

Final

Harlem Consolidated Schools District #122

**Employee Health and Dental Benefit Plan
Benefit Booklet/Plan Document**

Amended and Restated Effective January 1, 2005

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Notice to Plan Participants

Prior authorization of all hospital confinements is encouraged under the Plan. In addition to keeping the costs of the Plan under control, this program is designed to help you and your family avoid unnecessary hospital confinements and to assure that you and your dependents are receiving appropriate, quality medical care. It is not the intention of the Plan to dictate or direct medical care; only to assure appropriate care. Whenever possible you should discuss your course of treatment in advance with your physician.

Please refer to the section, "Hospital Pre-Admission Certification Program" beginning on page 28 in this booklet for an explanation of this program.

Introduction

This booklet describes the coverage provided under the Employee Health and Dental Benefit Plan (the “Plan”). The Plan is a self-funded plan maintained by Harlem Consolidated Schools District #122 (hereafter referred to as the “District”) and is designed to help protect you and your eligible covered dependents against the financial effects of illness or injury and to help pay your dental bills while encouraging good dental health.

This booklet, and the benefits described within it, is intended to replace all previously distributed materials. 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.

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

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

January 2005

Health Care Benefits

Schedule of Health Care Benefits

Benefits for “Eligible Health Care Expenses” described beginning on page 10 are provided based on the schedule outlined.

If you obtain services through a Preferred Provider, expenses incurred with the provider will be discounted based on the negotiated agreement with the Preferred Provider Organization (PPO) and you will be eligible to receive the maximum co-insurance payable under the Plan. Out-of-PPO Network expenses will be payable at the In-PPO Network co-insurance level only for:

- Emergency Medical Care; or,
- Services rendered while you or your dependent is receiving treatment at a PPO hospital, facility or physician’s office and for which you or your dependent had no choice of providers. Examples of these services include Emergency Room physician services, radiology, pathology, and anesthesiology charges.

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

Maximum Benefit Payable Under the Plan

The maximum benefits stated below represent the total benefit you or your dependent are eligible to receive. The maximums apply equally to In-PPO Network and Out-of-PPO Network expenses and include all benefits paid by the Plan on an individual's behalf while active or on coverage continuation, including prescription drugs payable through the Prescription Drug Program.

<p>All Eligible Expenses</p>	<p>Except as noted below, benefits are limited to a maximum of \$2,000,000 per person while covered by the Plan.</p> <p>If you or your dependent receive benefits under the Plan, up to the lesser of the following amounts will automatically be reinstated every January 1st:</p> <ul style="list-style-type: none"> • \$1,000; or, • if less than \$1,000 in benefits were paid, the amount of benefits received by the covered person during the previous calendar year. <p>You may also apply to have the entire \$2,000,000 maximum benefit reinstated by filing your written request with the District along with acceptable evidence of your (or your dependent's) evidence of insurability. This reinstatement of the entire maximum benefit is subject to the District's approval of your application.</p>
<p>Alcohol/Substance Abuse and Mental or Nervous Disorders</p>	<p>Eligible expenses incurred with a physician for the outpatient treatment of Alcohol or Substance Abuse and/or Mental or Nervous Disorders are limited to a maximum of 50 visits per person per calendar year.</p>
<p>Chiropractic</p>	<p>Benefits are limited to a maximum of \$1,500 per person per calendar year.</p>
<p>Naprapath</p>	<p>Benefits are limited to a maximum of \$1,500 per person per calendar year.</p>

Deductible

The deductible is the amount of first dollar health and dental charges that must be paid before benefits become payable under the Plan. The deductible is applied once per calendar year (January through December). Expenses incurred and applied toward the deductible during the last 3 months of the calendar year (October, November and December) will be carried over and applied toward the deductible for the following calendar year.

Deductible per Unit per Calendar Year	<i>Single Coverage (One Person)</i>	<i>Employee Plus One Dependent (Spouse or Child)</i>	<i>Family Coverage (3 or More Persons)</i>
2005	\$350 per person	\$350 per person, limited to a maximum of \$600 per unit	\$350 per person, limited to a maximum of \$900 per unit
2006	\$375 per person	\$375 per person, limited to a maximum of \$700 per unit	\$375 per person, limited to a maximum of \$950 per unit
2007	\$400 per person	\$400 per person, limited to a maximum of \$750 per unit	\$400 per person, limited to a maximum of \$1,000 per unit
Additional Emergency Room Deductible	If you or a covered dependent receives treatment through a Hospital Emergency Room, an additional deductible of \$50 per visit will be applied. This deductible will be waived if treatment is necessary due to an accident or an illness that occurred suddenly and unexpectedly.		

Out-of-Pocket Limit

The Out-of-Pocket limit is the maximum amount you will be required to pay *per person* as a result of your deductible and co-insurance for eligible health expenses incurred. After the Out-of-Pocket limit is met, the Plan will pay 100% of expenses incurred for the balance of the calendar year. The Out-of-Pocket Limit is applied once per calendar year (January through December). Expenses applied towards the Out-of-Pocket limit will be applied equally to the In-PPO Network and Out-of-PPO Network limit amounts. Once the In-PPO Network Out-of-Pocket limit is satisfied, no additional co-insurance will be taken for charges incurred with a PPO provider. However, the co-insurance will continue to be taken for charges incurred outside of the PPO network until the Out-of-PPO Network Out-of-Pocket limit is met.

	<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>
Out-of-Pocket Limit per Calendar Year		
2005	\$1,000	\$1,750
2006	1,100	1,850
2007	1,200	1,950
Expenses Not Included in the Out-of-Pocket Limit	<p>The Out-of-Pocket limit does not include:</p> <ul style="list-style-type: none"> • the \$50 Emergency Room deductible; • co-pays for prescription drugs and medicines; • excluded charges; • charges incurred in excess of any maximum benefit listed in the Plan; • charges incurred for the treatment of Alcohol/Substance Abuse and Mental or Nervous Disorders. 	

* The In-PPO Network Out-of-Pocket Limit will apply to those charges incurred if you or your covered dependent reside or travel more than 20 miles outside of the PPO service area.

Co-insurance for Eligible Medical and Surgical Expenses

(Subject to the Deductible, Maximum Benefit and Out-of-Pocket Limit provisions)

Refer to the section “Eligible Health Care Expenses” beginning on page 10 for a detailed list of eligible expenses

Diagnostic X-ray and Laboratory Services	100% of eligible expenses incurred other than dental x-rays or charges by a hospital while you or your dependent are confined. The calendar year deductible does not apply.				
Emergency Accident Care	100% of the first \$300 of expenses incurred as the result of and within 90 days of an accident; the calendar year deductible does not apply. Expenses in excess of this \$300 per accident maximum will be paid under the “Emergency Medical Care” benefit below.				
Hospital Emergency Room	90% of eligible expenses incurred at a Hospital Emergency Room for Emergency Medical Care. “Emergency Medical Care” means a treatment of a sudden and unexpected illness or an accidental injury. If the patient is admitted through the Hospital’s Emergency Room, charges incurred for that confinement will also be provided under this benefit. All follow-up care following discharge will be based on the In-PPO Network and Out-of-PPO Network schedule stated in this section.				
Emergency Medical Care					
Non-Emergency Medical Care	<table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: center; border: none;"><i>In-PPO Network</i></th> <th style="text-align: center; border: none;"><i>Out-of-PPO Network*</i></th> </tr> </thead> <tbody> <tr> <td style="border: none;">\$50 Emergency Room deductible (in addition to the Calendar Year deductible), then 90%</td> <td style="border: none;">\$50 Emergency Room deductible (in addition to the Calendar Year deductible), then 70%</td> </tr> </tbody> </table>	<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>	\$50 Emergency Room deductible (in addition to the Calendar Year deductible), then 90%	\$50 Emergency Room deductible (in addition to the Calendar Year deductible), then 70%
<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>				
\$50 Emergency Room deductible (in addition to the Calendar Year deductible), then 90%	\$50 Emergency Room deductible (in addition to the Calendar Year deductible), then 70%				

* If you or your covered dependent reside or travel more than 20 miles outside of the PPO service area, benefits will be payable at 80% up to the In-PPO Network Out-of-Pocket limit.

Co-insurance for Preventive Care

(Subject to the Deductible, Maximum Benefit and Out-of-Pocket Limit provisions)

Refer to the section “Eligible Health Care Expenses” beginning on page 10 for a detailed list of eligible expenses

Routine Mammograms	90%; the deductible does not apply	
	Eligible expenses are limited to one routine Mammogram performed between age 35 and age 39 and then one per calendar year upon attainment of age 40. Mammograms performed in conjunction with a suspected or diagnosed illness are not limited.	
Pap Smear and Office Visit	90%; the deductible does not apply	
	Eligible expenses are limited to one test and office visit per year.	
Prostate Test and Office Visit	90%; the deductible does not apply	
	Eligible expenses are limited to one test and office visit per year for persons age 40 and over.	
Colorectal Cancer Screening	90%; the deductible does not apply	70%; the deductible does not apply
	Eligible expenses are limited to once every 3 years for persons age 50 and over or for persons who are at least age 30 when there is a family history of colorectal cancer of an immediate family member.	
Well Child Care	<i>In-PPO Network</i> 90%; the deductible does not apply Eligible expenses include exams, immunizations and testing for children under age 3.	<i>Out-of-PPO Network*</i> Out-of-PPO Network expenses are not covered

* If you or your covered dependent reside or travel more than 20 miles outside of the PPO service area, benefits will be payable at 80% up to the In-PPO Network Out-of-Pocket limit.

Co-insurance for Eligible Medical and Surgical Expenses

(Subject to the Deductible, Maximum Benefit and Out-of-Pocket Limit provisions)

Refer to the section “Eligible Health Care Expenses” beginning on page 10 for a detailed list of eligible expenses

Ambulance	80% of eligible expenses incurred	
Chiropractic or Naprathic Care	80% of eligible expenses incurred (maximum benefit of \$1,500 per person per calendar year)	
Hospice Care	80% of eligible expenses incurred	
Private Duty Nursing	80% of eligible expenses incurred	
Skilled Nursing Facility	80% of eligible expenses incurred	
All Other Medical and Surgical Treatment	<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>
	90% of eligible expenses incurred	70% of eligible expenses incurred

* If you or your covered dependent reside or travel more than 20 miles outside of the PPO service area, benefits will be payable at 80% up to the In-PPO Network Out-of-Pocket limit.

Co-insurance for Treatment of Alcohol or Substance Abuse and/or Mental or Nervous Disorders

(Subject to the Maximum Benefit provision; the Deductible and Out-of-Pocket Limit does not apply)
Refer to the section “Eligible Health Care Expenses” beginning on page 10 for a detailed list of eligible expenses

	<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>
Inpatient/Partial Hospitalization Treatment Programs	90% of eligible expenses incurred. The calendar year deductible and Out-of-Pocket limit do not apply.	70% of eligible expenses incurred. The calendar year deductible and Out-of-Pocket limit do not apply.
Outpatient Physician Services	60% of eligible expenses incurred. The calendar year deductible and Out-of-Pocket limit do not apply.	50% of eligible expenses incurred. The calendar year deductible and Out-of-Pocket limit do not apply.
	Eligible expenses incurred with a physician for the outpatient treatment of Alcohol or Substance Abuse and/or Mental or Nervous Disorders are limited to a maximum of 50 visits per person per calendar year.	

* If you or your covered dependent reside or travel more than 20 miles outside of the PPO service area: benefits for Inpatient/Partial Hospitalization Treatment Program expenses will be payable at 80% and Outpatient Physician service expenses at 55%. All other provisions stated above will apply..

Eligible Health Care Expenses

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

In addition to the above definition of the term Eligible Expense, the following terms have the defined meaning as used in this Plan:

- an "Illness" means any physical or mental illness, disease or pregnancy;
- an "Injury" means a non-occupational bodily injury that is caused by an event that is sudden and not foreseen, and is exact as to time and place; and,
- a "Physician" means a person licensed by his or her state of practice to practice medicine and render health or dental care services for treatments covered under the Plan and who is a Doctor of Medicine, a Doctor of Dentistry, a Doctor of Osteopathy, a Doctor of Podiatry, a Doctor of Psychiatry, a Doctor of Psychology, a Doctor of Ophthalmology, a Doctor of Optometry, a Doctor of Chiropractic, and a Doctor of Naprapathy.

Expenses eligible under the Plan are:

1. Abortions –

services and supplies rendered in conjunction with an abortion when the life or health of the mother would be endangered by carrying the fetus to term or the pregnancy is the result of rape or incest;

2. Alcoholism/Substance Abuse Treatment -

services and supplies provided in conjunction with the treatment of alcoholism and/or substance abuse at a hospital, alcoholism/substance abuse treatment facility or through a Partial Hospitalization Treatment program, or for services rendered by a Psychiatrist, Psychologist, Licensed Clinical Social Worker or other counselor authorized by his or her state of practice to provide counseling services up to the maximum benefit specified under the *Schedule of Health Care Benefits*. As used in this provision, these terms have the indicated meaning:

- “Alcoholism and/or Drug Abuse” means any diagnosis listed under Alcohol and Drug Psychoses, Alcohol and Drug Dependence Syndrome and Nondependent Abuse of Drugs of the current edition of the International Classification of Diseases, except that tobacco and caffeine abuse are not included under this definition; and,
- “Partial Hospitalization Treatment Program” means a program provided through a hospital or alcohol/chemical dependency treatment facility which provides psychological therapy on an outpatient basis as an alternative to inpatient confinement or to provide transitional support following inpatient treatment and which meets the following requirements:
 - a. it provides care by one or more program therapists who are credentialed by the state in the field;
 - b. it is under the full supervision of a physician; and,
 - c. it maintains complete medical records on each patient;

3. Allergy Shots and Allergy Surveys;

4. Ambulance Service -

professional ambulance service to and from the nearest facility where emergency care or treatment is rendered, or to the nearest facility equipped to furnish medically necessary treatment when specialized treatment is not available at a local hospital. When an individual is being transferred from a Hospital or Extended Care 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. Transportation within the United States and Canada must be by regularly scheduled airlines or railroad or by air ambulance, and eligible expenses will only include transportation to and from the city or town where the illness or injury occurred to the nearest hospital qualified to render specialized treatment;

5. Ambulatory Surgical Facility -

services and supplies furnished by an Ambulatory Surgical Facility in support of outpatient surgery. An “Ambulatory Surgical Facility” is a facility accredited as such by the Joint Commission of the Accreditation of Health Care Organizations, or a facility that is state licensed and operated pursuant to law for the performance of surgery on an outpatient basis at the patient’s expense;

6. Anesthetics -

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

7. Birthing Centers –
charges for services, supplies and any professional services rendered and provided by a Birthing Center. A “Birthing Center” is a licensed place with the primary purpose of providing a place for live births, including prenatal and postpartum care, and which has a written agreement in force with at least one hospital for immediate transfer of patients who require treatment in a hospital;
8. Blood –
blood or blood products, including autologous blood donations or the services of a blood donor;
9. Cardiac Rehabilitation -
outpatient cardiac rehabilitation services prescribed by and under physician's supervision;
10. Chiropractic Care –
services of a Chiropractor or Physician for chiropractic care, up to the maximum benefit specified under the “Schedule of Health Care Benefits”;
11. Contact Lenses After Cataract Surgery -
initial lenses or glasses immediately following cataract surgery;
12. Cosmetic Reconstructive Surgery -
expenses incurred for reconstructive surgery to correct:
 - a. a condition which is the result of an accidental injury; or,
 - b. a birth defect resulting in the malformation or absence of a body part;
13. Dental Care -
services and supplies rendered for -
 - a. treatment required due to an accidental injury to sound and natural teeth, including replacement and related x-rays, provided such treatment is received within 6 months following the date the accident occurs. Expenses will be eligible beyond this 6-month period if treatment could not be initiated for medical reasons; or,
 - b. hospital expenses incurred in conjunction with a dental procedure when such procedure must be performed in a hospital due to the patient’s medical condition or age;

14. Diabetic Supplies –
equipment and supplies for the treatment of diabetes, including self-management services prescribed by a physician;
15. Diagnostic Testing -
charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, and similar established diagnostic testing generally approved by physicians throughout the United States;
16. Diagnostic X-ray and Laboratory Services -
x-ray examinations, laboratory tests and their interpretation performed in conjunction with the treatment of an injury or the diagnosis of a suspected illness which is exhibiting symptoms;
17. Durable Medical Equipment -
rental of durable medical equipment. Benefits will also be provided for the purchase of durable medical equipment if it can be shown that long-term use is planned and purchase is likely to cost less than monthly rental, or that the equipment cannot be rented. If the equipment is purchased, the Plan will provide benefits for its maintenance and repair. “Durable Medical Equipment” means equipment that is (a) prescribed by a physician in conjunction with an illness or injury for use in your home; (b) can withstand repeated use; and, (c) is eligible under Medicare;
18. Home Health Care -
charges for services and supplies provided by a Home Health Care Agency under the direction of a physician. A “Home Health Care Agency” is an agency licensed in the jurisdiction in which the home health services are delivered, a home health agency as defined by Medicare, or an agency or organization which provides a program of home health care and which is certified by the patient's physician as an appropriate provider of home health services and which has a full-time administrator, maintains written records of services provided to the patient, and has a staff that includes at least one physician and one Registered Nurse and provides full-time supervision by a physician or Registered Nurse.

19. Hospice Care -

hospice care services and supplies provided while confined in Hospice facility or for outpatient care. A “Hospice” means a health care program providing a coordinated set of services rendered at home, or on an outpatient or inpatient basis, for covered persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one physician and one Registered Nurse, and it must maintain the standards of the National Hospice Organization (NHO) and applicable state licensing requirements;

20. Hospital Expenses -

charges by a hospital for semi-private room and board, intensive care or cardiac care unit and all other necessary services and supplies incurred as an inpatient or outpatient. Eligible expenses will be limited for confinement in a private room to the hospital’s average semi-private room charge.

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

21. Mastectomy Expenses –

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

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

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

22. Maternity Expenses -

charges incurred by you or your covered spouse for prenatal care, delivery and postpartum care including services rendered by a Certified Registered Nurse Midwife. Eligible expenses do not include charges related to a dependent daughter's pregnancy or hospital expenses incurred for a healthy newborn immediately following birth if services are outside of the Preferred Provider Organization (PPO) Network.

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

23. Medical and Surgical Supplies -

orthopedic braces, casts, splints, trusses, crutches, cervical collars, head halters, traction apparatus, pacemaker, surgical dressings and supplies, including colostomy supplies and similar medically necessary items, when necessitated by an illness or injury;

24. Mental or Nervous Disorders -

charges for the treatment of Mental or Nervous Disorders at a hospital for treatment on an inpatient or outpatient basis, through a Partial Hospitalization Treatment program, or for services rendered by a Psychiatrist, Psychologist, Licensed Clinical Social Worker or other counselor authorized by his or her state of practice to provide counseling services up to the maximum benefit specified under the *Schedule of Health Care Benefits*. As used in this provision, the following terms have the defined meaning:

- a "Mental or Nervous Disorder" means any diagnosis listed in the *Mental Disorders* section of the current edition of the International Classification of Diseases, other than diagnoses listed under Alcohol and Drug Psychoses, Alcohol and Drug Dependence Syndrome and Nondependent Abuse of Drugs;

- a “Partial Hospitalization Treatment Program” means a program provided through a hospital which provides psychological therapy on an outpatient basis as an alternative to inpatient confinement or to provide transitional support following inpatient treatment and which meets the following requirements:
 - a. provides care by one or more program therapists who are credentialed by the state in the field;
 - b. is under the full supervision of a physician; and,
 - c. maintains complete medical records on each patient;

25. Morbid Obesity -

expenses for the surgical treatment of morbid obesity. “Morbid obesity” means a condition in which the body weight exceeds the normal weight by either 100 pounds or is twice the normal weight of a person of the same height, and conventional weight reduction measures have failed. A medical necessity review is required to evaluate the appropriateness of the procedure. Criteria, in most cases, are a Body Mass Index (BMI) of 35 or higher with two co-morbidities, or a BMI of 40 or more. The patient must either have a psychological evaluation or participate in education under the attending or treating physician, and must be able to demonstrate that they have failed on previous attempts of supervised weight loss;

26. Naprapathic Care –

services rendered by a Doctor of Naprapathy for treatment of locomotor disorders. Eligible expenses are limited to the maximum specified under the “Schedule of Health Care Benefits”;

27. Newborn Expenses (PPO Only) -

charges for the following services and supplies when rendered by a PPO Hospital and PPO Physician for a healthy newborn while hospital confined immediately following birth:

- a. nursery care and all other necessary services and supplies;
- b. physician charges for examinations, including surgical fees for circumcision;

Note: Expenses incurred for the above charges or for treatment of an illness of a newborn (for example, premature birth, congenital abnormality) will be eligible on the same basis as any other illness provided you enroll the child for coverage within the 31-day period immediately following the child's birth if you are not already enrolled for Family coverage (see the section "When Coverage Begins" on page 43 for more information on the enrollment procedure);

28. Nursing Care -

services of a Registered Nurse including services rendered for the following specialty practices for which he or she is certified: Certified Registered Nurse Anesthetist, Certified Registered Nurse Midwife, and a Nurse Practitioner. Eligible expenses include services rendered by a Licensed Practical Nurse when the patient is confined in a hospital, Skilled Nursing Facility or is receiving Home Health Care but do not include nursing services rendered by a nurse who ordinarily resides in the patient's home or who is a member of your family (your spouse, child, brother, sister, parent or parent-in-law);

29. Occupational Therapy -

occupational therapy rendered by a physician or by a licensed occupational therapist on an inpatient basis;

30. Optometric Services –

services rendered by an Optometrist provided such services would be eligible if rendered by a physician;

31. Oral Surgery –

services rendered by a physician, dentist or oral surgery for treatment of a fractured jaw or of accidental injuries to natural teeth within 6 months following the date the accident occurred. In addition, expenses for the following surgical procedures will also be considered an eligible expense: alveoloplasty, treatment of cellulitis, excision of soft tissue lesion of oral cavity, biopsy and excision of tori, excision of benign hard tumor, radicular or dentigerous cyst, closure of antral fistula, removal of salivary stone from duct or gland, and therapeutic nerve block with alcohol or sclerosing solutions;

32. Organ Transplants -

charges incurred in conjunction with the direct transplant of the following natural organ(s) from a human to the covered person:

- a. bone marrow transplant, including stem cell rescue;
- b. cornea transplant;
- c. heart transplant;
- d. heart-lung transplant;
- e. kidney transplant;
- f. liver transplant;
- g. lung transplant;

- h. prosthetic bypass for replacement vessels;
- i. tissue transplants.

When the covered person is the recipient of the organ transplant, eligible expenses will include the medical expenses of the donor which are incurred as the direct result of the transplant provided the donor has no other medical coverage. However, any fee or charge made by the donor for the organ(s) will not be considered an eligible expense. If the covered person is the live donor for a transplant procedure, benefits will be provided when the recipient's medical coverage does not cover such expense;

33. Oxygen -

oxygen and rental of equipment for its administration;

34. Physical Therapy -

physical therapy rendered by a physician or licensed physical therapist. Eligible expenses will not include services rendered by a physical therapist who is member of your family (your spouse, child, brother, sister, parent or parent-in-law);

35. Physician's Services -

- a. services rendered by a physician for medical care provided on an inpatient or outpatient basis, including office visits, home visits, hospital inpatient care, hospital outpatient visits and exams, and clinic care. Eligible expenses will also include services rendered by a qualified Physician Assistant;
- b. services rendered by a Surgeon or Assistant Surgeon. When the services of an Assistant Surgeon are rendered eligible expenses will be limited to 25% of the reasonable and customary expense of the primary surgeon. Eligible expenses will also include services rendered by a surgical assistant when such services are medically necessary and the assistant is certified by the state in which he or she practices. When the services of a surgical assistant are rendered, the combined cost of the surgeon and assistant's charge will be eligible up to the total usual and customary charge of the surgeon alone. A "surgical procedure" means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, and the injection of sclerosing solutions;

36. Pre-admission Testing –

x-ray and laboratory tests performed within 7 days prior to a schedule hospital admission;

37. Prescription Drugs -

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. Eligible expenses are limited to a maximum of 6 pills per month for treatment of a sexual dysfunction, and do not include contraceptive drugs or drugs used for cosmetic purposes. Drugs and medicines dispensed on an outpatient basis are eligible under the Prescription Drug Program;

38. Preventive Care –

expenses incurred for the following services and supplies –

a. routine mammograms performed based on the following schedule –

(1) one baseline mammogram for women between age 35 and 39; and

(2) once per year for women age 40 and over;

b. an annual Pap smear and related office visit;

c. an annual prostate test and related office visit for men age 40 and over;

d. colorectal cancer screening with sigmoidoscopy, proctosigmoidoscopy or colonoscopy and or fecal occult blood testing once every 3 years for persons who are at least age 50 or who are at least age 30 if an immediate family member of the person has a history of colorectal cancer;

39. Prosthetic Appliances -

prosthetic devices and special appliances required due to an illness or injury and their repair. Replacement of such devices or appliances are also eligible if required because of a change in the patient's physical condition or when replacement is more cost effective than its repair;

40. Radiation Therapy and Chemotherapy -

x-ray, radium, radioactive isotope therapy, and chemotherapy;

41. Renal Dialysis;

42. Respiratory Therapy -

respiratory therapy rendered by a qualified respiratory therapist;

43. Shock Therapy treatments;

44. Skilled Nursing Facility –

charges for room and board and other necessary services and supplies furnished on an inpatient basis when confinement commences within 14 days following discharge from a hospital confinement of at least 3 days or within 7 days following discharge from a previous confinement in a Skilled Nursing Facility. The confinement must be recommended by the patient's attending physician as necessary for the continued care or treatment of the illness or injury which caused the preceding hospital or Skilled Nursing Facility confinement. In addition, the patient must be under the regular care of a physician during the confinement.

A "Skilled Nursing Facility" is an institution which is primarily engaged in providing skilled nursing care and related services for persons who require medical or nursing care, and rehabilitation services for the rehabilitation of injured, disabled or sick persons, provided the facility is:

- a. accredited as an extended care facility by the Joint Commission on Accreditation for Health Care Organizations; or,
- b. is recognized by Medicare as an extended care facility; and,
- c. is not, other than incidentally, a place for rest, domiciliary care, the aged, the blind, the deaf, the mentally deficient, drug addicts or alcoholics, persons suffering from tuberculosis, or is not a hotel or motel;

45. Speech Therapy -

services rendered by a qualified speech therapist to restore normal speech lost due to an illness, injury or surgical procedure;

46. Sterilizations –

services rendered in conjunction with an elective sterilization;

47. Temporomandibular Joint Dysfunction –

charges incurred for the surgical treatment of Temporomandibular Joint Dysfunction;

48. Well Child Care (PPO Only) -

expenses for routine and well child care for children through age 2 including examinations, immunizations and testing if the services are provided by a physician participating in your PPO network.

Health Care Exclusions

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

1. Abortions –

services and supplies rendered in conjunction with an elective abortion unless the life or health of the mother would be endangered by carrying the fetus to term or the pregnancy is the result of rape or incest. This exclusion does not include expenses incurred for treatment of complications arising from an elective abortion;
2. Acupuncture;
3. Adoption Expenses;
4. Artificial Heart –

expenses related to insertion or maintenance of an artificial heart, except when used as either a bridge to a heart transplant or for support of blood circulation postcardiotomy;
5. Armed Forces/War -

any condition, disability or expense sustained as a result of duty as a member of the Armed Forces of any country, or a war or act of war which is declared or undeclared, invasion or civil war;
6. Claim Forms/Medical Reports –

expenses for preparing medical reports, itemized bills or benefit request forms;
7. Claim Submission Deadline -

charges for services or supplies for which you do not file a claim within one year following the date the service was rendered or the supply received or, if sooner, within 60 days following the effective date of coverage termination;
8. Cosmetic Services and Supplies -

charges incurred in connection with cosmetic surgery, services and supplies;

9. Custodial Care -

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

10. Dental Care –

charges for dental care, services or supplies and expenses eligible under the Dental portion of this Plan;

11. Educational or Vocational or Training Services and Supplies;

12. Experimental or Investigational Treatment –

any treatment, procedure, service, device or drug which is considered to be experimental or investigational treatment. An expense will be considered "experimental or investigational treatment" if:

- a. the treatment has not been approved by the US Food and Drug Administration 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;
- e. the predominant opinion of experts as expressed in published peer-reviewed literature is that further research is necessary in order to determine safety, toxicity of efficacy in comparison to conventional alternative; or,
- f. 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;

13. Eye Glasses/Vision Care –
eye examinations for diagnosis or treatment of a refractive error, including the fitting of eyeglasses or contact lenses, orthoptics, vision therapy or supplies;
14. Foot Care -
treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except for open cutting operations, corns, calluses or toe nails except for removal of nail roots;
15. Free of Charge -
services or supplies for which there is no legal obligation to pay, or expenses which would not be made except for the availability of benefits under this Plan;
16. Genetic Testing;
17. Government Services -
services or supplies provided by any government, except that services provided and billed by a Veteran's Administration facility for non-service related disabilities or by a Military Hospital will be eligible;
18. Hearing Expenses -
hearing exams, hearing aids or related expenses;
19. Hypnosis;
20. Illegal Activities, Illegal Occupation, Assault, Riot –
any condition, disability or expense sustained as a result of being engaged in an illegal occupation, commission or attempted commission of an assault or other illegal act, participation in a civil revolution or a 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;
21. Immunizations, Inoculations and Vaccinations –
immunizations (other than well child care), inoculations or vaccinations, except for tetanus shots following an accidental injury or RH (factor) shots for newborns;

22. Infertility –
treatment of infertility, infertility drugs and any surgical treatment of infertility including artificial insemination, in-vitro fertilization or embryo and fetal implants;
23. Learning Disorders or Behavioral Problems –
expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental or nervous treatment;
24. Mailing and/or Shipping and Handling Expenses;
25. Marital, Family or Sex Therapy;
26. Massage Therapy or Rolfing;
27. Medical Necessity –
services or supplies not medically necessary for the treatment of an illness or injury;

Note: To be considered medically necessary, the service or supply must be ordered by a physician and must be commonly and customarily recognized by the American Medical Association as appropriate in the treatment of the patient's diagnosed illness or injury. The fact that your physician may prescribe, order or recommend a service or supply does not mean that it is considered medically necessary;
28. Missed Appointments;
29. Not Recognized by the American Medical Association -
charges for investigative procedures which have not been recognized by the American Medical Association as accepted standards of medical practice and/or which are classified by the Centers for Medicare and Medicaid Services as investigational or as not reasonable or necessary;
30. Not Recommended by a Physician –
any service or supply not recommended by a physician or any condition not requiring treatment by a physician;

31. Not Specifically Included -
any other service or supply not specifically listed under the section “Eligible Health Care Expenses”;
32. Nuclear or Radioactive Contamination –
expenses 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;
33. Outside the United States –
charges incurred outside the United States (including by mail) if you or your dependent traveled to such a location for the purpose of obtaining medical services, drugs or supplies. However, this exclusion will not apply to charges incurred while outside of the United States for the purpose of business, travel or education provided the expense would otherwise be eligible under the Plan;
34. Occupational Therapy –
occupational therapy and supplies when not hospitalized;
35. Organ Transplant -
charges for organ transplant procedures not specifically listed under the section “Eligible Health Care Expenses”;
36. Orthotics, Orthopedic or Corrective Shoes –
orthotics, orthopedic or corrective shoes and supportive appliances for the feet;
37. Personal Comfort or Convenience Items -
 - a. personal comfort or service items while confined in a hospital including, but not limited to, radio, television, telephone and guest meals;
 - b. equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an illness or injury;
38. Pregnancy of a Daughter –
expenses related to the pregnancy of a dependent child;

39. Prescription Drugs and Medicines -
 - a. prescription drugs and medicines which are not approved by the Food and Drug Administration or which are prescribed for contraception or to promote fertility;
 - b. non-prescription drugs or medicines;
40. Radial Keratotomy;
41. Reasonable and Customary Limit -
charges for services or supplies deemed to be in excess of the amount considered reasonable and customary;
42. Reversal of Voluntary Sterilizations -
charges for services rendered to reverse any reproductive sterilization procedure;
43. Routine X-rays and Laboratory Services (unless specifically included);
44. Sanitarium or Rest Care;
45. Self-Inflicted –
services or supplies rendered in conjunction with the treatment of an intentionally self-inflicted injury or illness committed while sane or insane. However, this exclusion will not apply if injuries are sustained during an act of domestic violence or as a result of a diagnosed illness, including Mental or Nervous Disorder or an Alcohol or Drug Dependency;
46. Sex Transformations -
charges incurred in connection with any procedure or treatment designed to alter physical characteristics to those of the opposite sex;
47. Surrogate Expenses;
48. Telephone Calls/Consultations;
49. Temporomandibular Joint Dysfunction –
non-surgical treatment of Temporomandibular Joint Dysfunction;

50. Travel –
travel expenses of a physician or you or your covered dependent (other than ambulance transportation);
51. Vitamins and Nutritional Supplements;
52. Well Baby –
- a. well baby, nursing and physician care during the initial confinement of a healthy newborn if services are provided outside of the Preferred Provider Organization network;
 - b. well baby check-ups if services are provided outside of the Preferred Provider Organization network;
53. Weight Loss –
treatment, instruction, activities or drugs for weight reduction or control not prescribed by a physician;
54. Wigs and Artificial Hair Pieces;
55. Work Related -
injuries or illnesses arising out of or in the course of any occupation or employment for wage, profit or gain, or for which benefits are available under any Workers' Compensation Law or other similar laws.

Limitations of Coverage for Pre-Existing Conditions

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

date means the first day of coverage following the Open Enrollment period in which you enrolled your dependent(s) for coverage.

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

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

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

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

Note: If you or your dependent were covered under the group medical benefits plan maintained by the District prior to January 1, 2005, the pre-existing condition limitation will not apply to the extent satisfied under the prior plan.

Hospital Pre-Admission Certification Program

The Plan includes a Hospital Pre-Admission Certification Program. The program is designed to reduce health costs and help you and your family avoid unnecessary hospital confinements and to assure appropriate, quality medical care. The District has contracted with American Health Holding, an independent firm which includes medical professionals, to administer the program. It is the intention of this program to assure appropriate care, not to dictate or direct medical care.

The Notification Procedure

You, your attending physician, or a member of your family are encouraged to contact American Health Holding at least 7 days prior to any scheduled hospital admission. If you or your covered dependent are admitted to the hospital on an emergency basis or for a maternity, it is recommended that American Health Holding be contacted within 48 hours following admission. The information you will need to provide is as follows:

1. the employee's name, address and Social Security number;
2. the patient's name, address, telephone number, date of birth and sex;
3. the name, address and telephone number of the attending physician and the hospital;
4. the reason for the hospital confinement and expected (or, if an emergency, the actual) date of admission; and,
5. the name of the Harlem Consolidated School #122 Health and Dental Care Plan.

American Health Holding can be contacted by phoning 1-800-892-1893.

How the Program Works

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

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

Although this program does not effect the benefit you will receive under the Plan, you are encouraged to use this program to help you and your family avoid unnecessary hospital confinements and to assure appropriate, quality medical care.

The Preferred Provider Organization Network

The District has contracted with Employer's Coalition on Health (ECOH) and, through our claims administrator, Private Healthcare Systems (PHCS) to access a Preferred Provider Organization (PPO) network. Although you can go to the hospital or physician of your choice, benefits will be greater when you use the services of a provider participating in the PPO network. In addition, when you or a covered dependent receive treatment from a PPO provider for services and supplies covered under the Plan, charges will be discounted based on the negotiated agreement between the PPO and that provider.

In addition to the providers participating in the ECOH and PHCS PPO networks, our claims administrator has also contracted with the following organizations that have agreed to participate in the network:

- Dreyer Medical Clinic and
Dreyer Ambulatory Surgery Center – Aurora, Illinois
- University of Chicago Hospital and Health System
- effective on and after February 1, 2005 - Adventist Health Network which includes Hinsdale Hospital (Hinsdale, Illinois), LaGrange Memorial Hospital (LaGrange, Illinois), Glen Oaks Hospital (Glendale Heights, Illinois) as well as physicians in the Adventist Health Network PPO. To check whether your physician is in the Adventist Health Network, please call 630-856-6856.

A listing of hospitals and physicians participating in the ECOH and PHCS PPO Networks is available from the Human Resources Department. There may be changes in the directory listing from time to time. Therefore, you are urged to check with your hospital or physician before undergoing treatment to make certain of its participation status.

ECOH can be contacted at 1-800-990-3204 or through their website at www.ecoh.com; when traveling or attending school out-of-area call 1-800-678-7427 for a referral to a participating PHCS provider.

PHCS can be contacted at 1-800-240-1940 or through their Website at www.phcs.com.

Large Case Management

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

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

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

Prescription Drug Program

The District has contracted with PharmaCare to administer a Prescription Drug Program. An important component of this program is that the pharmacy benefits manager will maintain a drug history for you and each member of your family and monitor each prescription when it is filled to reduce the possibility of drug allergies or interactions between the prescriptions.

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 PharmaCare's Customer Service Department at 1-888-645-9303 or visit their website at www.pharmacare.com.

Schedule of Prescription Drug Benefits

The Plan will pay 100% of the cost of eligible prescription drug expenses remaining after your co-payment as stated below:

Retail Pharmacy Co-Payment (up to a 30-day supply)

Generic Drugs and Medicines	\$ 12 co-pay
Brand Name	18 co-pay

No benefits are payable if the cost of the prescription is less than the co-pay noted above

Mail Service Pharmacy Co-Payment (up to a 90-day supply)

Generic Drugs and Medicines	\$ 10.00 co-pay
Brand Name	20.00 co-pay

¹ No benefits are payable if the cost of the prescription is less than the co-pay noted above.

² Oral contraceptives for you or your spouse are eligible under the Mail Service Pharmacy program only.

Maintenance Drugs

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.

PharmaCare provides a mail service program for the purchase of maintenance drugs. A 90-day supply or refill of a maintenance drug can be purchased by completing the Confidential Patient Profile/Enrollment Form that will be provided to you and enclosing your prescription and the applicable co-pay. Your mail-order prescription will be sent to your home by PharmaCare within seven to ten days. You may also refill a mail service drug online at www.pharmacare.com.

Non-Maintenance Drugs

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. Your claim will automatically be processed by PharmaCare's on-line point-of-sale processing system, eliminating the need for you to complete a claim form.

If you fill a prescription at a pharmacy which is not participating in the PharmaCare network, you must file a claim for reimbursement. This can be done by submitting an itemized prescription receipt and completing the Direct Member Reimbursement Form, which can be obtained by calling PharmaCare's Customer Service Department at 1-888-645-9303.

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 PharmaCare's Customer Service Department at 1-888-645-9303 or visit their website at www.pharmacare.com.

Prescription Drug Expenses

Expenses eligible under this program are limited to a 34-day supply for non-maintenance drugs purchased at a network pharmacy, or a 90-day supply for maintenance drugs purchased through the mail-order program.

Expenses eligible under the program are defined in the separate contract between the District and PharmaCare. Therefore, please refer to PharmaCare's brochure for information concerning covered expenses or phone PharmaCare's toll-free number (1-888-645-9303) or access them through their website at www.pharmacare.com.

Dental Care Benefits

Schedule of Dental Care Benefits

Benefits for Eligible Dental Care Expenses are provided based on the schedule presented below:

Deductible

The Deductible is combined with eligible health charges.
Please refer to the section “Schedule of Health Care Benefits” beginning on page 2.

Benefits for Eligible Expenses

(Subject to the Deductible)

Routine Care	85% of eligible expenses incurred
Major Dental Services	50% of eligible expenses incurred
Maximum Benefit Payable	\$1,000 per person per calendar year

Eligible Dental Care Expenses

A charge for any of the services or supplies listed below will be considered eligible if it is reasonably necessary for the care of your or your dependent's dental condition. To be considered reasonably necessary, the service or supply must be ordered by a dentist licensed by his or her state of practice and must be commonly and customarily recognized as appropriate in the treatment of the patient's diagnosed dental condition. The service or supply must not be educational or experimental in nature, nor provided primarily for the purpose of dental or other research.

In addition to the above definition of the term “Eligible Expense”, the following terms have the defined meaning as used in this Plan:

- a “dental hygienist” means a person who is licensed by the state in which services are performed to practice dental hygiene and who works under the supervision and direction of a dentist; and

- a “dentist” means a person licensed by his state of practice to practice dentistry and render dental care services within the scope of his license for treatments covered under the Plan.

Routine Care

Expenses eligible under the Plan are:

1. oral examinations and prophylaxis, limited to twice per calendar year with at least 5 months between exams and cleanings;
2. examinations in connection with emergency palliative treatment;
3. examinations for consultation purposes;
4. bitewing x-rays, limited to twice per calendar year with at least 5 months between x-rays;
5. full mouth x-rays, limited to once per 36-month period;
6. topical application of sodium or stannous fluoride, limited to twice per calendar year with at least 5 months between applications;
7. space maintainers for missing primary teeth and habit-breaking appliances;
8. diagnostic x-ray and laboratory services required in relation to a dental procedure or surgery;
9. injection of antibiotic drugs by the attending dentist;
10. oral surgery, including surgical extractions;
11. administration of general anesthesia in connection with oral surgery;
12. amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed teeth;
13. treatment of periodontal and other diseases of the gums and supporting structures of the mouth;
14. endodontic treatment;
15. adjusting, relining or rebasing of dentures.

Major Dental Services

Expenses eligible under the Plan are:

1. gold restorations;
2. installation of crowns;
3. initial installation of dentures;
4. inlays and onlays;
5. initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace extracted natural teeth;
6. repair to existing dentures;
7. replacement of an existing partial or full removable denture or fixed bridgework, the addition of teeth to an existing partial or removable denture, or, to replace teeth which were extracted if satisfactory evidence is presented to the Plan that –
 - a. the addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed;
 - b. the existing denture or bridgework cannot be made serviceable and was installed at least 5 years prior to the replacement date;
 - c. the existing denture is an immediate temporary denture replacing one or more natural teeth extracted, replacement by a permanent denture is required, and the replacement takes place within 12 months from the placement of the temporary denture.

Dental Care Exclusions

Charges for the following are not eligible:

1. Alternative Services -
charges in excess of the usual and customary charge of the least expensive alternative service for material consistent with adequate dental care when such alternative services or materials are customarily provided;
2. Armed Forces –
services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the Armed Forces of a government;
3. Care Not Provided by a Dentist -
expenses for treatment by other than a dentist or dental hygienist;
4. Claim Forms, Dental Reports –
charges incurred for preparing dental reports, itemized bills or benefit request forms;
5. Claim Submission Deadline -
charges for services or supplies for which you do not file a claim within one year following the date the service was rendered or the supply received or, if sooner, within 60 days following the effective date of coverage termination;
6. Cosmetic Services -
services or supplies which are primarily for cosmetic procedures;
7. Duplicate Prosthetic Devices or Appliances;
8. Expenses Covered Under the Health Plan -
services covered under the Health care portion of this Plan;
9. Free of Charge -
services or supplies for which there is no legal obligation to pay, or charges which would not be made except for the availability of benefits under the Plan;

10. Government Care -
services or supplies provided or paid for by any governmental agency, or under any governmental program or law, except that services for which you or your covered dependent are required to pay will be eligible;
11. Hospital Charges;
12. Illegal Activities, Illegal Occupation, Assault, Riot –
any condition, disability or expense sustained as a result of being engaged in an illegal occupation, commission or attempted commission of an assault or other illegal act, participation in a civil revolution or a 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;
13. Implants –
tooth implants and related charges;
14. Mailing and/or Shipping and Handling Charges;
15. Missed Appointments -
charges for broken or missed appointments;
16. Mouth guards –
athletic mouth guards;
17. Myofunctional Therapy;
18. Not Accepted by the American Dental Association -
dental care which does not meet the standards of dental practice accepted by the American Dental Association;
19. Not Included as an Eligible Expense -
charges for any service or supply not included under the section “Eligible Dental Care Expenses”;
20. Not Recommended by a Dentist –
services or supplies not recommended as necessary by a dentist;

21. Orthodontic Services –
charges incurred in conjunction with an orthodontic procedure;
22. Periodontal –
 - a. procedures or appliances to stabilize periodontally involved teeth;
 - b. periodontal splinting;
23. Precision Attachments –
precision or semi-precision attachments;
24. Prior to Effective Date –
expenses incurred for services rendered prior to the effective date of coverage under the Plan;
25. Reasonable and Customary Limit -
charges for services or supplies deemed to be in excess of the amount considered reasonable and customary;
26. Replacement Charges -
replacement of lost, stolen or missing prosthetic devices;
27. Sealants -
expenses for application of sealants;
28. Self-Inflicted –
services or supplies rendered in conjunction with the treatment of an intentionally self-inflicted injury or illness committed while sane or insane. However, this exclusion will not apply if injuries are sustained during an act of domestic violence or as a result of a diagnosed illness, including Mental or Nervous Disorder or an Alcohol or Drug Dependency;
29. Training, Educational –
training, educational instruction or materials relating to dietary counseling, personal oral hygiene or dental plaque control;
30. Telephone Calls/Consultations;

31. Veneers –
veneers or facings on crowns or pontics to the second bicuspid;
32. Vertical Dimension/Occlusion –
procedures or appliances to increase vertical dimension or restore occlusion;
33. Work Related -
services or supplies sustained as a result of being engaged in any activity primarily for wage, profit or gain and which is covered by a Worker's Compensation Act or Employer's Liability Law.

Limitation of Dental Coverage/Pre-Treatment Estimate of Benefits

The Plan will consider eligible expenses based on the appropriate treatment necessary to eliminate oral disease or to replace missing teeth. For example, if a tooth can effectively be restored with amalgam filling but you elect to crown the tooth, the Plan will consider its benefits based on the usual and customary limit for the amalgam filling. You will be responsible for paying the remaining charges.

In addition, temporary services will be considered as an integral part of the final service rather than as a separate service. The allowance for both the temporary and permanent procedures may not exceed the usual and customary amount of the permanent procedure.

If your dentist recommends a course of treatment which is expected to exceed \$300 and you would like to know how much the Schedule of Benefits will allow before you or your dependent have the treatment, you can get a pre-treatment estimate of your benefits.

To obtain a pre-treatment estimate of benefits, your dentist should submit his or her treatment plan to the claims administrator, Benefit Systems & Services, Inc. (BSSI) showing the recommended course of treatment. BSSI will review the treatment plan and advise you and your dentist of the amount payable based on the Schedule of Benefits. A pre-treatment estimate of benefits is not a guarantee of payment.

Eligibility and General Plan Provisions

Who is Eligible for Coverage

You are eligible for the coverage described in this booklet if you are a full-time employee or you meet the eligibility requirements stated under the collective bargaining agreement under which you are employed with the District.

You may also elect to cover your eligible dependents residing within the United States. Dependents eligible under the Plan are:

- Your legal spouse, provided he or she:
 - meets all the requirements of a legal marriage in the State in which you reside. However, should the marriage laws of your state conflict with the definition of marriage as contained under the Federal Defense of Marriage Act, only those persons considered a spouse under the Federal Defense of Marriage Act are eligible for the continuation of coverage available through The Consolidated Omnibus Budget Reconciliation Act (COBRA).
 - is not eligible for coverage under their employer's health plan. If your spouse is eligible for coverage under his/her employer's health plan and his/her employer pays at least 50% of the cost of coverage, he/she must be enrolled in his/her employer's plan in order to qualify for coverage as your dependent under this Plan. If your spouse's employer contributes less than 50% of the cost of your spouse's coverage, this requirement of coverage under your spouse's employer's plan is waived. If your spouse ceases employment, he or she will be eligible for coverage as long as your spouse does not become re-employed and eligible for coverage with another employer.
- Your unmarried, dependent children:
 - through age 18; or,
 - through age 22 if a registered full-time student in regular attendance at an accredited vocational school, college or university. A full-time student means a student who is enrolled for at least 12 credit hours of study unless otherwise defined by the school or college in which the student is enrolled. Proof of a child's full-time student status will be required each semester or quarter during which he or she has a claim; or,
 - who is unable to support himself or herself because of a physical or mental handicap and has been continuously incapacitated since attainment of age 19 (or age 23, if he or she was a registered full-time student). Proof of incapacity must be submitted to the Human Resources Department upon enrollment or, if later, within

60 days after the date on which the dependent no longer will be eligible because of age, 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. In addition, the dependent child must meet all of the eligibility requirements other than age to continue to be eligible.

A child must be primarily dependent upon you for his or her maintenance and support unless you are assigned responsibility for medical expenses or coverage for the child through a court order or divorce decree.

Children eligible for coverage under the Plan include your natural child, step child, legally adopted child, a child who has been placed with you for adoption pursuant to an interim court order, a foster child who is residing with you in a normal parent-child relationship, a child who is a relative and for whom you have been appointed legal guardian, a child for whom you have legal custody, and a child who is recognized under a Qualified Medical Child Support Order (please refer to page 75 for additional information concerning a child's eligibility under a Qualified Medical Child Support Order).

Your parents are not eligible even though you may support them.

If both you and your spouse are employees of the District, you may not be covered as both an employee and as your spouse's dependent. In addition, your children may be considered as eligible dependents of either you or your spouse, but not both. If a child's parents are divorced and both are enrolled for Family coverage with the District, the child will only be considered the dependent of father. However, when a court order or divorce decree assigns responsibility for a child's medical or dental expenses to a specific parent, the child will only be considered the dependent of the named parent.

- Note:
- 1- Each person who was covered under the group benefits plan maintained by Harlem Consolidated Schools District #122 immediately prior to January 1, 2005, will continue to be covered on and after January 1, 2005, subject to the terms and conditions of this plan.
 - 2 - Coverage will be subject to a limitation of benefits for all pre-existing conditions as described in the section "Limitations of Coverage for Pre-Existing Conditions" beginning on page 27.
 - 3 - Benefits payable by the Plan may be reduced as described in the section "Coordination With Other Plans" beginning on page 62 for persons covered under more than one plan. Other reductions to benefits as described in this Summary Plan Description may also apply.

Who Pays for the Coverage

If you are an active employee, the District pays the entire cost of your coverage and shares the cost of coverage for your dependents, if you elect Family coverage. The Human Resources Department will advise you of the cost for coverage and the amount that will be deducted from your paycheck when you become eligible.

If you elect Family coverage, you may choose to make your contribution for coverage on a pre-tax basis under the District's Section 125 Plan. You will only be allowed to change your coverage election during the designated annual open enrollment period or, if sooner, within the 31-day period following the date your dependent qualifies for coverage as a Special Enrollee.

If you or your dependent qualifies for continuation coverage, you will be responsible for the full cost of coverage. You and/or your dependent will be provided with information regarding the premium amount and payment procedure at the time eligibility ceases.”

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. You will be asked to complete and file an enrollment form with the Human Resources Department when you first become eligible.

Coverage for Your Dependents

If you have eligible dependent(s) on the day you first become eligible and elect Family coverage, you must complete and submit the enrollment form electing Family coverage within 31 days of the date you are first eligible to the Human Resources Department. Once you are enrolled for Family coverage, any newly acquired eligible dependent will become covered on the date you acquire him or her, and notify the Human Resources Department. 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 in the section beginning on page 75.

If you do not have any eligible dependent(s) when you first become covered and acquire an eligible dependent later that you wish to enroll for coverage, you must complete and submit a new enrollment form electing Family coverage within 31 days of the date you acquire the eligible dependent. Coverage for the new dependent will begin at 12:00 A.M. on the date he or she becomes your dependent.

If you waive Family coverage or do not file your written election for Family coverage with the Human Resources Department within the 31 day periods specified in this section, your dependent(s) will be eligible only during the designated Open Enrollment period or, if sooner, within 31 days of the date they qualify as a Special Enrollee. Please refer to the section “Special Enrollees” for additional information.

Note: Please refer to the section “Limitations of Coverage for Pre-Existing Conditions” on page 27 for information on the potential limitation of coverage.”

Open Enrollment

The District will designate an Open Enrollment period during which time you may:

- Change the PPO network you and/or your covered dependent(s) will access during the enrollment year. Your spouse may make an election separate from the rest of the family.
- File an election to make your contributions for Family coverage on a pre-tax basis if you have not already done so.
- Change your coverage election from Single to Family or from Family to Single coverage.

The Open Enrollment period will be held in October (beginning October 2005). An election or change requested during the Open Enrollment period will become effective at 12:00 A.M. on the January 1st following the Open Enrollment period.

Note: Please refer to the section “Limitations of Coverage for Pre-Existing Conditions” on page 27 for information on the potential limitation of coverage.

Special Enrollees

A dependent who is not enrolled for coverage will qualify for coverage as a “Special Enrollee” if coverage was declined in writing when it was previously offered and any of the following apply:

1. your dependent(s) had coverage under another group health plan or health insurance coverage and that coverage ends as a result of “loss of eligibility”, or 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 acquire a new dependent child through birth, adoption, or placement for adoption.

If your dependent(s) qualify for coverage as a Special Enrollee, you must enroll for Family coverage within 31 days of the loss of the other coverage or within 31 days of the date of marriage, birth, adoption or placement of adoption, whichever is applicable. If you enroll for Family coverage within this 31-day period, coverage for your dependent(s) will begin at 12:00 A.M. on the day after the other group health plan or health insurance coverage ends or the date you acquire a new dependent or marry.

When Coverage Terminates

Effective Date of Termination for Employees

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

1. the last day of the calendar month in which your employment terminates or you retire (unless you qualify for continued coverage as a retiree. See the section “Continuation of Coverage for Retired Employees” beginning on page 50);
2. the last day of the calendar month in which you no longer meet the definition of an eligible employee except that if you cease active work due to:
 - a. an illness or injury coverage will continue until the last day of the period for which you qualify for sick leave; or,
 - b. a reduction in work force, coverage will continue until the last day of that school contract year (through summer);
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 you become a full-time member of the Armed Forces of any country;
5. the day the Plan is terminated.

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

- Family or Medical Leave -

If you are eligible for continued coverage based on the provisions of the Family and Medical Leave Act of 1993 (FMLA), coverage will continue as so required provided you agree to make the required contributions. An FMLA leave will be integrated with any other continuation to which you may otherwise be eligible, other than COBRA.

Termination of the coverage continuation provided under FMLA or your failure to return from leave will be considered a 'qualifying event' under COBRA. If you waive coverage continuation during an FMLA leave, coverage for you (and any dependent covered prior to your leave) will be reinstated at 12:00 A.M. on the first day you return to the District as an eligible employee. The pre-existing condition limitation of coverage will apply to the extent that you (or your dependent) satisfied the limitation-waiting period prior to beginning the leave. If the pre-existing condition limitation-waiting period was satisfied prior to your leave, you (or your dependent) will not have to meet a new waiting period. However, if the pre-existing condition waiting period was not satisfied prior to your leave, the remaining portion of the waiting period will need to be satisfied by that individual upon reinstatement of coverage. The limitation will only apply to conditions that were considered to be pre-existing prior to the FMLA leave.

- Military Leave -

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

If both husband and wife are eligible for coverage as employees and one spouse has been considered the covered employee and the other the covered dependent, and the spouse carrying the Family coverage no longer qualifies as an employee, the Family coverage may be switched to the remaining spouse. In order to do this, the remaining spouse must provide the Human Resources Department 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 will then be covered under the remaining spouse 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 Human Resources Department 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. the day on which you become legally divorced;
 - b. if you are an active employee, the day on which your spouse makes a written election to be covered by Medicare for Health coverage instead of this Plan; or,
 - c. if your spouse begins employment with an employer who provides group health coverage and pays at least 50% of their coverage but your spouse does not enroll for that coverage, the day on which your spouse would have satisfactorily completed any waiting period under that plan had he or she enrolled;
2. for a child, the last day of the calendar month in which -
 - a. he or she attains age 19 if not a full-time student at an accredited vocational school, college or university; or,
 - b. if a full-time student at an accredited vocational school, college or university, he or she –
 - (1) attains age 23; or, if sooner,
 - (2) graduates or is no longer enrolled and in attendance as a full-time student in an accredited school or college. A child will be considered a full-time student through any scheduled break between academic quarters or semesters prior to graduation, including summer vacation, except that if the child does not return to an accredited school or college after the break, his or her student status will be considered terminated as of 11:59 P.M. on the last day of the academic quarter or semester that ended prior to the break;

- c. the child marries;
 - d. the child ceases to be financially dependent upon you for support and maintenance (unless you are required to provide coverage for the child through a court order or divorce decree);
 - e. you are relieved of a court-order obligation to furnish health care coverage for the child;
3. if you request that your contributions for Family coverage be stopped, the last day of the period for which you have made your contribution; or,
 4. the day on which your spouse or child has resided outside of the United States for a period longer than 12 months.

Note: You or your dependent are responsible for notifying the Human Resources Department within 60 days following the date a dependent is no longer eligible for coverage because of divorce or because your child no longer meets the eligibility requirements. If the Human Resources Department 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.

Certificate of Creditable Coverage Upon Termination

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

1. upon termination of coverage under the Plan;
2. for an individual who is a Qualified Beneficiary and has elected COBRA coverage, upon termination of COBRA continuation coverage; and,
3. upon reaching the Plan's maximum benefit payable under the Plan (please refer to the "Schedule of Health Care Benefits").

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

Continuation of Coverage for Active Employees and Their Dependents

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

Continuation of Coverage During An Approved Leave of Absence

If your active employment ends because you take an approved leave of absence, you have the option of continuing coverage by making the required contribution for coverage. You and your eligible dependents (if Family coverage is in effect on the date your leave begins) will qualify for continued coverage until 11:59 P.M. on the earliest of the following dates:

- for a medical leave, the last day of the 24-month period immediately following the date the leave began;
- for a maternity or adoption leave, the last day of the 12-month period immediately following the date the leave began; and,
- for a personal leave, the last day of the approved leave period.

Coverage will terminate prior to the completion of the above period if you fail to make a timely payment of the premium required or if the Plan is ended. The Human Resources Department will advise you of the cost of coverage.

You will have to make a choice between continuing coverage under this continuation option and COBRA (see page 53).

Continuation of Coverage If You Become Totally Disabled

If your active employment ends because you become totally disabled, you have the option of continuing coverage by making the required contribution for coverage. You and your eligible dependents (if Family coverage is in effect on the date your leave begins) will qualify for continued coverage until 11:59 P.M. on the earliest of the following dates:

1. the day you are no longer considered to be totally disabled (unless you return to active work);
2. the last day of a 3-calendar month period beginning on the first day following the day coverage would have otherwise terminated;
3. the last day of the period for which you have paid for the coverage. The Human Resources Department will advise you of the cost to continue coverage;

4. the day you become covered under another group health plan without a limitation of coverage for the disabling condition; or,
5. the day the Plan is ended.

If your total disability continues beyond this 3-month continuation period, you will have the option of continuing coverage under one of the following options:

1. COBRA (see page 53); or,
2. if the District is making a contribution to the Illinois Municipal Retirement Fund in your behalf, the IMRF disability extension (see page 51).

Continuation of Coverage for a Disabled Student

If a dependent student over age 18 but less than age 23 becomes disabled, coverage will be extended without interruption until the last day of the quarter or semester at the school he or she was attending when the disability began. If your child cannot return to student status at the beginning of the next available quarter or semester, he or she will be given the option to extend coverage under COBRA as explained in the section beginning on page 53.

Continuation of Coverage for Retired Employees

Who is Eligible for Continuation

You are eligible to continue coverage as a retiree if you meet the requirements for continued coverage based on your employment agreement or the collective bargaining agreement under which you were employed.

If you qualify as an eligible retiree and your spouse and children are covered under the Plan on the day immediately prior to your retirement, you may also elect to continue coverage for your eligible dependents under this continuation option. However, if you marry or acquire an additional dependent child after your retirement, your new spouse and/or child are not eligible for coverage under this Plan.

You will have to choose between continuing coverage under this retiree coverage option and COBRA.

When Coverage Terminates

You are eligible to continue coverage for yourself and your covered dependents until 11:59 P.M. on the earliest of the following days:

1. the day on which you attain age 65. However, if you retired prior to March 29, 1996, coverage will continue until the day on which you attain age 70;

2. the date of your death;
3. the last day of the period for which you have paid for the coverage. The Human Resources Department will advise you of the cost of continue coverage;
4. for your spouse, the date you become legally divorced; or,
5. for your dependent children, the date on which they cease to meet the Plan's eligibility requirements (see the section "Who is Eligible for Coverage" for additional information).

Coverage will end prior to the above specified dates if the Plan is terminated.

If your spouse and/or dependent child's coverage terminates due to any reason other than your failure to pay the premium for continuation coverage by the required due date, he or she will be eligible to continue coverage under COBRA as explained beginning on page 53.

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

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

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

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

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

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

3. the day you die;
4. the last day of the period for which you have paid a premium by the applicable due date;
5. the day the Plan is ended.

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

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

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

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

Continuation of Coverage Following the Death of an IMRF Pension Recipient

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

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

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

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

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

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

COBRA continuation coverage is an extension of Plan coverage required under the Federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This law requires that most group health plans (including this Plan) give “Qualified Beneficiaries” the opportunity to continue their health care coverage when there is a “Qualifying Event” that results in a loss of coverage.

A Qualified Beneficiary will be offered COBRA continuation coverage based on the same coverage that was in effect on the day before the Qualifying Event. However, if you or your dependent are eligible for Medicare on the date of the Qualifying Event, benefits will be coordinated with Medicare as described in the section “Benefits for Persons Eligible for Medicare”. Any change to the coverage provided under this Plan for active employees will also apply to COBRA continuation coverage.

Each Qualified Beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as an active employee or dependent covered under the Plan, including any Open Enrollment or Special Enrollment rights available under this Plan.

COBRA continuation coverage does not apply to, and is not available for, life insurance, disability, accidental death or dismemberment benefits, or other non-group health plan benefits offered by the District. The Plan provides no greater rights than what is required under the COBRA legislation – nothing in this document is intended to expand your rights.

Qualifying Events

A “Qualifying Event” is any one of the following events that causes a loss of coverage under the Plan:

- For You -
 1. Your hours of employment (that is, the number of hours you work each week) are reduced; or,
 2. Your employment ends for any reason, other than due to your gross misconduct;
- For Your Covered Spouse -
 1. Your hours of employment (the number of hours you work each week) are reduced or your employment ends for any reason, other than due to your gross misconduct;
 2. Your death;
 3. You become entitled to Medicare (Part A, Part B or both) if entitlement to Medicare causes a loss of coverage under the Plan; or,
 4. You divorce or become legally separated (if legal separation causes a loss of coverage under the Plan). In addition, if you cancel your spouse’s coverage under the Plan in anticipation of a divorce or legal separation, the divorce or legal separation may still be considered a Qualifying Event even though your ex-spouse lost coverage earlier. If your ex-spouse notifies the Human Resources Department within 60 days after the divorce or legal separation and can establish that you canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage will be available for the period after the divorce or legal separation.

Note: You or your dependent are responsible for notifying the Human Resources Department in writing within 60 days following the date a dependent qualifies for continuation because of divorce. If the Human Resources Department is not notified within this 60-day period, the dependent(s) will not qualify for coverage continuation unless the District determines the Qualified Beneficiary did not receive his or her initial notice of COBRA rights and notice of the Qualifying Event was given as soon as was reasonably possible.

- For Your Covered Dependent Child(ren) -
 1. Your hours of employment (the number of hours you work each week) are reduced or your employment ends for any reason, other than due to your gross misconduct;
 2. Your death;
 3. You become entitled to Medicare (Part A, Part B or both) if entitlement to Medicare causes a loss of coverage under the Plan;

4. You divorce or become legally separated (if legal separation causes a loss of coverage under the Plan); or,
5. Your child no longer meets the definition of an eligible dependent under the Plan.

Note: You or your dependent are responsible for notifying the Human Resources Department in writing within 60 days following the date a dependent qualifies for continuation because of divorce or because your child no longer meets the eligibility requirements. If the Human Resources Department is not notified within this 60-day period, the dependent(s) will not qualify for coverage continuation unless the District determines the Qualified Beneficiary did not receive his or her initial notice of COBRA rights and notice of the Qualifying Event was given as soon as was reasonably possible.

Qualified Beneficiary

A “Qualified Beneficiary” is:

- Any individual who is covered under the Plan on the date coverage terminates due to a Qualifying Event listed above.
- A newborn infant or child placed for adoption with a former employee continuing coverage under COBRA provided the child meets the Plan’s eligibility requirements (for example, the child has not exceeded the Plan’s age limitation). However, the newborn or adopted child must be enrolled for COBRA continuation coverage within 31 days of his or her birth or placement for adoption. The child’s COBRA continuation coverage will last as long as it does for other Qualified Beneficiaries within the former employee’s family. If the former covered employee or family member fails to notify the District in a timely fashion of the child’s birth or adoption, the child will not be eligible for COBRA coverage.
- A child of a covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee’s period of employment. This child is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

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

Your Responsibility to Report a Qualifying Event

You or your dependent are responsible for notifying the Human Resources Department in writing within 60 days following the date a dependent qualifies for continuation because of divorce or because your child no longer meets the eligibility requirements. Please refer to the paragraph entitled “Notice Procedures” for details on how to notify the District that a Qualifying Event has occurred. If the Human Resources Department is not notified within this 60-day period, the dependent(s) will not qualify for COBRA continuation coverage unless the District determines the Qualified Beneficiary did not receive his or her initial notice of COBRA rights and notice of the Qualifying Event was given as soon as was reasonably possible.

If you (or a family member) fail to notify the Human Resources Department in writing of a Qualifying Event, and any claims are paid mistakenly for expenses incurred after the Qualifying Event date, then you or your qualifying family member will be required to reimburse the Plan for any such claims paid.

Information about the cost of the continued coverage and the election form will be provided to the Qualified Beneficiary’s last known home address at the time of eligibility for COBRA continuation coverage.

Electing COBRA Continuation Coverage

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

Your dependents will be notified in writing of their rights if you die or if your eligibility for Medicare results in the termination of your dependent’s coverage.

If your dependent(s) become eligible due to a divorce or a child no longer meeting the eligibility requirements and the District receives timely notice that a Qualifying Event has occurred, your dependent(s) will be notified in writing of their right to COBRA continuation coverage.

Each Qualified Beneficiary who was covered under the Plan on the date coverage terminated is entitled to elect COBRA continuation coverage independently. You may elect COBRA continuation coverage on behalf of your spouse and/or dependent children. If you decline your right to COBRA continuation coverage, your spouse and/or children are still entitled to elect the continuation for themselves. A parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

A Qualified Beneficiary may elect COBRA continuation coverage even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date of their COBRA election. However, COBRA coverage will terminate automatically if, after electing COBRA, the Qualified Beneficiary becomes entitled to Medicare benefits 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).

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

To elect COBRA continuation coverage, the Election Form must be completed and mailed within the required 60-day election period. Your Election Form must be sent to:

Harlem Consolidated Schools District #122
Attention: Human Resources Department
P.O. Box 2021
Loves Park, IL 61130

The Qualified Beneficiary's election for COBRA continuation coverage must be in writing (via the Election Form) and must be sent to the address specified above. Verbal notice, including notice by telephone or in-person, is not acceptable.

A Qualified Beneficiary may change a prior refusal of COBRA continuation coverage at any time within their 60-day election period by using the Election Form and following the procedures specified on the Election Form. The Qualified Beneficiary's COBRA continuation coverage will begin on the date he or she rescinds their waiver of coverage (in other words, there will be a gap in coverage between the date of termination and the date of the written election to continue coverage).

Special Considerations in Deciding Whether to Elect COBRA Continuation Coverage

In considering whether to elect COBRA continuation coverage, please bear in mind that failure to elect COBRA will affect the individual's future rights under other Federal laws for which they may be eligible.

First, if a group health plan is required to comply with HIPAA, the individual can avoid having pre-existing condition exclusions apply to them if they do not have more than a 63-day gap in health coverage. An election of COBRA coverage may help avoid such a gap.

Second, if a Qualified Beneficiary does not elect COBRA coverage for the maximum time available to them, they will lose their guaranteed right to purchase an individual health insurance policy that does not impose a pre-existing condition exclusion.

Finally, a Qualified Beneficiary may have the right to request special enrollment in another group health plan for which he or she is otherwise eligible (such as a plan sponsored by their spouse's employer) within 30 days after their group health coverage under this Plan ends because of a Qualifying Event. If entitled to this special enrollment, the Qualified Beneficiary will also have the same special enrollment right at the end of the maximum COBRA continuation period available to them.

The Maximum COBRA Continuation Coverage Period

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

36-Month Qualifying Events. If a spouse or dependent child lose group health coverage because of the employee's: death, divorce, legal separation, or entitlement to Medicare, or because a child no longer meets the definition of an eligible dependent under the Plan, the maximum coverage period for the spouse and dependent child is 36 months from the date of the Qualifying Event.

18-Month Qualifying Events. If the employee, spouse or dependent child loses group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in employment hours, the maximum continuation coverage period is 18 months from the date of the Qualifying Event. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

- Disability Extension

The 18-month maximum continuation may be extended up to a maximum of 29 months if you or another covered Qualified Beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage *and* you notify the District in a timely fashion. This extension is available to all Qualified Beneficiaries within your family who are continuing coverage due to your termination or reduction in hours of employment. During the additional 11-month extension you may be charged up to 150% of the applicable premium. To benefit from this extension, you must notify the District in writing within 60 days after the date of the Social Security Administration's determination and before the end of the original 18-month period. In addition, your notice must include the name of the disabled Qualified Beneficiary, the date that the Qualified Beneficiary became disabled, and the date that the Social Security Administration made its determination. A copy of the Social Security Administration's determination must accompany your written notice. If these procedures are not followed or if the notice is not provided in writing to the District within the required timeframe, the 11-month disability extension will not be available. If the 11-month disability extension is granted, the affected individual must also notify the District within 30 days of any final determination made by the Social Security Administration that the individual is no longer disabled.

- Second Qualifying Event Extension

If a second Qualifying Event occurs within the 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours. This extension is available to all dependents who are Qualified Beneficiaries due to an employee's termination of employment or reduction in employment hours. "Second Qualifying Events" are the former employee's death, divorce or legal separation from his or her spouse, or if a child no longer meets the

definition of an eligible dependent under the Plan. In all of these cases, the District must be notified in writing of the second Qualifying Event within 60 days of the date the event occurs. Your notice must include what Second Qualifying Event occurred and the date it happened. If these procedures are not followed or if the notice is not provided in writing to the District within the required 60-day period, the additional COBRA continuation coverage extension will not be available.

- Medicare Extension for Spouse and Dependent Children

As noted earlier, if an employee loses group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in employment hours, the maximum continuation coverage period is 18 months from the date of the Qualifying Event for the employee and his/her covered spouse and children. While this remains true for the former covered employee, COBRA provides an extension of this continuation period for the employee's covered spouse and dependent children if, while still employed and within 18 months prior to the employee's termination of employment or reduction in employment hours, the employee becomes entitled to Medicare. If this occurs, the employee's covered spouse and dependent children will be eligible for COBRA continuation coverage for a maximum of 36 months beginning on the date of the employee's entitlement to Medicare even though this entitlement occurred while the employee and dependents were still covered.

Termination Before the End of the Maximum Coverage Continuation Period

The law provides that COBRA may be terminated before the end of the maximum coverage period stated in the preceding section for any of the following five reasons:

1. The Plan no longer provides group health coverage to any of its employees;
2. The premium for COBRA is not paid on time. Premium will be considered paid when the envelope is postmarked. If a check is returned for insufficient funds, the premium will not be considered paid;
3. After electing COBRA, the Qualified Beneficiary becomes covered under another group health plan. You must notify the District in writing within 30 days if, after electing COBRA coverage, a Qualified Beneficiary becomes covered under another group health plan. If the other group plan contains a pre-existing condition exclusion or limitation for a condition the Qualified Beneficiary has, he or she will continue to qualify for COBRA continuation coverage until the pre-existing condition exclusion or limitation no longer applies. The other group plan will be considered the primary payer of benefits;

Note: Under the Federal law, the Health Insurance Portability and Accountability Act of 1996, a group health plan's pre-existing condition exclusion or limitation may be offset by the amount of creditable plan coverage the individual has attained prior to enrolling in the health plan.

4. After electing COBRA, the Qualified Beneficiary becomes entitled to Medicare. You must notify the District in writing within 30 days if, after electing COBRA coverage, a Qualified Beneficiary enrolls in Medicare Part A or B. You must use the notice procedures specified in the paragraph entitled “Notice Procedures”;
5. The Qualified Beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. The affected individual must notify the District within 30 days of any final determination that the individual is no longer disabled.

COBRA Continuation Coverage Premiums

The COBRA regulations dictate how COBRA continuation coverage premiums may be calculated. Under COBRA, a Qualified Beneficiary’s premium may not exceed 102% of the cost to the group health plan (this includes both employer and employee contributions) for coverage of an active employee or dependent who is not receiving continuation coverage. In the case of an extension of continuation coverage due to a disability, the Qualified Beneficiary’s premium may not exceed 150% of the group health plan’s cost for the additional 11-months of COBRA continuation coverage. These rates are reviewed and subject to change once a year at the Plan’s anniversary date. A Qualified Beneficiary’s applicable premium will not be increased during the plan year unless there is a disability extension, or the Qualified Beneficiary changes his or her coverage, or if the Plan subsidizes a portion of the premium and the Plan discontinues its subsidy.

Payment for COBRA Coverage

If COBRA continuation coverage is elected in a timely manner, an Initial Premium Notice will be forwarded to the Qualified Beneficiary reflecting the total premium due from the Qualifying Event date through the last day of the applicable billing cycle. Payment of the Initial Premium is required within 45 days of the date COBRA continuation coverage is elected. If the full payment is not received (envelope postmarked) within this 45-day grace period, COBRA continuation coverage will be canceled retroactive to the coverage termination date.

All COBRA premiums must be paid by check (personal or certified) or by money order. Cash payments will not be accepted.

Claims will not be processed or prescriptions filled until a Qualified Beneficiary has both elected COBRA and made their first payment (please refer to the paragraph below entitled “Important Note – Coverage Reinstatement” for additional information). Although not required, if you wish to expedite reinstatement of coverage you may forward a partial premium payment along with your Election Form (for example, one month’s premium). The total amount due on the Initial Premium Notice will be adjusted accordingly. However, if the full payment of the Initial Premium is not received (envelope postmarked) within the 45-day grace period required for Initial Premiums, COBRA continuation coverage will be canceled retroactive to the last day for which you have paid premium.

COBRA continuation coverage runs on a month-to-month basis. Therefore, after you make your initial payment for COBRA continuation coverage, premium for each following month of COBRA continuation coverage will be due on the first day of each calendar month with a 30-day grace period. If premiums are not paid (envelope postmarked) by the last day of the premium payment grace period, COBRA continuation coverage will end as of the last day for which premiums were paid on time.

The District will send monthly premium notices to the Qualified Beneficiary. A notice is only a reminder that a premium is due. It is not a bill. A Qualified Beneficiary must make their payment by the due date or within the grace period whether or not a notice is received. The Qualified Beneficiary's premium will not be considered paid in full if their check is returned by their bank due to insufficient funds (the check "bounces"). If this occurs, the District will notify the Qualified Beneficiary in writing. If the Qualified Beneficiary does not make full payment of the specified premium due by certified check or money order within 15 days from the date of the notice, the Qualified Beneficiary's COBRA continuation coverage will end as of the last date he or she has made sufficient premium payment.

The initial and subsequent monthly payments for COBRA continuation coverage should be sent to the District at the following address:

Harlem Consolidated Schools District #122
Attention: Human Resources Department
P.O. Box 2021
Loves Park, IL 61130

Important Note Concerning Coverage Reinstatement : A Qualified Beneficiary's COBRA continuation coverage will be in force as long as payment is made before the end of the grace period for each period of coverage (for example, each month). If a Qualified Beneficiary makes his or her premium payment later than its due date but during the grace period, their coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is received. No claims will be paid or prescriptions filled until premium is paid for the month in which the charges are incurred. This means that any claim submitted for benefits while coverage is suspended may be denied and will have to be resubmitted once coverage is reinstated.

Notice Procedures

The Plan requires that all notices must be made in writing. Verbal notice, including notice by telephone, is not acceptable and will not meet the Plan's notice requirement.

Notices must be made in writing and mailed to:

Harlem Consolidated Schools District #122
Attention: Human Resources Department
P.O. Box 2021
Loves Park, IL 61130

Notice must be made no later than the last day of the required notice period. Notice is considered to have been made on the date the envelope mailed to the District is postmarked or, if notice is delivered by carrier or in person, the date it is signed as being received by that office.

All notices must include: the name of the Plan, the name and address of the employee covered under the Plan, the name(s) and address(es) of the Qualified Beneficiary(ies), the Qualifying Event and the date the event happened.

Keep Your Plan Administrator Informed

In order to protect your family's rights to COBRA continuation coverage, you should keep the Human Resources Department informed of any changes in your marital status (divorce or legal separation) or the addresses of you or any of your covered family members. All COBRA notices will be sent to the last known address. You should also keep a copy of any notices you send for your records.

Contact Information

If you have questions regarding your COBRA continuation coverage, please contact:

Harlem Consolidated Schools District #122
Attention: Human Resources Department
P.O. Box 2021
Loves Park, IL 61130

Additional information regarding COBRA can also be obtained by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Regional and District EBSA office addresses and phone numbers are available through EBSA's website at www.dol.gov/ebsa/.

Coordination With Other Plans

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

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

of benefits and the provider of service accepts Medicare assignment, the “allowable expense” will be equal to the reasonable and customary amount approved by Medicare; this limitation will not apply if the provider does not accept Medicare assignment. When a plan provides its benefits in the form of services rather than in cash payments, the reasonable and customary cash value of the service performed is considered to be a benefit paid. If an individual is covered under a Managed Care Organization plan, such as a Health Maintenance Organization (HMO)), and obtains treatment outside of the service provider network, the Plan will consider the charges to have been reimbursed by the Managed Care Organization plan at the same level it would have paid had the individual utilized a participating provider. Therefore, no benefits will be payable by the Plan if a Managed Care Organization plan reimburses network treatment at 100% and the individual obtains treatment outside of the service provider network.

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

1. an automobile insurance policy or a plan which does not have a coordination of benefits provision is the primary plan;
2. if a person is a covered employee under one plan, and a covered dependent under another plan, the plan that covers the person as an employee is the primary plan;
3. if a child is covered under more than one plan and the parents are not separated or divorced, the father’s plan is the primary plan. If an irresolvable conflict should arise between the two plans because the other plan has a rule based on the birthday of the parents, the claims administrator, acting on behalf of the Plan Sponsor, shall have the authority to resolve such dispute by superseding the gender rule and using the other plan’s rule in determining the order of benefits;
4. if a child is covered under more than one plan and the parents are separated or divorced, the primary plan is determined as follows:
 - a. the plan of the natural parent having responsibility for the child’s health care expenses by court decree pays first. If the court decree splits the responsibility equally between the divorced parents, the primary plan is the plan of father;
 - b. in the absence of a court decree -
 - (1) the plan of the natural parent having legal custody pays; then,
 - (2) the plan of the spouse (if any) of the natural parent with legal custody pays; then,
 - (3) the plan of the natural parent without legal custody pays last;
5. if a person is a covered active employee under one plan and a covered retired or laid off employee under another plan, the plan that covers the person as an active employee or a dependent of an active employee is the primary plan;

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

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

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

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

Benefits for Persons Eligible for Medicare

The Plan will pay benefits primary to 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 or if you are a retiree, 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 as described below:

- First the amount of benefit paid or payable by Medicare Part A and Part B will be determined.
- Then the benefit normally payable by the District Benefit Plan will be determined.
- Finally, if the total benefit normally payable by the District Benefit Plan is more than the benefit available from Medicare, you will receive an amount equal to the difference.

For example, if Medicare benefits are \$1,000 and the regular benefits under the District Plan would have been \$1,300, you will receive \$300. If Medicare benefits exceed the normal District Plan benefits, the District Benefit Plan will make no payment.

You should contact a Social Security office as soon as you or your dependent becomes eligible for Medicare.

Subrogation/Right of Reimbursement

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

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

Additional information concerning this provision is provided under the section "Subrogation/Right of Reimbursement" beginning on page 73.

Right of Recovery

In the event of any overpayment of benefits, the Plan will have the right to recover the amount of the overpayment. When an employee is paid a benefit greater than should have been paid under the Plan, the employee will be requested to refund the overpayment. If the refund is not received from the employee following a request of recovery, the amount of the overpayment will be

deducted from the employee's future benefit payments. Similarly, if payment is made on the behalf of a covered employee or his or her dependent to a hospital, physician or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from that provider or, as an alternative, reduce future benefit payments by an amount equal to the overpayment.

Reasonable and Customary Expenses

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

How to Apply for Benefits

What Information Is Needed

The following information must be submitted to our claims administrator, Benefit Systems & Services, Inc., (BSSI) for each claim:

- your name;
- the patient’s name;
- the District’s name;
- the name and address of the provider of care, including his or her tax identification number;
- the diagnosis;
- the type of service rendered, with diagnosis and/or procedure codes;
- the date(s) of services;
- the amount of charges; and,

- if the claim is for an injury, a description of the accident, including how and when it occurred.

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

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

- Spouse's Employer -

BSSI will need to know if your spouse is employed or changes employers and, if so, the name and address of his/her employer and whether or not they have group coverage through this employer;

- Student Status -

BSSI will require the name and address of the school at which a child age 19 or over is attending to verify his/her full-time student status each semester or quarter during which your child has a claim;

- Divorce Decree -

if a child's parents are separated or divorced, BSSI will require information concerning which parent has been assigned responsibility for the child's coverage;

- Coordination of Benefits -

if you or a dependent have a claim for benefits and the Plan is not the primary plan, BSSI will require a copy of the Explanation of Benefits (EOB) you receive from the other plan. An EOB is a statement from an insurer or claims processor that shows the action taken on a claim.

Where to File the Claim

ECOH PPO

If you (or your spouse) have chosen the ECOH network, all hospital and health claims should be forwarded to the PPO at the following address:

Employer's Coalition on Health (ECOH)
P.O. Box 303
Onalaska, WI 54650-0303

ECOH can be contacted at 1-800-990-3204 or through their website at www.ecoh.com; when traveling or attending school out-of-area call 1-800-678-7427 for a referral to a participating PHCS provider.

The PPO will determine whether your claim is for charges incurred with a PPO provider. If so, the PPO will apply the appropriate discount to your claim. Following its review the PPO will forward the claim to the claims administrator, Benefit Systems & Services, Inc. (BSSI), for adjudication.

All dental claims should be forwarded to:

Benefit Systems & Services, Inc.
760 Pasquinelli Drive, Suite 320
Westmont, Illinois 60559-5555
1-800-423-1841
www.benefit-sys.com

Private Healthcare Systems (PHCS) PPO

If you have chosen the Private Healthcare Systems (PHCS) PPO network, all hospital, health and dental claims should be forwarded to our claims administrator, Benefit Systems & Services, Inc. (BSSI) at:

Benefit Systems & Services, Inc.
760 Pasquinelli Drive, Suite 320
Westmont, Illinois 60559-5555
1-800-423-1841
www.benefit-sys.com

PHCS can be contacted at 1-800-240-1940 or through their Website at www.phcs.com.

When to File the Claim

Claims must be submitted for reimbursement under the Plan within one year following the date on which the claim is incurred. For example, if you incur an expense on July 1, 2005, you must submit that claim no later than by June 30, 2006, in order to receive benefits under the Plan. However, if your coverage or your dependent's coverage terminates, claims must be submitted within 60 days following the effective date of termination. If a claim is not submitted within these time periods for reasons beyond your control (for example, the absence of legal capacity) the claim may be eligible if you provide evidence of the circumstance which prevented earlier submission.

Website Assistance

Our claims administrator, Benefit Systems & Services, Inc. (BSSI), has established a secure website in which you are able to:

- view submitted claims and status for yourself and your dependents;
- view eligibility status for yourself and your dependents;
- view deductible and Out-of-Pocket accumulations for yourself and your dependents;
- obtain an email notification that a claim has been paid and you can retrieve the Benefit Summary directly from the website (if this option is selected, a Benefit Summary will no longer be mailed to you);
- have access to the PPO and Prescription Drug Networks to locate participating providers;
- access forms; and,
- e-mail BSSI with questions about benefits or payments.

BSSI will provide you with a unique Personal Identification Number (PIN) number. After you have signed on to the website for the first time, you will be able to change your User name and password.

You can visit the BSSI website at <http://www.benefit-sys.com>.

Review of a Denied Claim

If a claim is completely or partially denied, you will receive an explanation from the claims administrator, Benefit Systems & Services, Inc. (BSSI). If you disagree with the decision on your claim, you may obtain a review by submitting a written request. The appeal must be made in writing and include any written comments, documents, records or other information relating to the claim that you would like to be taken into consideration. The appeal must be submitted within 60 days of the denial and directed to:

President
Benefit Systems & Services, Inc.
760 Pasquinelli Drive, Suite 320
Westmont, Illinois 60559-9999

You will be given written notice on the decision of your appeal, usually within 60 days.

Miscellaneous Administrative Provisions

Amendment, Alteration or Termination of the Plan

This Plan may be amended, changed or discontinued by the District at any time without the consent of any covered person.

Assignment

No covered person shall have the right, except as specified in this Plan, to assign, alienate, anticipate or commute any payments under the Plan. Except as prescribed by law, no payments shall be subject to the debts, contracts or engagements of any covered person, or to any judicial process to levy upon or attach the same for payment. Any covered person, however, may with the District's approval, authorize the District to pay benefits under the Plan directly to the person or organization on whose charges a claim is based. The District shall be discharged from all liability to the extent of any payment made in accordance with any such authorization.

Examination

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

Claim Procedure

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

Legal Proceedings

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

Proof of Claim

Written proof covering the occurrence, character and extent of the loss of which a claim is made must be given to the claims administrator within twelve months following the date on which the claim is incurred. However, if your coverage or your dependent(s) coverage terminates, claims must be submitted within 60 days following the effective date of termination. Failure to furnish proof will not reduce any claim if it shall be shown that it was not reasonably possible to furnish such proof on time and that it was furnished as soon as was reasonably possible.

If the Plan is terminated, all claims must be submitted within 60 days of termination.

Payment of Benefits

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

Unclaimed Payments

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

Workers Compensation Not Affected

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

Severability

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

Pronouns

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

Mistake of Fact

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

Indemnity

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

Employment Rights

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

Controlling Law

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

Plan Year

The Plan year is July 1 through June 30.

Subrogation/Right of Reimbursement

- A. If a Covered Person receives any benefits arising out of an injury or illness (herein, referred to collectively as “Injury”) for which the Covered Person has or may have any claim or right to recovery:
1. payments under this Plan shall be made on the condition that this Plan will be reimbursed out of the proceeds of such claim or right to recovery;
 2. payment of benefits under this Plan shall be conditioned upon, and no payments under this Plan of benefits shall be made until, acknowledgment in a form specified by the Plan of the agreement of the Covered Person, and his attorney, to the terms of this Section; and,
 3. payment of benefits may be revoked, and the Plan may seek refunds of payments, where acknowledgement of the Plan’s right under this Section is incomplete or impaired.
- B. The Covered Person agrees:
1. to give the Plan notice of intent to pursue a claim against a responsible party, or any decision not to pursue such a claim, as provided in paragraph E. below;
 2. to refrain from doing anything to prejudice the Plan’s rights to reimbursement or subrogation, or the pursuit of claims directly or indirectly to recover reimbursement of benefits paid;
 3. to cooperate fully and exclusively with the Plan and its appointed agents regarding subrogation rights, including executing and delivering all instruments and papers (including the execution of a subrogation form) and do whatever else is necessary to fully protect any and all subrogation or reimbursement of rights;
 4. that any such funds received will be held in constructive trust for the reimbursement of the Plan;
 5. to direct any attorneys or fiscal intermediaries to hold recovery of all funds related to the Injury in trust for the benefit of the Plan, and to direct that such parties deal exclusively with the cost recovery agent for the Plan;
 6. to assign to the Plan and its designees all rights against such agents and attorneys to enforce this direction; and
 7. that the Plan will be reimbursed in full before any amounts (including, but not limited to, attorney fees or costs), incurred are deducted from such funds.

- C. Recoveries subject to the Plan's reimbursement claims shall include funds or rights acquired by the Covered Person (1) from any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the Covered Person's own insurance coverage); (2) any person, entity, corporation, plan, association, liability coverage or other at fault party as a result of judgment, settlement, arbitration award, or any other arrangement; or (3) worker's compensation award, settlement or agreement.
- D. Without limiting the preceding paragraph C., this Plan will be subrogated to all claims, demands, actions and right of recovery against any person, corporation and/or other entity who has or may have caused, contributed to or aggravated the Injury which the Covered Person claims an entitlement to benefits under the Plan, and to any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the Covered Person's own insurance coverage).
- E. The Covered Person agrees to notify the Plan of any decision to pursue other sources of recovery for Injury and to notify the Plan of this decision in writing within a reasonable time. If the Covered Person decides not to pursue any other claims, or fails to notify the Plan of a decision within a reasonable time, the Covered Person authorizes and assigns all choses in action, and rights to the Plan to pursue, sue, compromise or settle any such claims in this name, to execute any and all documents necessary to pursue said claims, and agrees to cooperate with the Plan in the prosecution of any such claims. Regardless, any other provision, document or policy notwithstanding, the Plan alone, through the Plan Administrator and appointed agents, shall be the exclusive assignee of recovery rights (including subrogation rights) so that any other purported assignments are revoked and nullified. This provision imposes no obligation on the Plan to pursue the assigned rights, nor contribute any funds toward expenses of litigation or settlement.
- F. The amount of the Plan's subrogation interest will be deducted first from any recovery by or on behalf of the Covered Person without regard to whether the Covered Person is made whole. This paragraph is intended as an express and complete repudiation of the "make whole" doctrine and should be interpreted consistent with this intention. If any party or insurance coverage or other source makes payment before this Plan pays, no benefits will be paid under this Plan to the extent of such payment.

Medical Case Management

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

Free Choice of Physician

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

Qualified Medical Child Support Orders

Definitions

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

- “Alternate Recipient” means any child of an employee who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan with respect to such employee.
- “Medical Child Support Order” means any court judgment, decree or order (including approval of settlement agreement) which:
 1. provides for child support for a child of an employee under the Plan or
 2. provides for health coverage to such a child under state domestic relations law (including a community property law); and
 3. relates to benefits under this Plan.
- “Qualified Medical Child Support Order” (QMCSO) means a Medical Child Support Order which:
 1. creates or recognizes an Alternate Recipient’s right to receive benefits for which an employee or his/her dependent is eligible under the Plan; and

2. meets the following requirements:
 - a. clearly specifies the name and last known mailing address (if any) of the employee and the name and mailing address of each Alternate Recipient covered by the order;
 - b. clearly specifies a reasonable description of the type of coverage to be provided by the Plan to each Alternative Recipient, or the manner in which such type of coverage is to be determined;
 - c. clearly specifies the period to which such order applies;
 - d. clearly specifies each plan to which such order applies; and
 - e. does not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

Procedures

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

1. promptly notify, in writing, the employee, each Alternate Recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and these QMCSO procedures for determining whether such order is a QMCSO;
2. permit the Alternate Recipient to designate a representative to receive copies of notices sent to the Alternate Recipient regarding the Medical Child Support Order;
3. within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the employee, each Alternate Recipient covered by the order, and each representative for these parties of such determination.

Effect of Determination

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

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

2. any payment for benefits in reimbursement of expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian (or the provider, with the approval of the custodial parent or guardian). A payment of benefits to an official of a State or political subdivision thereof whose address has been substituted for the address of the Alternate Recipient, shall be treated as payment of benefits to the Alternate Recipient for purposes hereof;
3. if any QMCSO requires an employee who is enrolled in the Plan under Single coverage to provide health coverage for an Alternate Recipient, such child shall be added to the Plan and the appropriate contributions for Family coverage will be withheld from the employee's compensation;
4. if any Qualified Medical Child Support Order requires an employee who is not enrolled in the Plan to provide health coverage for an Alternate Recipient, the employee and child shall be enrolled in the Plan, and the appropriate contributions for Family coverage will be withheld from the employee's compensation;
5. except as provided under the section "National Medical Support Notice", coverage of the Alternate Recipient shall be effective as of the latest of:
 - a. the first day of the month specified in the Order;
 - b. the first day of the month following the determination by the Plan Administrator; or
 - c. the earlier of (1) the first day of the month following the receipt by the Plan of the first premium payment required for coverage, if any, or (2) the effective date of a court or administrative order requiring the District to withhold from the participant's compensation, the participant's share, if any, of premiums for health coverage and to pay such share of premiums to the Plan;
7. if the Plan and any fiduciary under the Plan acts in accordance with the provisions of these procedures in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, the Plan's obligation to the employee and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

Special Eligibility Rules for Qualified Medical Child Support Orders

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

Termination of Coverage

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

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

National Medical Support Notice

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

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

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

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

HIPAA Privacy Rule Compliance

In order to comply with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the "504" provisions") the provisions of this section will establish the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information.

The Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Harlem Consolidated School District #122 to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

Definitions

All terms defined in the HIPAA Privacy Rule shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this section.

Plan means the Harlem Consolidated School District #122 Employee Health and Dental Benefits Plan

Plan Documents mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the Harlem Consolidated School District #122 Employee Health and Dental Benefits Plan Document.

Plan Sponsor means the Harlem Consolidated School District #122.

The Plan's Disclosure of Protected Health Information to the Plan Sponsor- Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, *only if* the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and,

3. the Plan Sponsor agrees to comply with the Plan provisions as contained in this section.

Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor

The Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the Protected Health Information of the Plan's individuals by the Plan's business associate, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

The Plan (and any business associate acting on behalf of the Plan), may not, and may not permit a health insurance issuer or HMO to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

Disclosure of Individuals' Protected Health Information-Disclosure by the Plan Sponsor

The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.

The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan Sponsor will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:

1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or,
2. modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the “504” provisions.

Required Separation between the Plan and the Plan Sponsor

In accordance with the “504” provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals’ Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan:

1. Assistant Superintendent, Human Resources
2. Business Manager/Treasurer
3. Administrative Assistant to the Assistant Superintendent
4. Administrative Assistant, Benefits
5. Payroll Clerk
6. Secretary, Sub Finder/Flex Care

This list reflects the employees, classes of employees or other workforce members of the Plan Sponsor who receive individuals’ Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals’ Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals’ Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA Security Rule

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 165 (the “Security Regulations”) and effective April 20, 2005.

Definitions

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

Plan means the Harlem Consolidated School District #122 Employee Health and Dental Benefits Plan.

Plan Documents mean the Plan’s governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the Harlem Consolidated School District #122 Employee Health and Dental Benefits Plan Document.

Plan Sponsor means the Harlem Consolidated School District #122.

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

Plan Sponsor Obligations

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

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

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

Certificate of Adoption

I certify that the Harlem Consolidated Schools District #122 Employee Health and Dental Benefit Plan Benefit Booklet/Plan Document restated as of January 1, 2005, is adopted by the Board of Education.

Signature

Title

Date

Attested

Addendum Schedule of Benefits for Administrators

Schedule of Health Care Benefits

If you are an employee who is classified as an Administrator of the District, benefits for “Eligible Health Care Expenses” described beginning on page 10 will be provided based on the schedule outlined.

If you obtain services through a Preferred Provider, expenses incurred with the provider will be discounted based on the negotiated agreement with the Preferred Provider Organization (PPO) and you will be eligible to receive the maximum co-insurance payable under the Plan. Out-of-PPO Network expenses will be payable at the In-PPO Network co-insurance level only for:

- Emergency Medical Care; or,
- Services rendered while you or your dependent is receiving treatment at a PPO hospital, facility or physician’s office and for which you or your dependent had no choice of providers. Examples of these services include Emergency Room physician services, radiology, pathology, and anesthesiology charges.

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

Maximum Benefit Payable Under the Plan

The maximum benefits stated below represent the total benefit you or your dependent are eligible to receive. The maximums apply equally to In-PPO Network and Out-of-PPO Network expenses and include all benefits paid by the Plan on an individual's behalf while active or on coverage continuation, including prescription drugs payable through the Prescription Drug Program.

All Eligible Expenses	<p>Except as noted below, benefits are limited to a maximum of \$2,000,000 per person while covered by the Plan.</p> <p>If you or your dependent receive benefits under the Plan, up to the lesser of the following amounts will automatically be reinstated every January 1st:</p> <ul style="list-style-type: none"> • \$1,000; or, • if less than \$1,000 in benefits were paid, the amount of benefits received by the covered person during the previous calendar year. <p>You may also apply to have the entire \$2,000,000 maximum benefit reinstated by filing your written request with the District along with acceptable evidence of your (or your dependent's) evidence of insurability. This reinstatement of the entire maximum benefit is subject to the District's approval of your application.</p>
Alcohol/Substance Abuse and Mental or Nervous Disorders	<p>Eligible expenses incurred with a physician for the outpatient treatment of Alcohol or Substance Abuse and/or Mental or Nervous Disorders are limited to a maximum of 50 visits per person per calendar year.</p>

Deductible

**Calendar Year
Deductible
(Health and Dental
Expenses Combined)**

Except as specifically noted, the deductible is the first \$275 of eligible health and dental expenses incurred by you or your covered dependent during a calendar year. The maximum deductible that will be applied for a family (you and your dependents) during a calendar year is limited to \$825.

Expenses incurred and applied towards satisfaction of the calendar year deductible during the month of October, November and December will also be applied towards satisfaction of the calendar year deductible for the following calendar year.

**Emergency Room
Deductible**

If you or a covered dependent receives treatment through a Hospital Emergency Room, an additional deductible of \$50 per visit will be applied. This deductible will be waived if treatment is necessary due to an accident or an illness that occurred suddenly and unexpectedly.

Out-of-Pocket Limit

The Out-of-Pocket limit is the maximum amount you will be required to pay *per person* as a result of your deductible and co-insurance for eligible expenses incurred. After the Out-of-Pocket limit is met, the Plan will pay 100% of expenses incurred for the balance of the calendar year. The Out-of-Pocket Limit is applied once per calendar year (January through December). Expenses applied towards the Out-of-Pocket limit will be applied equally to the In-PPO Network and Out-of-PPO Network limit amounts. Once the In-PPO Network Out-of-Pocket limit is satisfied, no additional co-insurance will be taken for charges incurred with a PPO provider. However, the co-insurance will continue to be taken for charges incurred outside of the PPO network until the Out-of-PPO Network Out-of-Pocket limit is met.

	<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>
Amount	\$750 per person per calendar	\$1,500 per person per calendar year
Expenses Not Included in the Out-of-Pocket Limit	<p>The Out-of-Pocket limit does not include:</p> <ul style="list-style-type: none"> • the \$50 Emergency Room deductible; • co-pays for prescription drugs and medicines; • excluded charges; • charges incurred in excess of any maximum benefit listed in the Plan; • charges incurred for the treatment of Alcohol/Substance Abuse and Mental or Nervous Disorders; • the co-insurance for charges incurred for services or supplies covered under the Dental portion of this Plan. 	

* The In-PPO Network Out-of-Pocket Limit will apply to those charges incurred if you or your covered dependent reside or travel more than 20 miles outside of the PPO service area.

Co-insurance for Eligible Medical and Surgical Expenses

(Subject to the Deductible, Maximum Benefit and Out-of-Pocket Limit provisions)

Refer to the section “Eligible Health Care Expenses” beginning on page 10 for a detailed list of eligible expenses

Diagnostic X-ray and Laboratory Services	100% of eligible expenses incurred other than dental x-rays or charges by a hospital while you or your dependent are confined. The calendar year deductible does not apply.	
Emergency Accident Care	100% of the first \$300 of expenses incurred as the result of and within 90 days of an accident; the calendar year deductible does not apply. Expenses in excess of this \$300 per accident maximum will be paid under the “Emergency Medical Care” benefit below.	
Hospital Emergency Room Emergency Medical Care	90% of eligible expenses incurred at a Hospital Emergency Room for Emergency Medical Care. “Emergency Medical Care” means a treatment of a sudden and unexpected illness or an accidental injury. If the patient is admitted through the Hospital’s Emergency Room, charges incurred for that confinement will also be provided under this benefit. All follow-up care following discharge will be based on the In-PPO Network and Out-of-PPO Network schedule stated in this section.	
Non-Emergency Medical Care	<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>
	\$50 Emergency Room deductible (in addition to the Calendar Year deductible), then 90%	\$50 Emergency Room deductible (in addition to the Calendar Year deductible), then 70%

* If you or your covered dependent reside or travel more than 20 miles outside of the PPO service area, benefits will be payable at 80% up to the In-PPO Network Out-of-Pocket limit.

Co-insurance for Preventive Care

(Subject to the Deductible, Maximum Benefit and Out-of-Pocket Limit provisions)

Refer to the section “Eligible Health Care Expenses” beginning on page 10 for a detailed list of eligible expenses

Routine Mammograms	90%; the deductible does not apply	
	Eligible expenses are limited to one routine Mammogram performed between age 35 and age 39 and then one per calendar year upon attainment of age 40. Mammograms performed in conjunction with a suspected or diagnosed illness are not limited.	
Pap Smear and Office Visit	90%; the deductible does not apply	
	Eligible expenses are limited to one test and office visit per year.	
Prostate Test and Office Visit	90%; the deductible does not apply	
	Eligible expenses are limited to one test and office visit per year for persons age 40 and over.	
Colorectal Cancer Screening	90%; the deductible does not apply	70%; the deductible does not apply
	Eligible expenses are limited to once every 3 years for persons age 50 and over or for persons who are at least age 30 when there is a family history of colorectal cancer of an immediate family member.	
Well Child Care	<i>In-PPO Network</i> 90%; the deductible does not apply Eligible expenses include exams, immunizations and testing for children under age 3.	<i>Out-of-PPO Network*</i> Out-of-PPO Network expenses are not covered

* If you or your covered dependent reside or travel more than 20 miles outside of the PPO service area, benefits will be payable at 80% up to the In-PPO Network Out-of-Pocket limit.

Co-insurance for Eligible Medical and Surgical Expenses

(Subject to the Deductible, Maximum Benefit and Out-of-Pocket Limit provisions)

Refer to the section “Eligible Health Care Expenses” beginning on page 10 for a detailed list of eligible expenses

Ambulance	80% of eligible expenses incurred	
Chiropractic	80% of eligible expenses incurred	
Hospice Care	80% of eligible expenses incurred	
Private Duty Nursing	80% of eligible expenses incurred	
Skilled Nursing Facility	80% of eligible expenses incurred	
All Other Medical and Surgical Treatment	<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>
	90% of eligible expenses incurred	70% of eligible expenses incurred

* If you or your covered dependent reside or travel more than 20 miles outside of the PPO service area, benefits will be payable at 80% up to the In-PPO Network Out-of-Pocket limit.

Co-insurance for Treatment of Alcohol or Substance Abuse and/or Mental or Nervous Disorders

(Subject to the Maximum Benefit provision; the Deductible and Out-of-Pocket Limit does not apply)
Refer to the section “Eligible Health Care Expenses” beginning on page 10 for a detailed list of eligible expenses

	<i>In-PPO Network</i>	<i>Out-of-PPO Network*</i>
Inpatient/Partial Hospitalization Treatment Programs	90% of eligible expenses incurred. The calendar year deductible and Out-of-Pocket limit do not apply.	70% of eligible expenses incurred. The calendar year deductible and Out-of-Pocket limit do not apply.
Outpatient Physician Services	60% of eligible expenses incurred. The calendar year deductible and Out-of-Pocket limit do not apply.	50% of eligible expenses incurred. The calendar year deductible and Out-of-Pocket limit do not apply.
	Eligible expenses incurred with a physician for the outpatient treatment of Alcohol or Substance Abuse and/or Mental or Nervous Disorders are limited to a maximum of 50 visits per person per calendar year.	

* If you or your covered dependent reside or travel more than 20 miles outside of the PPO service area: benefits for Inpatient/Partial Hospitalization Treatment Program expenses will be payable at 80% and Outpatient Physician service expenses at 55%. All other provisions stated above will apply..

Schedule of Prescription Drug Benefits

If you are an employee who is classified as an Administrator of the District, the Plan will pay 100% of the cost of eligible prescription drug expenses remaining after your co-payment as stated below:

Retail Pharmacy Co-Payment (up to a 30-day supply)

Generic Drugs and Medicines	\$ 6 co-pay
Brand Name	12 co-pay

Mail Service Pharmacy Co-Payment (up to a 90-day supply)

Generic Drugs and Medicines	\$ 6.00 co-pay
Brand Name	12.00 co-pay

Schedule of Dental Care Benefits

If you are an employee who is classified as an Administrator of the District, benefits for Eligible Dental Care Expenses are provided based on the schedule presented below:

Deductible

The Deductible is combined with eligible health charges.
Please refer to the section “Schedule of Health Care Benefits” beginning on page 2.

Benefits for Eligible Expenses

(Subject to the Deductible)

Routine Care	85% of eligible expenses incurred
Major Dental Services	50% of eligible expenses incurred
Maximum Benefit Payable	\$1,000 per person per calendar year