for benefits under this Plan. If the recipient of the transplant is covered by this Plan but the donor is not, the donor’s expenses will be eligible. However, payments made on behalf of the donor will be charged towards the recipient’s maximum benefit. If both the donor and recipient are covered under the Plan, expenses incurred by the donor will be considered as part of the recipient’s claim.

m) The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.
Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician’s exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

Prescription drugs and medicines which are approved by the Food and Drug Administration, prescribed by a physician for the treatment of an illness or injury and which are dispensed on an inpatient basis or by a hospital, clinic or physician’s office. Drugs and medicines dispensed on an outpatient basis are eligible under the Prescription Drug Program thru MEDTRAK;

Preventive Care. Covered Charges under Medical Benefits are payable for Preventive Care as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. A current listing of required preventive care can be accessed at www.HealthCare.gov/center/regulations/prevention.html.

Charges for PreventiveWell Adult Care. Preventive well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for PreventiveWell Child Care. Preventive well child care is care by a Physician that is not for an Injury or Sickness.

The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts. Adjustments, repair and replacement of such device or appliance are also eligible if required because of a change in the patient’s condition.

Reconstructive Surgery. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

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

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

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

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

Spinal Manipulation/Chiropractic services by a licensed Chiropractor up to the amount specified in the Medical Benefits Schedule.

Sterilization procedures.

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

Coverage of Well Newborn Nursery/Physician Care.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.
This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the first 4 days after birth while the newborn child is Hospital confined as a result of the child's birth.

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

Group health plans 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 cesarean 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 her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require a provider to obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Charges for Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

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

(x) Diagnostic x-rays.

(y) **Diabetic Supplies** — equipment and supplies for the treatment of diabetes, including self-management services prescribed by a physician.

(z) Renal Dialysis.

(aa) Respiratory Therapy rendered by qualified respiratory therapists.

(ab) **Shock Therapy treatments.**

(ae) **Autism Spectrum Disorders.** Diagnosis and treatment of autism spectrum disorders prescribed by a physician for dependent children under the age 21 up to the maximum specified in the “Schedule of Health Care Benefits” for the following services:

- a. psychiatric care
- b. psychological care
- c. habilitative or rehabilitative care (counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual); and
- d. therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas:
  - self-care and feeding
  - pragmatic, receptive, and expressive language
  - cognitive functioning
  - applied behavioral analysis, intervention, and modification
  - motor planning
  - sensory processing

Autism Spectrum Disorders Treatment will not be subject to the Mental or Nervous Disorders maximums.
A treatment must be considered medically necessary if it is reasonably expected to:

- prevent the onset of an illness, condition, injury, disease or disability;
- reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or help an individual achieve or maintain maximum functional activity in performing daily activities.

(ad) **Clinical Trials.** The Plan will cover routine patient costs for items and services furnished in association with approved clinical trials with respect to cancer or another life-threatening disease or condition. A Plan Participant must be eligible according to the approved trial protocol; and the participating provider has concluded that the individual's participation would be appropriate or the Plan Participant provides medical and scientific information establishing their participation in the approved trial would be appropriate. Benefit shall be consistent as mandated by PPACA PHS Sec. 2709. Benefits will be paid up to the Reasonable and Customary Allowance. Subject to Deductible and Co-insurance.

(ae) **Smoking cessation/Nicotine Use or Addiction.** Care and treatment for smoking/Nicotine cessation programs, including deterrent products. See Pharmacy Benefit.

(af) **Wig or Hairpiece.** Charges associated with the purchase of a wig or artificial hairpiece needed as a result of cancer treatment when prescribed by physician.
COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Hines and Associates
(800) 944-9401

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after a Medical Emergency.

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

The Pre-Certification Notice program is designed to assist you in determining the course of treatment that will maximize your benefits under this plan, reduce health costs and help you and your family to avoid unnecessary out-of-pocket expenses.

Pre-admission review of all Hospital Admissions, Certain Outpatient Surgeries, CT Scans, MRI, and PET Scans is required under your Plan. To avoid penalties please call Hines prior to receiving any such services or within 48 hours of an emergency admission. Failure to call may result in a $300 penalty.

For Pre-certification call Hines at 1-800-944-9401.

Pre-certification does not guarantee benefits or coverage. For benefits and coverage questions call IPMG at 1-800-423-1841.

To avoid a $300 penalty when do I need to call to Pre-Certify?

- 48 hours prior to a Hospital Admission
- Within 2 business days following an emergency Hospital Admission
- MRI outpatient
- PET Scan outpatient
- CT Scan outpatient
- CT Angiogram outpatient

What Outpatient Procedures should I call to Pre-Certify?

- Chemotherapy/radiation oncology
- Infusions – high cost injectables
- Dialysis
- DME – Durable Medical Equipment over $2000
- Home Care

What Outpatient Surgical Procedures should I call to Pre-Certify?

- AICD and Biventricular device insertions
- APLD - Automated Percutaneous Lumbar Discectomy
- AV Fistula or graft access for dialysis
- Bariatric (weight loss) Surgery (is excluded by the Plan)
- Biopsies
- Blepharoplasty
- Breast Reduction
- Excess skin removal arms and chest and legs
- Hysterectomies
- IDET – Intradiscal Electrothermal Annuloplasty
- Nasal Surgeries
- Maxillo-facial surgery
- Panniculectomy
- Percutaneous Radiofrequency Neurotomy, Artificial Intervertebral Disk Implantation
• Sclerotherapy
• Shock wave lithotripsy for plantar fascitis
• Tonsillectomies / Adenoidectomies in adults
• UP3 / UPPP - Uvulopalatopharyngoplasty
• Varicose Vein Surgery
• Ventral Hernia Repair

* Unsure When To Pre-Certify – Make the Phone Call

**UTILIZATION REVIEW**

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

The program consists of:

1. (a) Precertification of the Medical Necessity for non-emergency services before Medical and/or Surgical services are provided:

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

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

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

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

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

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

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

**Here's how the program works.**

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

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator Hines and Associates at (800) 944-9401 at least 48 hours before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact Hines and Associates within 48 hours of the first business day after the admission.

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

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by $300.

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

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

SECOND AND/OR THIRD OPINION PROGRAM

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

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

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

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

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

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

CASE MANAGEMENT

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

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

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

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

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

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

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

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

**Active Employee** is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

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

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

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

**Brand Name** means a trade name medication.

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

**Clinical Trials** means a prospective biomedical or behavioral research study of human volunteers designed to answer specific questions about biomedical or behavioral interventions (drugs, treatments, devices, or new ways of using known drugs, treatments, or devices). Clinical trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious, and effective. A clinical trial is one type of clinical research that follows a pre-defined plan or protocol.

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

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

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

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

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

**Emergency Services** means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

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

**Employer** is Macomb Community Unit School District #185.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.
Essential Health Benefit means, to the extent they are covered under the Plan, ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services (including behavioral health treatment); prescription drugs, rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care). Such benefit shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulation issued pursuant thereto. Spinal manipulations, wigs/hairpieces, services related to organ donation, and charges related to the diagnosis and treatment of: infertility (including prescription drugs), and autism spectrum disorders are not Essential Health Benefits.

Experimental and/or Investigational

Experimental of Investigational means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered Experimental/Investigational if the Covered Person is required to sign a consent form which indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational. Treatment is also considered Experimental/Investigational if such treatment has not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services, Food and Drug Administration (FDA), or any other comparable state governmental agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII. A drug, device or biological product is considered Experimental/Investigational if it does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigation device exemption or an investigational new drug exemption.

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

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

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

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests; its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

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

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

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

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

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

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

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

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

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

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

**Infertility** means incapable of producing offspring.

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

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

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period. Note: Late enrollees are not eligible under the Plan for the 2013 Calendar Year Open Enrollment.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.
Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

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

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

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

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

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

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

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

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

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

Plan means Macomb Community Unit School District #185 Employee Health Care Plan, which is a benefits plan for certain Employees of Macomb Community School Unit District #185 and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.
Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

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

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

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

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

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

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

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

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

5. It has an effective utilization review plan.

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

7. It is approved and licensed by Medicare.

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

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

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

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

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Network Provider charges, the Usual and Reasonable Charge will be the contracted rate.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.
Variable Employee means part-time, temporary or seasonal employees.
PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Pharmacy Benefit Contract.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) Abortion. Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy. This exclusion does not apply to expenses incurred for treatment of complication arising from an elective abortion; or as required under PPACA.

(2) Behavioral Problems. Services or supplies received during a hospital confinement when the confinement is primarily for behavioral problems or social maladjustment or other anti-social actions which are not specifically the result of Mental Illness.

(3) Broken Appointments, Claim Forms. Charges by a physician for broken appointments, or for the completion of claim forms and/or medical reports.

(4) Claim Submission Deadline. Charges for services or supplies for which you do not file a claim within 12 months following the date the service was rendered or the supply received or, if sooner, within 90 days following the date your coverage terminates.

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

(6) Counseling services provided by a social worker or pastoral therapy. However, eligible expenses do include services rendered by a Psychiatrist, Registered Clinical Psychologist, LCSW and MSW when overseen by a physician.

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

(8) Dental care. Treatment of the teeth, gums, alveolar process or supplies used in such treatment or for dental appliances.

(9) Duplicate Coverage under the Plan. Services or supplies to the extent benefits are duplicated because the spouse, parent and or child are employees of the District and each is covered separately under this Plan.

(10) Educational or vocational testing. Services for educational or vocational testing or training.

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

(12) Excess of Maximum Benefit Provisions. Any charge that is excluded and/or denied as being in excess of any maximum benefit provision contained in the primary plan when that plan limits its normal benefits for individuals covered under another plan.

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

(14) Experimental, Investigational Treatment or not Medically Necessary. Any treatment, procedure, service, device, drug or biological product which is considered to be experimental or investigational treatment or which results from experimental or investigational treatment. An expense will be considered “experimental or investigational treatment” if:
the treatment has not been approved by the US Food and Drug Administration, Federal Dept. of Health & Human Services, or any other comparable federal or state governmental agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVII at the time the treatment is provided;

b. the treatment is the subject of on-going Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared with the standard means of treatment or diagnosis;

c. the treatment is governed by a written protocol that references determinations of safety, toxicity and/or efficacy in comparison to conventional alternatives and/or has been approved or is subject to the approval by an Institutional Review Board (IRB) or the appropriate committee of the provider institution;

d. the treatment is being provided subject to the patient’s execution of an informed consent that references determinations of safety, toxicity or efficacy in comparison to conventional alternative; or,

e. a three member board of certified specialists practicing in the same or a related specialty as the specialist and facility providing the treatment or course of treatment selected by the claims administrator for the plan, determines that the treatment, procedure, service, device or drug is experimental or investigational;

f. the treatment is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies.

(15) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting and orthoptics or visual training. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(16) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails.

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

(18) **Gene Therapies, Xenographs or Cloning.**

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

(20) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician; except wig or artificial hairpiece needed as a result of cancer treatment when prescribed by a Physician.

(21) **Health Maintenance Organization.** Any confinement, treatment, service or supply if the expense is incurred by a patient whose primary coverage is under a Health Maintenance Organization (HMO) plan.

(22) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan. This exclusion does not apply, however, to hearing tests to determine hearing loss.

(23) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance or felony. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a
reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(24) **Infertility.** Charges incurred for the treatment of infertility including artificial insemination, in vitro fertilization and embryo transfer procedures, or other direct attempt to induce pregnancy, including drug therapy. This exclusion does not apply, however, to charges incurred for the diagnosis and treatment of medical problems that contribute to the condition of infertility.

(25) **Insurrection or Riot.** Any treatment or service resulting from participation in insurrection or riot. 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;

(26) **Marital or pre-marital counseling or Family Counseling.** Care and treatment for marital or pre-marital counseling or family counseling.

(27) **Milieu Therapy.** Milieu therapy or any confinement in an institution primarily to change or control ones environment.

(28) **Naprapathy or Naturopath.** Services provided by a Naprapath or Naturopath.

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

(30) **No Fault Automobile Coverage.** Any treatment which is covered by no-fault automobile state provisions or other similar legislations.

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

(32) **No Physician recommendation or Recognized by the American Medical Association.** Care, treatment, services or supplies not recommended and approved by a Physician or which are not recognized by the American Medical Association as generally accepted and medically necessary for the diagnosis and/or treatment of the illness or injury; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

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

(34) **Nuclear.** Sickness or Injury arising directly or indirectly from nuclear reaction, nuclear radiation or radioactive contamination however such nuclear reaction, nuclear radiation or radioactive contamination may have been caused.

(35) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered.

(36) **Organ Transplants.** Charges for organ transplant procedures not specifically listed as an eligible expense, or expenses relating to non-human organ or tissue transplants.

(37) **Outside the United States.** Expenses for any treatment administered outside the United States if the individual traveled to the location where the treatment was received for the purpose of obtaining the treatment.

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

(39) **Phone Consults.** Charges levied by a physician for advice given by him/her by telephone or other means of telecommunication.

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

(41) **Punitive or exemplary damages.**

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

(43) **Recreational or Educational Therapy.** Recreational or educational therapy, or forms of non-medical self-care or self-help training and any related diagnostic testing, including changes incurred for special education or training for learning disabilities.

(44) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(45) **Requested by a Third Party.** Routine examinations requested by a third party, such as physical exams required by summer camps, employment, marriage, insurance, sports, court ordered exams, etc.

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

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

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

(49) **Sexual Dysfunction or Inadequacies.**

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

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

(52) **Temporomandibular Joint Syndrome.** Treatment of Temporomandibular Joint Syndrome (TMJ) with intraoral prosthetic devices, or any other method which alters vertical dimension or treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

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

(54) **War.** Expenses resulting from or caused by war, whether declared or undeclared, civil war, invasion, hostilities, riot or resistance to armed aggression.

(55) **Work Related.** Expenses for an injury or sickness arising out of, or in the course of employment for wage or profit and for which the Covered Person is entitled to benefits under any Workers’ Compensation or occupational disease law or any other similar employer liability law whether or not the covered person has applied for such benefit.
PRESCRIPTION DRUG BENEFITS

How the Prescription Drug Program Works

The Plan Sponsor has contracted with MedTrak to administer a Prescription Drug Program. You may contact MedTrak, at 1-800-771-4648, with any questions.

Your Health Care Plan identification card confirms to the pharmacy that you and your eligible dependents are entitled to use this program. When you present this card to any network pharmacy you will be charged the applicable co-pay. If you fill a prescription at a pharmacy which is not participating in the MedTrak network, you must file a claim for reimbursement.

A listing of pharmacies participating in the network will be provided to you. If you have any questions regarding the program or require assistance, you may call MedTrak at 1-800-771-4648.

PRESCRIPTION DRUG BENEFITS – as Listed under the Schedule of Benefits

QHDHP - All eligible Prescriptions are applied to the deductible. After the deductible is met the co-pay will be applied. Once the Out-of Pocket limit is met no further co-pay will apply.

Maintenance Drugs – up to a 90-day supply

A maintenance drug is any drug you are required to take on a regular basis for a period longer than 30 days. Examples of maintenance drugs are medications for diabetes, hypertension or angina. You may fill a prescription for maintenance drugs at a retail pharmacy or thru the mail-order drug program.

MedTrak provides a mail-order drug program for the purchase of maintenance drugs. A 90-day supply or refill of a maintenance drug can be purchased by completing the patient profile on the mail-order envelope that will be provided to you and enclosing your prescription and the applicable co-pay.

You may also phone MedTrak’s toll-free number (1-800-771-4648) and give them the name of the physician who prescribed the medicine. Your mail-order prescription is filled by MedTrak within two weeks and is sent to your home or office via First Class mail or UPS.

Eligible Prescription Drug Expenses

Expenses eligible under this program are limited to a 30-day supply (or 100 Units) filled at a retail pharmacy or a 90-day maintenance supply (or 300 Units) filled at a retail pharmacy or purchased through the mail-order program. Expenses eligible under the program are defined in the separate contract between the Plan Sponsor and MedTrak.

If you have any questions regarding the program, need more information concerning what specific drugs, either new or existing, are covered, or require assistance you may call MedTrak’s Member Services at 1-800-771-4648.

Drugs and medicines prescribed by a physician, approved by the Food and Drug Administration (FDA) for use in the treatment of the individual’s illness or injury and dispensed by a licensed pharmacist. Eligible expenses are as summarized in “Schedule of Prescription Drugs” and as defined under separate contract between the Plan Sponsor and MedTrak.

A drug that has been approved by the FDA but is used for a purpose other than that for which the FDA has approved it may also be eligible if all of the following criteria are met:

a. the drug is not otherwise excluded, for example, it is not for Experimental or Investigational Treatment; and,
b. the use of the drug is appropriate and generally accepted for the condition being treated; and,

c. if the drug is used for the treatment of cancer, the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, or The Compendia-Based Drug Bulletin, recognize it as an appropriate treatment for that form of cancer.

**Coordination of Prescription Drug Benefits With Other Plans**

If another plan, including a Medicare Part D prescription drug plan, is primary for a member of your family (it should pay its benefits first), you should give the pharmacy both ID cards and any secondary benefits for which this Plan is responsible may be processed at the point of sale. If, for some reason, this does not occur, you may submit copies of the prescription and the primary plan's Explanation of Benefits (or a copy of the receipt for the co-payment if the other plan has a drug card or mail-order program) to MedTrak for reimbursement using the patient profile found on the mail-order envelope.
HOW TO SUBMIT A CLAIM

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

What Information Is Needed

The following information must 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 type of service rendered, with diagnosis and/or procedure codes;
- the date(s) of services;
- the amount of charges;
- 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, Civil Union Partners Employer, Dependent Employer -

  need to know if employed or changes employers and, if so, the name and address of his/her employer and whether or not they have group coverage available through this employer. Please note that if your spouse is eligible for coverage under their employer subsidized (at least 50%) major medical insurance and does not enroll for that coverage they are not eligible under the Plan.

- Divorce Decree -

  if a child’s parents are separated or divorced, we 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, IPMG – Employee Benefits Services 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.

- Military Dependents --

  Proof of Illinois residency and a copy of “Certificate of Release or Discharge from Active Duty”.

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Where to File the Claim

All claims should be forwarded to the Preferred Provider Organization (PPO) at:

HFN
P O Box 3428
Oak Brook, IL  60522-3428
www.hfninc.com

The PPO, in turn, will review the claim to determine if the service provider is participating in the network and, if so, calculate the appropriate discount. Following its review of the claim the PPO will forward the claim to the claims administrator for adjudication.

If you have any questions concerning the benefits offered under this Plan or would like to know whether a particular service or supply is covered under the Plan, please call IPMG Employee Benefits Services at (800) 423-1841.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days (or within 90 days if coverage terminates) of the date charges for the service were incurred. Benefits are based on the Plan’s provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it’s not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

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

PROCESSING CLAIMS AND APPEALS

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan’s reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual’s eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan’s final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.
A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator’s notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan’s procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

**Urgent Care Claim**

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

A Physician with knowledge of the claimant’s medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider’s determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

- **Notification to claimant of Claim determination** 72 hours
- **Insufficient information on the Claim, or failure to follow the Plan’s procedure for filing a Claim:**
  - **Notification to claimant, orally or in writing** 24 hours
  - **Response by claimant, orally or in writing** 48 hours
  - **Benefit determination, orally or in writing** 48 hours
  - **Notification of Adverse Benefit Determination on Appeal** 72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan’s benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other
Similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

**Concurrent Care Claims**

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification to claimant of benefit reduction</td>
<td>Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal</td>
</tr>
<tr>
<td>Notification to claimant of rescission</td>
<td>30 days</td>
</tr>
<tr>
<td>Notification of determination on Appeal of Urgent Care Claims</td>
<td>24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)</td>
</tr>
<tr>
<td>Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims</td>
<td>As soon as feasible, but not more than 30 days</td>
</tr>
<tr>
<td>Notification of Adverse Benefit Determination on Appeal for Rescission Claims</td>
<td>30 days</td>
</tr>
</tbody>
</table>

**Pre-Service Claim**

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

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification to claimant of Adverse Benefit Determination</td>
<td>15 days</td>
</tr>
<tr>
<td>Extension due to matters beyond the control of the Plan</td>
<td>15 days</td>
</tr>
<tr>
<td>Insufficient information on the Claim: Notification of</td>
<td>15 days</td>
</tr>
<tr>
<td>Response by claimant</td>
<td>45 days</td>
</tr>
<tr>
<td>Notification, orally or in writing, of failure to follow the Plan’s procedures for filing a Claim</td>
<td>5 days</td>
</tr>
<tr>
<td>Notification of Adverse Benefit Determination on Appeal</td>
<td>30 days</td>
</tr>
</tbody>
</table>
Post-Service Claim

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

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification to claimant of Adverse Benefit Determination</td>
<td>30 days</td>
</tr>
<tr>
<td>Extension due to matters beyond the control of the Plan</td>
<td>15 days</td>
</tr>
<tr>
<td>Extension due to insufficient information on the Claim</td>
<td>15 days</td>
</tr>
<tr>
<td>Response by claimant following notice of insufficient information</td>
<td>45 days</td>
</tr>
<tr>
<td>Notification of Adverse Benefit Determination on Appeal</td>
<td></td>
</tr>
</tbody>
</table>

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

1. Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

2. The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

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

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

5. A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

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

7. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

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

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

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

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:
Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan’s standard, if any, that was used in denying the Claim.

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

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

A description of the Plan’s internal and external review procedures and the time limits applicable to such procedures.

A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

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

Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan’s internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan’s External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

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

(2) The denial relates to the claimant’s failure to meet the Plan’s eligibility requirements;

(3) The claimant has exhausted the Plan’s internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.
Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

1. The claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;
4. The terms of the Plan;
5. Appropriate practice guidelines;
6. Any applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

1. A general description of the reason for the External Review, including information sufficient to identify the claim;
2. The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
3. References to the evidence or documentation the IRO considered in reaching its decision;
4. A discussion of the principal reason(s) for the IRO's decision;
5. A statement that the determination is binding and that judicial review may be available to the claimant; and
6. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:
(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

Claim Appeals should be submitted to:

Claim Appeal Administrator
IPMG – Employee Benefits Services
225 Smith Road
St. Charles, IL 60174
COORDINATION OF BENEFITS

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

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

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

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

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

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

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

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

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

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Spouses and Working Civil Union Partners who have access to employer subsidized (at least 50%) major medical insurance are only allowed on this Plan if they have enrolled thru their employers Health Plan. The District then will become the secondary payor. Please note this provision does not affect children or spouses who are not employed or do not have access to employer subsidized medical insurance.

3. Plans with a coordination provision will pay their benefits up to the Allowable Charge:
(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

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

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

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

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

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

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

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

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

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

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

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

(6) COB credits are not eligible to be paid out.

Benefits for Persons Eligible for Medicare

For IMRF Continuees and Their Dependents

The date the retired or disabled Employee (or your Dependent) becomes entitled to all Medicare benefits even if the employee (or dependent) has not enrolled in the Medicare benefits. Pursuant to the Department of Insurance ruling dated February 18, 2003, Medicare entitlement no longer ceases your eligibility for IMRF coverage continuation. You are eligible to continue coverage under the Macomb CUSD #185 IMRF Medicare Eligible Retirees Plan. IMRF Medicare Eligible Retirees will automatically be rolled to this Plan in the month they become Medicare Eligible regardless of whether or not they purchase Medicare coverage. See the IMRF Medicare Eligible Retirees Plan for Coordination of Benefit Rules.

For All Other Covered Individuals

The Plan will pay its benefits before Medicare in the following circumstances ("Medicare" means the Health Insurance for Aged and Disabled Program established by Title XVIII of the Social Security Act of 1965, as then constituted or later amended):

1. if you are an active employee and you or your spouse are age 65 or older. However, if you make a written election to have Medicare as your primary Health coverage, you and your dependents will not be eligible for coverage under the Plan. If your spouse is age 65 or older when you are less than age 65 and your spouse elects Medicare as his or her primary Health coverage, he or she will not be eligible for coverage under the Plan;

2. if you are in a “current employment status” (as defined by Medicare) and you or your dependent are eligible for Medicare as the result of a disability condition, other than End Stage Renal Disease; or,

3. if you or your dependent are disabled due to End Stage Renal Disease, but only for the period of time defined by current legislation. After this time period, your benefits will be coordinated with Medicare, Part A and Part B, as described in the previous section.

If the Plan is not the primary payer of benefits as described above, the Plan will coordinate its benefits with 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.

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

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

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

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

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

1. automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

2. must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's
100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

**Defined terms:** "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

**Recovery from another plan under which the Covered Person is covered.** This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

**Rights of Plan Administrator.** The Plan Administrator has a right to request reports on and approve of all settlements.
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Macomb Community Unit School District #185 Employee Health Care Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

The Plan Administrator is Macomb Community Unit School District #185, 323 W Washington St, Macon, Illinois, 61455, (309) 833-4161. COBRA continuation coverage for the Plan is administered by IPMG - Employee Benefits Services, 225 Smith Road, St. Charles, Illinois 60174, (800) 423-1841. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

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

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

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

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish
eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual’s status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual’s Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

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

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

1. The death of a covered Employee.
2. The termination (other than by reason of the Employee’s gross misconduct), or reduction of hours, of a covered Employee’s employment.
3. The divorce or legal separation of a covered Employee from the Employee’s Spouse. If the Employee reduces or eliminates the Employee’s Spouse’s Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse’s coverage was reduced or eliminated before the divorce or legal separation.
4. A covered Employee’s enrollment in any part of the Medicare program.
5. A Dependent child’s ceasing to satisfy the Plan’s requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

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

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

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

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

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

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

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

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

**IMPORTANT:**

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

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

Macomb Community Unit School District #185
323 W Washington St
Macomb, Illinois 61455

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

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

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

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

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

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

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

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

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

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

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

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

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

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

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

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

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

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

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

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

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

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

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

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

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

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

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

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

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

IF YOU HAVE QUESTIONS
If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.
KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Macomb Community Unit School District #185 Employee Health Care Plan is the benefit plan of Macomb Community Unit School District #185, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Macomb Community Unit School District #185 to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Macomb Community Unit School District #185 shall appoint a new Plan Administrator as soon as reasonably possible.

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

DUTIES OF THE PLAN ADMINISTRATOR.

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

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

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below). Terms not defined have the same meaning as they have in the HIPAA Privacy Rule contained in the Code of Federal Regulations at 45CFR Parts 160 and 164.

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

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

2. Permitted Uses and Disclosures. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy
Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

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

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

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

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

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

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

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

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

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

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

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

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

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

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

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

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(9)(2)(iii) of the Privacy Standards.

The following members of Macomb Community Unit School District #185's workforce are designated as authorized to receive Protected Health Information from Macomb Community Unit School District #185 Employee Health Care Plan ("the Plan") in order to perform their duties with respect to the Plan: Custodian/Document Shredder, Records Secretary/Special Education, Bookkeeper/Payroll, Superintendent, Assistant Superintendent for Instruction, Executive Secretary/Board Recording, Financial Secretary/Treasurer, Educational Secretary/Receptionist, Administrative Secretary/Human Resources, Technology Director, Technology Consultant, Insurance Committee, School Psychologists, School Social Workers.

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

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media. Terms not defined have the same meaning as they have in the HIPAA Privacy Rule contained in the Code of Federal Regulations at 45CFR Parts 160 and 164.

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

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

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived solely from the funds of the Employer.

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

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

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

PLAN NAME

Macomb Community Unit School District #185 Employee Health Care Plans

HPID NUMBER: 7548264796

TAX ID NUMBER: 37-6216729

PLAN EFFECTIVE DATE: July 1

EFFECTIVE DATE OF PLAN RESTATEMENT: January 1, 2017

PLAN YEAR ENDS: June 30th

EMPLOYER INFORMATION

Macomb Community Unit School District #185
323 W Washington St
Macomb, Illinois 61455
(309) 833-4161

PLAN ADMINISTRATOR

Macomb Community Unit School District #185
323 W Washington St
Macomb, Illinois 61455
(309) 833-4161

AGENT FOR SERVICE OF LEGAL PROCESS

Macomb Community Unit School District #185
323 W Washington St
Macomb, Illinois 61455
(309) 833-4161

CLAIMS ADMINISTRATOR

IPMG Employee Benefits Services
225 Smith Road
St Charles, Illinois 60174
(800) 423-1841
BY THIS AGREEMENT, Macomb Community Unit School District #185 Employee Health Care Plans are hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Macomb Community Unit School District #185 on or as of the day and year first below written.

By
Macomb Community Unit School District #185

Date July 17, 2017

Witness

Date July 17, 2017
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Medicaid</th>
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<tbody>
<tr>
<td>Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a></td>
<td>Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a></td>
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<tr>
<td>Phone: 1-855-692-5447</td>
<td>Medicaid Phone (In state): 1-800-866-3513</td>
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<td>Medicaid Phone (Out of state): 1-800-221-3943</td>
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<tr>
<th>ALASKA – Medicaid</th>
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<tr>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
</tr>
<tr>
<td>Phone (Outside of Anchorage): 1-888-318-8890</td>
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<tr>
<td>Phone (Anchorage): 907-269-6529</td>
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<tr>
<th>ARIZONA – CHIP</th>
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<tr>
<td>Website: <a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a></td>
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<tr>
<td>Phone (Outside of Maricopa County): 1-877-764-5437</td>
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<tr>
<td>Phone (Maricopa County): 602-417-5437</td>
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<tr>
<th>FLORIDA – Medicaid</th>
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<tr>
<td>Website: <a href="https://www.flmedicaidtprecovery.com/">https://www.flmedicaidtprecovery.com/</a></td>
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<tr>
<td>Phone: 1-877-357-3268</td>
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<tr>
<th>GEORGIA – Medicaid</th>
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<tr>
<td>Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a></td>
</tr>
<tr>
<td>Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)</td>
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<tr>
<td>Phone: 1-800-869-1150</td>
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<th>IDAHO – Medicaid and CHIP</th>
<th>MONTANA – Medicaid</th>
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<tr>
<td>State</td>
<td>Program</td>
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<tr>
<td>Idaho</td>
<td>Medicaid</td>
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<td>Indiana</td>
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<td>Nevada</td>
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<td>Iowa</td>
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<td>Kansas</td>
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<td>Kentucky</td>
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<td>TTY</td>
<td>1-800-977-6741</td>
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<td>Massachusetts</td>
<td>Medicaid and CHIP</td>
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<td>New Jersey</td>
<td>Medicaid and CHIP</td>
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<tr>
<td>MINNESOTA – Medicaid</td>
<td>NORTH CAROLINA – Medicaid</td>
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<td>Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a></td>
<td>Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a></td>
</tr>
<tr>
<td>Click on Health Care, then Medical Assistance</td>
<td>Phone: 919-855-4100</td>
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<tr>
<td>Phone: 1-800-657-3629</td>
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<tr>
<td>MISSOURI – Medicaid</td>
<td>NORTH DAKOTA – Medicaid</td>
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<tr>
<td>Phone: 573-751-2005</td>
<td>Phone: 1-800-755-2604</td>
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<tr>
<td>OKLAHOMA – Medicaid and CHIP</td>
<td>UTAH – Medicaid and CHIP</td>
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<tr>
<td>Phone: 1-888-365-3742</td>
<td>Phone: 1-866-435-7414</td>
</tr>
<tr>
<td>OREGON – Medicaid and CHIP</td>
<td>VERMONT– Medicaid</td>
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<tr>
<td>Website: <a href="http://www.hijossaludablesoregon.gov">http://www.hijossaludablesoregon.gov</a></td>
<td>Phone: 1-800-250-8427</td>
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<td>Phone: 1-877-314-5678</td>
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<tr>
<td>PENNSYLVANIA – Medicaid</td>
<td>VIRGINIA – Medicaid and CHIP</td>
</tr>
<tr>
<td>Website: <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a></td>
<td>Medicaid Website: <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a></td>
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<tr>
<td>Phone: 1-800-692-7462</td>
<td>Medicaid Phone: 1-800-432-5924</td>
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<td>CHIP Website: <a href="http://www.famis.org/">http://www.famis.org/</a></td>
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<td>CHIP Phone: 1-866-873-2647</td>
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<tr>
<td>RHODE ISLAND – Medicaid</td>
<td>WASHINGTON – Medicaid</td>
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<tr>
<td>Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a></td>
<td>Website: <a href="http://hrsa.dshs.wa.gov/premiumpynt/Apply.shtml">http://hrsa.dshs.wa.gov/premiumpynt/Apply.shtml</a></td>
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<tr>
<td>Phone: 401-462-5300</td>
<td>Phone: 1-800-562-3022 ext. 15473</td>
</tr>
<tr>
<td>SOUTH CAROLINA – Medicaid</td>
<td>WEST VIRGINIA – Medicaid</td>
</tr>
<tr>
<td>Phone: 1-888-549-0820</td>
<td>Phone: 1-877-598-5820, HMS Third Party Liability</td>
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<tr>
<td>SOUTH DAKOTA - Medicaid</td>
<td>WISCONSIN - Medicaid</td>
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<tr>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a></td>
</tr>
<tr>
<td>Phone: 1-888-828-0059</td>
<td>Phone: 1-800-362-3002</td>
</tr>
<tr>
<td>TEXAS - Medicaid</td>
<td>WYOMING - Medicaid</td>
</tr>
<tr>
<td>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
<td>Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a></td>
</tr>
<tr>
<td>Phone: 1-800-440-0493</td>
<td>Phone: 307-777-7531</td>
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</tbody>
</table>

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

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

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

OMB Control Number 1210-0137 (expires 09/30/2013)