GALESBURG

COMMUNITY UNIT SCHOOL DISTRICT #205

HEALTH CARE PLAN

Plan Description with Revisions through 8-1-15

GENERAL INFORMATION: The Plan Sponsor/Plan Administrator/Agent for Legal Process is Community Unit School District #205, 932 Harrison, Galesburg, IL 61402-1206. Phone (309) 973-2000. The end of the plan year is July 31. The Plan Sponsor reserves the right to amend or discontinue the Plan. You contribute to the Plan in amounts determined by the Plan Sponsor with the balance of costs paid by the Plan Sponsor. The Claim Administrator is Mutual Medical Plans, Inc., 416 Main Street, Peoria, IL 61602. Phone (309) 674-0888 or 1-800-448-4689.

ELIGIBILITY: You and your dependents become eligible on the first of the month following your date of Board approved "Qualified Employment" with the Plan Sponsor. You must apply within 30 days of the date you first become eligible, with coverage effective on the first of the month following completion of the enrollment card. If you decline coverage, it may be possible to enroll yourself and dependents in the future provided you apply within 30 days after your other coverage ends. A person eligible for the Plan may enroll within 60 days of the eligibility date, termination date, or premium assistance eligibility date of Medicaid or CHIP. If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you must request enrollment within 30 days of the marriage, birth, adoption or placement for adoption with coverage effective the date of the event. Dental and Vision benefits may be elected at your initial enrollment or during annual enrollments in August with premiums payable starting September and coverage effective on January 1 following enrollment. Dental must be carried at least 2 years before exchanging Dental for Vision, or vice versa. If you do not enroll under the above provisions, you may not enroll in the Plan. If you have another health plan that penalizes you or your spouse if you do not enroll in this Plan, then you will not be eligible for this Plan unless an exception is made by the Plan Sponsor. If your spouse is employed where medical coverage is offered or subsidized for any employees, the spouse will not be covered in this Plan unless enrolled in the other employer's program, unless an exception is made by the Plan Sponsor.

TERMINATION: Coverage will be terminated: 1) upon resignation or termination of employment, 2) when any required contributions are not made, 3) the date a dependent is no longer eligible, 4) the date you have exhausted FMLA leave and/or applicable benefit time defined as vacation, personal leave, or sick leave, 5) at the end of the month in which your qualified employment terminates, or 6) when the Plan Administrator determines it is in the best financial interest of the plan member. With Board approval, meeting the required criteria for 'job share', a Qualified tenured employee, who has had coverage in the Plan a minimum of two years, may elect to continue with the coverage(s) enrolled in at the time of 'job share' election, as long as qualified for 'job share.' Those who meet the requirements for pension under IMRF or TRS may continue coverage in the Plan with coverage(s) enrolled in at the time of 'retirement' election. Coverage may be continued under federal legislation commonly referred to COBRA. See Addendum A for COBRA, Privacy and other details. Dental and Vision coverage ends when the retiree reaches age 65.

DEFINITIONS: "You" and "employee" means an employee of Galesburg C.U.S.D. #205 or the Knox-Warren Special Education District.

"Qualified Employment" for certified staff means 1) a minimum of an .8 assignment contractual, or 2) contracted for a minimum of 144 of 180 days (extended days do not apply). "Qualified Employment" for support personnel means scheduled to work a minimum of 30 hours per week.

"Dependent" means your lawful spouse who resides with you in common residence, and your unmarried under age 19 natural child, adopted child, child placed with you for adoption, or stepchild, and for whom you or your spouse have legal guardianship or legal custody. A child referenced above who is at least age 19 but under age 26 (age 30 if a veteran residing in Illinois) may be covered without regard to residence, financial support, or marriage providing that you or your spouse have legal guardianship or legal custody of the child, or had such guardianship or custody when the child turned age 18. Future enrollment of a qualified dependent child is available each year in the final month of the Plan year for a dependent child who has had at least 90 days of coverage with another private or public health care plan without a 63 day gap in coverage prior to the date a signed application is received by the Plan Sponsor.

"Hospital" means an institution providing care for the sick under supervision of a staff of physicians and nurses on a 24 hour basis. It does not include health resorts or nursing homes, skilled nursing homes, step down units, or long term care facilities, but it does include a state licensed surgery center or a substance abuse treatment center that has an agreement with the Plan or claim administrator.

"Physician" means a duly licensed M.D., D.O., O.D., D.P.M., D.D.S., D.C., Certified Physician's Assistant, Midwife, Nurse Practitioner, and in the case of outpatient mental care, a clinical psychologist, regional mental health center, L.C.S.W., or L.C.P.C. A nurse practitioner will be covered for an office visit as a nurse visit code 99211, however billed, and for lab work only when approved by the Claim Administrator.

"Reasonable and customary" means the fee most commonly charged for a service by other health care providers, as determined by the claim administrator. "Maximum Allowable Charge" means an amount determined by the Claim Administrator to be appropriate for the services rendered.

MAJOR MEDICAL BENEFITS

The following applies to covered reasonable and customary charges after discounts. A $750 deductible per person ($2,250 family) applies to expenses incurred in a calendar year. The Plan pays 80% with the following exceptions: Galesburg Cottage Hospital is paid at 100%. Services received from other providers within Knox, Warren, Peoria, Fulton, Henry and McDonough counties are payable at the lesser of 50% or the negotiated preferred Cottage Hospital per diem or case rate if the services are available at Cottage Hospital or Methodist Medical Center. A $500 co-pay will be applied per inpatient and/or outpatient hospital admission other than at Cottage or Methodist. A $200 co-pay will be applied to each hospital emergency room visit (including Cottage and Methodist). This co-pay will be waived with inpatient admittance immediately following. The co-pay for covered physician office visits is $30 with the balance paid at reasonable and customary or the maximum allowable charge. If claims on an individual are expected by the Plan to exceed $50,000 in a consecutive 12 month period, the Plan reserves the right to determine the health care provider. If a provider is not approved, hospital benefits will be paid at the Galesburg Cottage Hospital contract rates. The out-of-pocket expense limit is $1,500 per person ($4,500 per family) for expenses incurred in a calendar year. The following will not apply to the out-of-pocket expense limitation: deductibles, co-pays, charges over reasonable and customary or the maximum allowable charge, amounts payable at the lesser of 50% or negotiated per diem, Dental expenses, Vision expenses, and non-covered expenses.

1. Hospital room and board charges up to the hospital's semi-private rate; charges for intensive care, coronary care or similar special care units; and outpatient or inpatient hospital miscellaneous services and supplies when necessary to treat a condition of illness or injury. Inpatient pre-admission and length of stay certification are available from the claim administrator.
2. Physician professional fees and chiropractic care to a maximum of 10 visits per year.
3. Orthotics, and leg, arm, neck and back braces, or services of a registered physical therapist or occupational therapist when prescribed by a physician. (Note that physical therapy is payable at 50% within Knox, Warren, Peoria, Fulton, Henry and McDonough counties when available at Cottage Hospital).
4. Professional ground or air ambulance service when medically necessary to transport a patient to the nearest hospital where required treatment can be provided.
5. Durable medical equipment rental, or purchase at the claim administrator's option, when such rental type equipment is customarily used only for medical purposes.
6. Private duty nursing and hospice or home health care services when the service provider is not a relative and does not normally reside in the same home as the patient, but only prescribed by a physician and approved by the Claim Administrator.
7. Artificial limbs and other prosthetic appliances for illnesses or accidents. Oxygen, blood and administration charges. TPN and FDA approved injectable medications that are not excluded by the Plan, when medically necessary and obtained from a vendor designated by the Plan.
8. Services of a licensed speech therapist to restore speech loss due to injury, stroke or surgery.
9. Diabetes self-management training. Routine mammograms (1 per year age 35 and older), routine fecal occult blood testing and sigmoidoscopy once every 3 years age 50 and older (29 and older with a personal history of --or-- has a first degree family member with a history of colorectal cancer). Age 18 and older: routine pap tests, PSA tests, digital exams, and prostate specific antigen tests. Office visits related to routine tests in this paragraph are not covered except for one (1) well care visit per calendar year for the purpose of pap (for women who have not had a hysterectomy) or prostate check (for men age 50 and over, unless personal or family history of prostate cancer).

PRESCRIPTION DRUG PLAN (Not available with MRP or High Deductible Health Plan)

Insulin, insulin syringes, and most prescription only drugs when purchased from a retail pharmacy may be obtained at co-pays of $10 generic, $40 brand for formulary drugs, and $70 for non-formulary drugs up to a 30-day supply **with 2 refills allowed at retail pharmacies**. Mail order co-pays are $20 generic, $100 formulary, and $175 non-formulary for up to a 90-day supply. For retail and mail order specialty drugs, you pay 20% up to a maximum of $200 per prescription. Non-formulary drugs are only covered if the formulary drug has been unsuccessful as determined by your physician and Medco. Drugs not covered are birth control pills and devices, fertility drugs, drugs for sexual enhancement, smoking deterrents, hair growth, or cosmetic purposes, injectables other than insulin unless preauthorized by the Plan, dietary drugs, drugs not approved by the FDA, or use of narcotic drugs beyond 30 days in a calendar year, unless authorized by the Claim Administrator in 30 day increments for medical necessity, but not to exceed 180 days overall in a calendar year. Drug plan co-pays are not an eligible expense under the Major Medical Benefits. Dependents who have other prescription drug coverage may not be covered under this drug plan.

HIGH DEDUCTIBLE HEALTH PLAN BENEFITS (HDHP)

The HDHP has the same scope of benefits and exclusions as the Major Medical. However, the deductible per person for expenses incurred in a calendar year is $3,000 per person and $9,000 per family. Out-of-network limits are the same as the Major Medical with no out-of-pocket limit. In-network benefits are 100% after the deductible. Routine exams, tests and procedures are covered in full up to $1,000 per person per calendar year with the balance payable after the deductible. A drug discount program is available and drugs covered under the regular drug plan may be filed to Mutual Medical for reimbursement. The Major Medical co-pays for emergency room and non-PPO hospitals apply.

DENTAL BENEFITS (Available only in addition to Medical Benefits)

The Plan pays reasonable and customary fees of a licensed dentist up to a maximum benefit of $750 per individual for expenses incurred in a calendar year as noted below. The date you take possession of a dental appliance will be the date the expense is incurred.

100% -- No Deductible: Routine oral exams, prophylaxis after a $10 co-pay, bitewing x-rays, and fluoride (to age 19) twice per calendar year. Full mouth x-rays once in 36 consecutive month period. Intra-oral x-rays, space maintainers, and palliative emergency treatment to relieve pain.

80% -- $100 per person calendar year deductible applies. Fillings, extractions and oral surgery and related general anesthesia, endodontics including pulpotomy, pulp capping and root canal therapy, periodontics and apicoectomy, denture repair and relining and recementing inlays/onlays/crowns.

50% -- $100 per person calendar year deductible applies. Gold foil restorations, inlays and onlays, crowns and crown buildups, full and partial dentures, fixed and removable bridges, and mouth guard for Bruxism.

VISION BENEFITS (Available only in addition to Medical Benefits)

The Plan pays up to $125 per person for exams, frames and lenses or contact lenses incurred in a calendar year. The date you take possession of frames, lenses, or contact lenses will be the date the expense is incurred.

ALTERNATE PLANS

The MRP, or if you elect, the Maxi plan, can provide more total benefits by supplementing, rather than duplicating, another health care plan. An individual may not be covered under both the Major Medical Benefits and one of the alternate plans, or by more than one of the alternate plans. Except for the Maxi Plan, you may not be covered under a different benefit plan than your dependents unless an exception is approved by the Plan, and an individual may not be covered under a similar alternate plan or plans at more than one place of employment.

MEDICAL REIMBURSEMENT PLAN (MRP)

Employees covered by Tri-Care or another employer sponsored health plan may elect only this plan, unless an exception is approved by the Plan Sponsor. This plan can significantly increase your overall benefits. Deductibles, co-pays and co-insurance (but not co-insurance for using your other plan's non-PPO hospitals unless approved by this Plan) under a medical or prescription plan not sponsored by District 205 are covered in full. If not a covered benefit of your other plan under any circumstances, reasonable charges will be paid in full for office visits, routine exams, and up to 10 chiropractic visits incurred in a calendar year. Benefits are paid directly to you when you send a copy of your other plan's explanation of benefits, or a copy of your prescription receipt showing your co-pay, to Mutual Medical. Write the health care provider's name and phone number on the explanation of benefits.

MAXI PLAN and MAXI II PLAN

If you have other coverage that is secondary to this Plan you may elect the Maxi Plan. The Maxi Plan covers the same scope of eligible expenses as Major Medical Benefits without a deductible or co-insurance. All covered services are payable at 100% except that inpatient hospital billed charges are paid up to a maximum of $1,500 per admission. The Maxi Plan also pays in full for routine medical exams and the co-pays under any drug plan. A person may change from the Major Medical Plan to the Maxi Plan, or vice-versa, at any time. Except for inpatient hospital billed charges, the same PPO provisions apply that are in the Major Medical Benefits. The Maxi II option is the same as the Maxi Plan, except Maxi II does not cover hospital billed charges, oncology services, or prescription drugs, except for preventative care, emergency care, or clinical trial expenses other than for the trial drug.

AFFORDABLE CARE PLAN (ACP)

*** No additional employee premium contribution * No deductible, no co-pays, no co-insurance**
*** No overall annual or lifetime dollar limits * No pre-existing condition limits**

The ACP is designed for individuals whose benefits are expected by the Claim Administrator to exceed $50,000 or more in a year. Each year, if you qualify, you may remain in the ACP, or elect to come back to your group major medical plan at any time. Here is how it works. Starting with 1-1-2014 and each month thereafter, you may select the carrier of your choice on a Exchange marketplace without having to answer health questions or being subject to pre-existing limits. The ACP will pay your premiums, minus any federal government subsidy for which you may be eligible under PPACA. The ACP will also reimburse you for all deductibles, co-pays and co-insurance for both medical and prescriptions under your chosen fully insured health plan with the Exchange carrier of your choice, plus these same items under your major medical for the year that you select or end the ACP. Clinical trial services but not the drug, preventative and ER services are also covered in full. Arrangements can be made to qualify the first of any month with one week notice. While not everyone can qualify, everyone in the group benefits because of reduced claims that affect employee contributions. To determine if you qualify, contact Mutual Medical at 1-800-448-4689, or consult with the individual in your HR department that handles health insurance. If you do not qualify for all of the features of the Affordable Care Plan, you may qualify for a modified version of the plan as determined by you and the Plan Sponsor.

LIMITATIONS AND EXCLUSIONS

The Plan will not pay for:

1. Hospital or related physician charges during inpatient admissions primarily for care which can be provided safely on an outpatient basis as determined by the claim administrator. Charges exceeding reasonable and customary or the maximum allowable charge as determined by the claim administrator. Job related injuries or illnesses covered by or pending under Worker's Compensation or similar legislation, or for which a final decision has not been made by the Industrial Commission on a claim filed under Worker's Compensation. Expenses payable by Medicare, or which would have been payable if the person had properly enrolled in Medicare, except where contrary to law (not applicable to individuals who were retired and over age 65 and covered by Plan as of 8-1-02). Custodial care primarily for assistance with activities of daily living. Care that is provided or can be provided at home, by a nursing home, skilled nursing facility, step-down unit, or long-term care facility. Education or training not specifically mentioned as a benefit of the Plan. Expenses for which you, the employee, are not liable for payment including expenses on adult dependents where you have not assumed legal liability for medical bills.
2. Routine physical exams not specifically listed on page 3 or 4 of the Plan. Immunizations and vaccinations. Routine foot care such as trimming nails or callouses. Orthopedic shoes. IQ testing. Hearing aids or eyeglasses and tests for the fitting thereof unless specifically covered under Vision benefits. Expenses denied by an HMO or other health care plan for (a) lack of pre-treatment approval, (b) use of non-network providers, or (c) failure to follow claim procedures.
3. Hospital admissions commencing or other services, appliances, vision or dental products received before an individual's effective date of coverage or after termination of coverage. Personal comfort or convenience items such as television rental, barber services, special or guest meals, telephone calls, travel expenses, stair lifts, van lifts, or medical complications related to a non-covered service. Services or supplies not specifically listed as a benefit of the Plan. Expenses not related to the diagnosis or treatment of an illness or injury unless specifically included as a benefit.
4. Cosmetic surgery unless necessary to correct congenital deformity of a dependent child or repair traumatic injuries incurred while covered under the Plan. Expenses related to dependent daughter pregnancy, sex changes, penile implants, reverse sterilization, infertility, sexual dysfunction, radial keratotomy or a similar procedure, weight reduction, or exercise or fitness programs except for phase 1 or 2 cardiac rehabilitation following cardiac surgery or a heart attack. Mastectomy in the absence of a malignancy. Breast reduction or enlargement except for post mastectomy reconstruction of a covered mastectomy. Wigs and hair transplants. Growth hormones. Benefits exceeding $500 maximum per person per year for removal of benign moles and nevi.
5. Rhinoplasty or any nose surgery except for tumors or cysts or to repair nasal injury incurred while covered under the Plan. Hospital charges for a vasectomy or other surgery that can be performed in a physician's office. Home uterine monitoring devices. Insulin pumps.
6. Services of a dentist except as set forth under Dental Benefits or surgery to correct facial injuries incurred while covered under the Plan. Treatment for TMJ or to alter vertical dimension. Lost or misplaced dentures, or the placement of crowns, bridges or dentures more than once in a 5 year period for the same teeth.
7. Injury or illness due to war or act of war or while serving on active military duty. Services not authorized by a physician as necessary treatment, or services (including organ transplants) which are considered experimental, investigational or not medically necessary by Medicare criteria. Expenses related to kidney dialysis beyond 150% of the Medicare National Fee of the Physician's Fee Reference.
8. Self-inflicted injury or illness. Injury or illness sustained by a person participating in a riot, commission of a felony, or while under the influence of illegal drugs or alcohol beyond the Illinois legal BAC limit. Use of narcotic drugs beyond 30 days in a calendar year, unless authorized by the Claim Administrator in 30 day increments for medical necessity, but not to exceed 180 days overall in a calendar year. Inpatient substance abuse treatment not provided by White Oaks or Chestnut Health Systems. Mental benefits exceeding 30 inpatient days per person incurred in a calendar year or 40 inpatient days lifetime maximum benefit per person under District 205 health care plans.
9. Marriage counseling or sexual therapy. Services or supplies received when a person travels to another country primarily for the purpose of obtaining such services or supplies.
10. Expenses covered by or pending under auto, property and casualty, or liability insurance or for which another party is liable.

CLAIM PROCEDURES

ALWAYS PRESENT YOUR COMPANY HEALTH CARE PLAN ID CARD WHEN RECEIVING COVERED HOSPITAL AND MEDICAL SERVICES BECAUSE THE CARD CONTAINS BILLING DIRECTION FOR YOUR HOSPITAL AND DOCTOR.

Hospitals and physicians may file claims directly to Mutual Medical using either their standard forms, forms provided them by Mutual Medical, your Medical Claim form, or itemized bills with a diagnosis and your ID number. You may also file claims directly to Mutual Medical with a completed Medical Claim form. Bills must be itemized and itemized bills cannot be returned. Claims must be filed within 180 days after the end of the calendar year in which the expense is incurred.

Benefits are normally payable to the provider unless the claim indicates that the bill has already been paid, in which case benefits are payable to you. However the Plan reserves the right to not recognize assignment, and the right to pay benefits directly to you, or in the event of your death to a relative, as determined by the Claim Administrator.

The Plan reserves subrogation rights and the right to recover any overpayment of benefits from you or any person or organization. If payments which should have been made by the Plan are made by another health care plan or program, the Plan shall have the right to pay over to any such organization making such payments any amount it shall determine to be warranted to satisfy this provision, and the Plan shall be fully discharged from liability.

CLAIM APPEALS
(For Major Medical, Maxi Plan and MRP, Maxi II and ACP Benefit Packages)

You may contact the Claim Administrator for additional clarification on how a claim was paid or denied. If you do not agree with the Claim Administrator's reason for denying a claim or issuing a rescission of coverage, you may file a written appeal to the Plan Administrator within 180 days after the claim is denied or rescission issued. The appeal should indicate: Employee Name and Social Security Number, Patient Name, Name of Plan Sponsor, Claim Number of Denied Claim, Date(s) of Service, Provider(s) of Service, Specific reason(s) you feel the claim should be paid including reference to Plan provisions, Relevant documents or other information. When reviewing your appeal, the Plan Administrator will take into account all information you submit without regard to whether the information was considered when the claim was denied. If the denial was due to medical judgment, the Plan Administrator will consult with an appropriate medical professional who was not, directly or indirectly, involved with the claim denial. You may obtain information relevant to a denied claim, including the name of any medical expert who gave advice relative to the denial, free of charge. The Plan will provide you, free of charge, with any new or additional evidence considered or generated in connection with the claim or new or additional rationale, for the Plan's decision as soon as possible in advance of the appeal decision date for your response, prior to that date. A written response to the appeal will be made within 60 days after the Plan Administrator receives the above necessary information. The response will be sent to the employee's address currently on file, or to a different address at your request. Any claim denial or appeal denial will sufficiently identify the claim involved, the diagnosis code, the treatment code, the denial code, and their corresponding meanings; the Plan's applicable standards; and, if an appeal, a discussion of the Plan's decision. The Plan Administrator's decision on an appeal shall be final and not subject to litigation except as set forth below.

For Maxi II and ACP Benefit Packages

If the appeal is denied under the Maxi II or ACP Benefit Packages for lack of medical necessity or for rescission of coverage, you may also file a request for an external appeal of the decision within 123 days of receipt of notice of the decision (or the first business day following that date if a weekend or legal holiday). Within 5 days of the receipt of this request the Plan will determine if you (1) were covered under the Plan at the relevant time, (2) met the requirements for eligibility under the Plan, (3) exhausted the Plan's internal appeal procedures, and (4) have provided the Plan all information and forms to process the external review. Within 1 day of determining the above, the Plan will notify you whether you are eligible for external review or the information needed to be eligible for external review and the reasons for the plan determination. If eligible, the Plan will randomly assign your appeal to an independent review organization (IRO) in accordance with the requirements of, and in compliance with, DOL Technical Release 2010-01. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. The IRO will timely notify you in writing of your eligibility and acceptance for external review. You may submit additional information to the IRO as allowed by the IRO in the notice. The Plan will provide the IRO all related documents within 5 days of assignment of the IRO. If the Plan fails to do so the IRO may terminate the external review and reverse the claim denial and notify you within one business day after making that decision. The IRO must provide the Plan with any information you submit within one business day. The external review may be terminated if the Plan reverses its denial based on this information. The Plan will notify you within one business day after reversing the denial upon reconsideration. The IRO will decide the external appeal after reviewing all information and will review the claim de novo and not bound by any decisions or conclusions reached during the Plan's internal claims and appeal processes. In addition, the IRO will consider, as appropriate: (1) your medical records, (2) the attending provider's recommendation, (3) reports by health care professionals and other documents submitted by you, the Plan, or your provider, (4) the terms of the Plan, (5)

appropriate practice guidelines, (6) any applicable clinical review criteria developed and used by the Plan, and (7) the opinion of the IRO clinical reviewers, all in accordance with the requirements of DOL Technical Release 2010-01. The IRO will provide written notice of its decision within 45 days of its receipt of your appeal. The IRO's notice of decision will comply with the requirements of DOL Technical Release 2010-01 and will contain: (1) a general description of the reason for the request for external review, including information sufficient to identify the claim; (2) the date the IRO received the assignment to conduct the external review and the date of the IRO decision; (3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision; (4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; (5) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you; (6) a statement that judicial review may be available to you; and (7) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by you, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws. Upon receipt of a notice of a final external review decision reversing the denial, the Plan immediately must provide coverage or payment for the claim. If your external appeal is denied, you have a right to file a civil action under Section 502 of ERISA provided you file it within 90 days after the appeal is denied.

COORDINATION OF BENEFITS

If you or a dependent have any other health care plan coverage, benefits will be coordinated so that not more than 100% of covered charges are paid or reimbursed. Your spouse's coverage will be primary on him or her. If you have other coverage as the subscriber or as a survivor, it will be primary. The Plan will be secondary to any plan, including individual medical policies not purchased through the Plan Sponsor, which do not have a coordination of benefits provision. In the case of a dependent child, the parent whose birthday falls earliest in the year will be considered primary. In the case of children with divorced parents, in the absence of court determined responsibility, the parent with custody will be primary. Coverage a dependent child has through other than a parent or step-parent will be primary over this Plan. Any coordination of benefits issue arising which is not addressed herein or within the Plan's other provisions will be settled using the NAIC guidelines.

STATEMENT OF RIGHTS UNDER THE NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or going to have a covered mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis, and;
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same exclusions, deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Review your benefit option selected for deductible and co-insurance information. If you would like more information on WHCRA benefits, call your plan administrator at 309-973-2112.

NOTIFICATION OF COBRA RIGHTS AND REQUIREMENTS

Coverage may continue in certain instances where coverage under the Plan would normally end. The information below advises you of your rights and obligations under this continuation coverage, made possible under federal legislation commonly referred to as COBRA. A person who is eligible for continuation is called a "qualified beneficiary." Each qualified beneficiary, or the parent or legal guardian of a minor qualified beneficiary, has a right to make a separate election for a qualified beneficiary or for such minor. The events making a person eligible are called "qualifying events." Questions may be directed to the plan administrator. This notice describes your rights under this continuation coverage under the Plan and you may contact the Plan Administrator with questions or for more information.

Eligibility for Continuation The following qualifying events make a Plan participant eligible as a qualified beneficiary. If an employee's medical coverage terminates because of termination of employment (other than for gross misconduct) or reduction of hours, the employee is a qualified beneficiary and may elect to continue the medical coverage. If you are a spouse/dependent of an employee, and were covered under the Plan at the time of the qualifying event, or born of the employee or adopted by the employee during the period of COBRA continuation and qualify as a "dependent" under the Plan, you have the right to continuation coverage if medical coverage terminated for any of the following events: (1) Death of an employee (2) Termination of the employee's employment (other than for gross misconduct) or reduction in hours worked (3) Divorce or legal separation (4) Employee becomes covered under Medicare (5) Dependent child no longer meets the definition of an eligible dependent under the Plan (6) Substantial reduction in retiree coverage due to employer bankruptcy reorganization.

Notice of Qualifying Event/Election Period The Plan Sponsor will provide notice of the availability of continuation coverage when the following qualifying events occur: (1) Employee's death (2) Loss of coverage due to employee's termination of employment (other than for gross misconduct) or reduction of work hours (3) Loss of coverage due to Medicare entitlement (4) Substantial reduction in retiree coverage due to employer bankruptcy reorganization. Plan participants must notify the Plan Sponsor in writing within 60 days of a divorce, separation, child losing dependent status in order to arrange for continuation coverage. The Plan Administrator will then provide the plan participants an election notice. An election for continuation coverage must be made within the 60-day election period beginning on the later of the date the coverage would end because of one of the qualifying events described above or the date the participant(s) is sent COBRA notice. In order for the Plan Administrator to notify you of your COBRA rights, it is important for you to keep the Plan Administrator advised of your current address.

Period of Continuation will terminate on the earliest of the following dates: (1) The end of: (a) 18 months, in the case where the coverage ended because of termination of employment (other than for gross misconduct) or reduction of hours (b) 36 months total, for dependents of the plan participant who have other including second qualifying events (c) 29 months, for employees and dependents if either the employee or a qualified dependent beneficiary is classified as disabled under the terms Title II or XVI of the Social Security Act within 60 days of the time of termination of employment or reduction of hours provided you notify the Plan Sponsor in writing within 60 days after you receive notice of disability from the Social Security Administration, and providing that you provide such notice to the Plan Sponsor before the end of the initial 18 months of COBRA continuation (2) The date after the COBRA election on which the person first becomes: (a) covered under any other group health plan, as an employee or otherwise (NOTE: Qualified beneficiaries, i.e., employee, spouse and/or dependents, who become covered by another group insurance program, are allowed to continue COBRA coverage only if the other group insurance plan has a pre-existing condition limitation or exclusion clause that applies to that individual's coverage. COBRA coverage will continue only to the time period specified above, or if earlier, when the pre-existing conditions restriction no longer applies) (b) entitled to benefits under Medicare (3) The date the premium is not paid (4) The date the Plan Sponsor no longer provides group health coverage to any of its employees (5) In the case where continuation of coverage is extended to 29 months, this extended coverage will be terminated the first day of the month following 30 days after the final determination that the individual is no longer disabled. You are required to notify the Plan Sponsor within 30 days of any event described above which would cause COBRA coverage to end.

Election and Premium Payment If continuation coverage is chosen, this coverage will be identical to the coverage provided under the Plan prior to the qualifying event. Qualified beneficiaries choosing to continue coverage under COBRA must pay the entire premium amount (plus a 2% administration charge, or plus 50% during an 11 month disability extension) to the Plan Sponsor on a monthly basis. (Monthly premium rates are subject to change annually.) Payroll deduction is not available to COBRA participants. Checks should be made payable to the Plan Sponsor. The qualified beneficiary's first payment deadline is 45 days after the date of their continuation election. The subsequent payment due date is the first day of the month for which coverage is purchased with a deadline of 30 days after the due date. Failure to pay premiums by these deadlines will result in termination of coverage. Information on current premiums is available by contacting the Plan Sponsor. Failure to elect COBRA coverage may cause you to avoid having pre-existing conditions apply to you in other group plans if you have more than a 63-day gap in health coverage, and will cause you to lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition if you do not exhaust COBRA coverage. You have a right to request special enrollment under certain plans that you are eligible for if you (a) apply within 30 days of coverage termination related to the initial qualifying event or (b) apply within 30 days of exhaustion of COBRA continuation coverage, If you reject COBRA coverage before the deadline for election, you may still elect COBRA before the election deadline by completing a new election form and your coverage will be effective on the date the form is received by the Plan Administrator or its designee.

PRIVACY INFORMATION

The Claims Administrator may release to, or obtain from any party, without consent of or notice to any person, any information the Plan Administrator or Claims Administrator deems necessary to carry out the provisions of the Plan. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Claims Administrator may only use or disclose such information when related to treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Claims Administrator such information as may be necessary to carry out this provision.

Only individuals, and their clerical support staff, who are involved with Plan administration, supervision or management, shall be given protected health information, and only to the extent necessary to perform duties assigned by the Plan Administrator. In addition, the Plan Sponsor hereby certifies and agrees that it will: (a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law; (b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan; (c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor; (e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) Make available protected health information in accordance with 45 C.F.R. 164.524; (g) Make available health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526; (h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528; (i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.; (j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

GRANDFATHERED HEALTH PLAN

This group health plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Act), however the Maxi II and ACP may or may not be grandfathered. As permitted by the Act, a grandfathered health plan can preserve coverage that was in effect when the law was enacted. Being a grandfathered plan means that your plan may not include certain consumer protections of the Act that applies to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered plan and what might cause a plan to change from a grandfathered plan status can be directed to the Plan Administrator (Plan Sponsor, see page 2 of your Plan). Or you can contact the U.S. Department of Health and Human Services at www.healthreform.gov.

LEGISLATION AND OTHER PROVISIONS

If provisions of the Plan conflict with applicable State or Federal laws, present or future, such legislation shall prevail. You should rely upon this document to estimate or determine benefits available. Information you receive from any source will not be valid if it conflicts with the language of this Plan. If the Plan determines that provisions herein are incompatible with another health care plan, the Plan may take any action it deems appropriate to best serve the interest of the Plan and the individual Plan member. Any retroactive termination of coverage must be approved by the Plan. If claims on an individual are expected by the Plan to exceed $50,000 in a consecutive 12 month period, the Plan reserves the right to determine the health care provider. If a provider is not approved, hospital benefits will be paid at the Galesburg Cottage Hospital contract rates. If necessary to avoid financial hardship to the employee, the Claim Administrator may elect to negotiate additional payments for kidney dialysis related expenses or a kidney transplant. Where it is to the financial benefit of the Plan and an individual, the Plan may, with approval of the Plan Administrator, assist the individual financially as determined by the Plan Administrator [i.e. Premium in alternate plan].

GALESBURG COMMUNITY UNIT SCHOOL DISTRICT #205 HEALTH CARE PLAN ("PLAN")
CREDITABLE COVERAGE IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D PRESCRIPTION COVERAGE

1. **MEDICARE PRESCRIPTION DRUG COVERAGE IS AVAILABLE TO EVERYONE WITH MEDICARE.**

2. **IT HAS BEEN DETERMINED THAT PRESCRIPTION DRUG COVERAGE UNDER OUR PLAN, ON AVERAGE FOR ALL PLAN PARTICIPANTS, IS EXPECTED TO PAY OUT AT LEAST AS MUCH AS THE STANDARD MEDICARE PRESCRIPTION DRUG COVERAGE WILL PAY AND IS CONSIDERED CREDITABLE COVERAGE.**

3. **READ THIS NOTICE CAREFULLY AND KEEP IT WHERE YOU CAN FIND IT BECAUSE IT EXPLAINS THE OPTIONS YOU HAVE UNDER MEDICARE AND CAN HELP YOU DECIDE IF YOU WANT TO ENROLL.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage. Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Individuals leaving Plan coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

If you drop your coverage with our Plan and enroll in a Medicare prescription plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the cost and coverage of Medicare prescription plans available in your area.

If you choose to enroll in Medicare Part D, you will still be eligible to receive current health care benefits. If you drop or lose coverage with your current Plan and do not enroll in Medicare Part D after your coverage ends, you may be required to pay more to enroll in Medicare Part D at a later date. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare Part D, you will pay a premium surcharge of 1% per month for the months you did not have such coverage (example, 19% for 19 months), and you will have to pay the higher premium for as long as you have Part D. You may have to wait until the following November to enroll.

Medicare enrollees will receive by mail from Medicare the "Medicare & You" handbook each year. Medicare prescription plan vendors may also be contacting you. Other information sources include your State Health Insurance Assistance program, www.medicare.gov, phone Medicare at 1-800-MEDICARE (1-800-633-4227) or 1-877-486-2048 for TTY users. For people with limited income and resources, extra help is available to pay for Medicare Part D through the Social Security Administration which can be visited online at www.socialsecurity.gov, phoned at 1-800-772-1213 (TTY 1-800-325-0778).

Keep this notice. If you enroll in one of the new Medicare prescription plans, you may need to provide a copy of this notice to the Medicare plan in order to avoid paying the higher premium penalty for late enrollment.