St. Charles
Community Unit School District #303

Summary Plan Description (SPD)
Employee Healthcare Plan

January 1, 2018

This booklet is your Summary Plan Description (SPD). Its purpose is to summarize the provisions of the Health Care Plan, which provide and/or affect payment or reimbursement for charges related to your medical care. This document supersedes any and all SPDs and/or Plan Documents previously issued to you by St. Charles Community Unit School District 303.

The Health Care Plan is funded by St. Charles Community Unit School District 303 and your employee contributions. The benefits and principal provisions of the group plan are described in this document. They are in effect only if you are eligible for the coverage, become covered, and remain covered in accordance with the provisions of the group plan.

The purpose of providing a comprehensive medical plan is to protect you and your family from serious financial difficulties resulting from necessary medical care. However, we all must recognize and deal with the rising cost of health care. Being informed about the specific provisions of your Plan will help both you and St. Charles Community Unit School District 303 maintain reasonable rates in the future.

We have prepared these pages as a guide for you to become familiar with your Plan and thereby an informed consumer of health care. It will take a cooperative effort among hospitals, physicians, you and us—St. Charles Community Unit School District 303—to make our Plan work, now and in the future.

All health benefits described herein are being provided and maintained for you and your covered dependents by St. Charles Community Unit School District 303, hereinafter referred to as the "District."

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Plan Description

Purpose

This document details the benefits, rights, and privileges of Covered Individuals (as later defined), in a fund established by ST. CHARLES COMMUNITY UNIT SCHOOL DISTRICT 303 (the "District") and referred to as the "Plan." This document explains the times when the Plan will pay or reimburse all or a portion of Eligible Expenses.

Effective Date of Plan	January 1, 2018
Name of Plan	St. Charles Community Unit School District 303 Health Care Plan
Name and Address of Plan Sponsor	St. Charles Community Unit School District 303 201 South 7th Street St. Charles, IL 60174
Name and Address of Medical Claims Administrator	BCBS of IL 300 E. Randolph Street Chicago, IL 60601 800-828-3116
Name and Address of Medical Review Organization	BCBS of IL 300 E. Randolph Street Chicago, IL 60601 800-828-3116
Employer I.D. Number	36-6007357
Plan Number	510
Type of Plan	Welfare Plan providing medical, prescription drug, dental, vision, and life insurance.
Agent For Legal Service	St. Charles Community Unit School District 303
Funding of the Plan	St. Charles Community Unit School District 303 and Employee Contributions.
Medium For Providing Benefits	Fully-insured and self-funded contract administration, provided in accordance with this document and group insurance certificates in accordance with this document and by the Claims Administrator.
Fiscal Year of the Plan	Begins January 1 and ends December 31

Plan Sponsor and Plan Administrator

The Plan Sponsor and Plan Administrator is St. Charles Community Unit School District 303, which has the authority to control and manage the operation and administration of the Plan. The Plan Administrator or its delegate has the sole authority and discretion to interpret and construe the terms of the Plan and to determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, payment of benefits or claims under the Plan and any and all other matters arising under the Plan. The decision of the Plan Administrator will be final and binding on all interested parties.

Contributions to the Plan

The amount of contributions to the Plan is to be made on the following basis: The District will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the District and the amount to be contributed (if any) by each covered Employee. Notwithstanding any other provision of the Plan, the District's obligation to pay claims otherwise allowable under the terms of the Plan will be limited to its obligation to make contributions to the Plan as set forth in the preceding sentence. Payment of said claims in accordance with these procedures will discharge completely the District's obligation with respect to such payments. In the event that the District terminates the Plan, then as of the effective date of termination, the District and Covered Individuals will have no further obligation to make additional contributions to the Plan.

Plan Modification and Amendments

Subject to any negotiated agreements, the District may modify, amend, or discontinue the Plan without the consent of Covered Individuals. Any changes made shall be binding on each Employee and on any other Covered Individuals. This right to make amendments shall extend to amending the coverage (if any) granted to retirees covered under the Plan, including the right to terminate such coverage (if any) entirely.

Termination of Plan

The District reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the District will continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Covered Individuals, until all contributions are exhausted.

Plan Is Not a Contract

The document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Employee of the District the right to be retained in the service of the District or to interfere with the right of the District to discharge or otherwise terminate the employment of any Employee.

Claim Procedure

The District will provide adequate notice in writing to any Covered Individuals whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Covered Individuals. Further, the District will afford a reasonable opportunity to any Covered Individuals, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the District for that purpose.

Protection Against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the District finds that such an attempt has been made with respect to any payment due or to become due to any Covered Individual, the District in its sole discretion may terminate the interest of such Covered Individual or former Covered Individual in such payment, and in such case will apply the amount of such payment to or for the benefit of such Covered Individual or former Covered Individual, his or her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Covered Individual or former Covered Individual, as the District may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment. This Provision does not prohibit a Covered Individual from assigning his or her benefits to an Eligible Provider.

Indemnification of Employees

Except as otherwise provided under applicable law, no director, officer, or Employee of the District or of the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan and will be indemnified and held harmless by the District from and against any such personal liability, including all expenses reasonably incurred in his or her defense if the District fails to provide such defense. The District and the Plan each may purchase fiduciary liability insurance consistent with applicable law.

Compliance

It is the intent of this Plan to comply with all federal regulations that govern health care including TEFRA (Tax Equity Fiscal Responsibility Act of 1982), DEFRA (the Deficit Reduction Act of 1984), COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), HIPAA (Health Insurance Portability and Accountability Act of 1996), PPACA (Patient Protection and Affordable Care Act of 2010 also referred to as ACA - Affordable Care Act), and any regulations that may become effective.

Eligibility

New Hires

- Full-Time Employees: Employees designated by the District as Full-Time Employees who work 30 hours or more per week on a regular basis. Coverage for Full-Time Employees, if properly elected, will be effective on the first of the month coincident with or next following 30 days of continuous employment with the District.
- Qualifying Part-Time Employee: Any other Employees, including but not limited to Seasonal Employees, who are not Full-Time Employees to the extent that such Employees average 30 hours of services per week over the Employee's applicable Initial Measurement Period (as defined in the Plan Eligibility Appendix adopted by the District). Coverage for such Employees, if properly elected, will be effective on the first day of the Qualifying Part-Time Employee's New Employee Stability Period (as defined by the Plan). A Qualifying Part-Time Employee will remain eligible throughout the New Employee Stability period to the extent that the Employee remains employed, subject to the Plan's Break in Service (as defined by the Plan) rules.

Note: if there is a gap between the end of the Qualifying Part-Time Employee's New Employee Stability Period and the start of the Qualifying Part-Time Employee's first Ongoing Employee Stability Period (see below), the Qualifying part-Time Employee will remain eligible under the Plan until the day preceding the start of the ongoing Employee Stability Period to the extent the Employee remains employed, subject to the Plan's Break in Service rules.

If a Qualifying Part-Time Employee transfers to a Full-Time Employee position prior to the start of the Qualifying Part-Time Employee's New Employee Stability Period, the Employee will become eligible for coverage. If elected, coverage for such new Full-Time Employee will become eligible on the first of the month following the date he or she becomes a Regular Full-Time Employee / If elected, coverage for such new Regular Full-Time Employee will become eligible on the first of the month following 30 days of Full-Time employment with the District.

Ongoing Employees

Once an Employee has completed the Plan's Initial Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period to the extent that the Ongoing Employee remains employed, subject to the Plan's Break in Service rules. Such coverage, if elected, will be effective on the first day of the Plan's Ongoing Employee Stability Period.

Whether an Employee averages 30 Hours of Service per week will be determined in accordance with policies and procedures adopted by the Plan Administrator.

Impacts of Breaks in Service

Any Employee who resumes Hours of Service following a Break in Service (as defined in the Plan Eligibility Appendix) will be treated as a New Hire and eligibility for coverage under the Plan upon return will be determined in accordance with

the New Hire rules above. If, however, the Employee experiences a period without any Hours of Service, and resumes Hours of Service without experiencing a Break in Service, the Employee will be treated as a continuous Employee. A continuous Employee resuming Hours of Service after a period with no Hours of Service that does not constitute a Break in Service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with No Hours of Service. Such coverage will be effective on the first day of the month that coincides with or follows the date the Employee resumes Hours of Service.

Contribution

The Plan may be evaluated from time to time to determine the amount of Employee contribution that is required (if any).

Dependent Eligibility

Your eligible covered dependents, as defined below, may also be covered:

- your legal spouse or Civil Union Partner;
- your child(ren) under 26 years of age (under 30 years of age if eligible military veteran), regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, or any combination of those factors. Child(ren) means a natural child, a stepchild, an adopted child including a child who is in your custody under an interim court order of adoption or who is placed with you for adoption, a child for whom you are a legal guardian per a written court order, or dependents of your Civil Union Partner; and
  - Military veteran dependents must have:
    - Served in the active or reserve components of the U.S. Armed Forces, including the National Guard;
    - Received a release of discharge other than a dishonorable discharge; and
    - Submitted proof of service using a DD2-14 form, otherwise known as a "certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information on how to obtain a copy of a DD2-14, the veteran can call the Illinois Department of Veterans' affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.
  - children age 26 and over who are physically or mentally disabled and dependent upon you for support. To continue coverage, you must provide proof of the disability when the child's coverage would normally end. You may also need to provide proof of the disability from time to time to maintain coverage; and
  - grandchildren that are under your legal guardianship.

Dependent Spouse Coverage

Medical and Vision Plans

If your dependent spouse is not employed full-time outside of D303 and is not eligible or covered for benefits under a plan provided by their employer, they are eligible for benefits under the D303 Healthcare Plan with D303 as primary.

If your dependent spouse is a full-time employee outside of D303 and is eligible or covered for benefits under a plan provided by his or her employer, your dependent spouse must elect those benefits or they will not be considered an eligible dependent for coverage under this Plan. Once your dependent spouse has elected benefits through their employer, they can be enrolled in the D303 Healthcare Plan as secondary (see also Coordination of Benefits).

However, if your dependent spouse has lost or will lose coverage under the other plan as a result of loss of eligibility (due to such reasons as termination of employment or change of employment status); termination of the group plan for such coverage; or has exhausted COBRA continuation coverage, your dependent spouse will be eligible for coverage with the D303 Healthcare Plan as primary, subject to the provisions which relate to Special Enrollees. Such spouse may enroll within 31 days after loss of coverage. Coverage will be effective on the date coverage is lost.

Dental Plan

Your dependent spouse is eligible for the D303 dental benefits regardless of their employment status.

Coverage for Newborns

A newborn child will become covered from the moment of birth, provided you have made arrangements to enroll the newborn child for coverage and you enroll the child within 31 days after the date your child is born and make the required retroactive contributions.

Qualified Medical Child Support Orders

A Qualified Medical Support Order (QMCSO) is a court issued document that designates a particular person or persons responsible for obtaining a child's Medical Care. If we receive such an order, we are legally obligated to enroll that child for coverage as your dependent with or without your authorization. You will be required to pay any increased employee contribution that result from this child being added.

Dual Coverage

If you and your spouse both work for D303, only one of you can cover your eligible children.

When Coverage Begins

Eligible employees' coverage will be made effective on the first day of the calendar month that falls on or next follows:

- the date you complete the required one full calendar month waiting period from the day you began work;
- your eligibility date, if you enroll on or before that date; or
- the date you enroll, if you do so within 31 days after your eligibility date.

If you do not enroll within 31 days of becoming eligible, you will not be eligible for enrollment again until the next Open Enrollment period. You will, however, be allowed to enter the Plan at any time if you experience a change in family status, see Change in Family Status.

When Dependent Coverage Begins

Your covered dependents are eligible for coverage at the same time you are. Dependent coverage will be effective with respect to each eligible dependent you then have on the first day of the calendar month that falls on or next follows: the date you are eligible for coverage if you enroll your dependents on or before that date; or

- the date you enroll your dependents.

To ensure that proper coverage is in effect at all times, notify the Employee Benefits Department of any change in your family status, see Change in Family Status.

Your newborn or newly adopted child will be covered immediately, provided you have made arrangements to enroll the child within 31 days after birth or adoption and have made the required retroactive contributions. If you do not enroll the child and make the required retroactive contributions within 31 days of birth or adoption, you will have to wait until the next Open Enrollment period.

Change in Family Status

Once your coverage begins, it must remain in effect until the next Open Enrollment period. In exchange for the tax advantages of pre-tax contributions, the IRS limits opportunities for change during the year. You may not change, start or stop your medical coverage during the year unless you experience one of the following changes in family status. The change in coverage must be consistent with the change in family status and you must provide documentation to support the change (i.e. birth certificate for change in dependents, marriage or civil union certificate for change in marital status, etc.).

- A change in marital status, including marriage, civil union, death of a spouse, divorce, legal separation or annulment.
- A change in the number of dependents, including birth, adoption, change in legal custody (including a QMCSO) of a dependent child, a dependent child Placed for Adoption with you, or death of a dependent child.
- Please note; if you already have Family Coverage and you are adding another child, you must notify us of the existence of your new dependent within 31 days after the date you acquired the dependent or you will have to wait until the next Open Enrollment period.
- When you or your Dependent becomes eligible for premium assistance under The Children's Health Insurance Program (CHIP) or Medicaid. Enrollment must be requested no more than 60 days after eligibility for the premium assistance.
- When you or your Dependent's prior coverage under The Children's Health Insurance Program (CHIP) or Medicaid is terminated due to loss of eligibility. You must request enrollment under this Plan no later than 60 days after the day of loss of eligibility.

- A change in employment status, including termination or commencement of employment and commencement or return from an unpaid leave of absence by you, your spouse, or dependent.
- A change in work schedule, including a reduction or increase in hours of employment by you, your spouse, or dependent including a change from part-time to full-time employment or vice versa.
- Entitlement to Medicare or Medicaid by you, your spouse, or dependents (i.e. if you become entitled to health coverage under Medicare or Medicaid, you can elect to cancel or reduce coverage under the Plan. Conversely, if you lose eligibility under Medicare or Medicaid, you can elect to commence or increase coverage under the healthcare Plan.
- The loss of medical coverage under another employer's medical plan due to the exhaustion of COBRA coverage or cessation of eligibility for such other coverage.
- If you waive coverage under this healthcare Plan because you have coverage under another plan through your spouse and your spouse later loses coverage as a result of loss of eligibility, you may enroll in this healthcare Plan.

To make a change in your coverage, your request must be completed and submitted within 31 days of the date the qualifying event took place. However, you will have 60 days to enroll for the loss of CHIP or Medicaid coverage, or within 60 days of when eligibility for premium assistance under CHIP or Medicaid is determined. If you wait longer than the time specified above, you will have to wait until the next Open Enrollment period to make the change.

A change in coverage will be "consistent" with a change in family status if the coverage change is: (1) on account of such change in status and (2) corresponds with such change in status. For example, if, after you enroll, a Qualified Medical Child Support Order (QMCSO) is entered, you may add coverage for a dependent if the QMCSO requires it, or cancel coverage for a dependent if the QMCSO requires a former spouse or another individual to provide coverage for the dependent and that coverage is so provided.

When Coverage Ends

For Employees
You will no longer be entitled to the healthcare Benefits described in this document if either of the events stated below should occur.

- When you leave the Employer for any reason.
- The end of the month following the date you no longer meet the previously stated description of an Eligible Person in this document
- When you fail to make the required contributions for coverage.
- The end of the month following the date the Healthcare Plan of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this document. It is the responsibility of the employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the employer's agreement with the Claim Administrator.

No Benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Healthcare Plan described in this document. However, termination of the employer agreement with the Claim Administrator and/or termination of your coverage under the Healthcare Plan shall not affect any claim for Covered Services rendered prior to the effective date of such termination.

When your healthcare coverage ends, you have two options to continue benefits at your own expense. One option is to continue the same benefits under COBRA as explained in the COBRA Section of this document. The other option is to convert your group coverage to individual coverage.

Upon termination of your coverage under the Healthcare Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under the Healthcare Plan.

For Dependents
A Dependent's coverage will end on the earlier of:

- the end of the month following the date your coverage ends;
- the end of the month following the date the event occurs which makes him or her ineligible (for example, attainment of age 26 for dependent children, date of divorce, etc.); or
- the end of the month following the date you fail to make the required contributions for coverage.

Important Notice Requirements
Under the law, the employee or an eligible dependent has the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the later of: 1) the date the qualifying event occurs; 2) the date coverage is lost; or 3) the date the beneficiary is notified – through this document or the general COBRA notice. Such notice must be in writing to the Benefit Coordinator, and contain the name of the Covered Individuals affected by the event and the date and nature of the event. The District has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement, no later than 30 days after the date the Employee loses coverage due to the qualifying event.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will ensure that the employee and the employee's eligible covered dependents are notified within 14 days of the right to choose continuation coverage. Under the law, the employee and eligible covered dependents have 60 days from the later of: the date the employee or his or her eligible covered dependent(s) would lose coverage because of one of the events described above or the date the employee or his or her eligible covered dependent(s) are advised by the Plan Administrator of the right to continue coverage, to inform the Plan Administrator that the employee and/or the eligible covered dependents want continuation coverage.

Notice to the employee's eligible covered spouse of the right to elect continuation coverage under the Plan will be deemed notice to any eligible covered dependent children residing with the employee's spouse. If the employee or his or her eligible covered dependent(s) do not elect continuation coverage within this election period, then the right to continuation coverage based on COBRA rules will be lost.

An eligible employee may elect COBRA continuation coverage for an eligible child who is born to, or placed for adoption with such employee while the employee's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the employee has notified the Plan Administrator in writing within 30 days of the child's birth, adoption or placement for adoption.

Coverage Continuation

Leave of Absence
If you are planning to take a leave of absence longer than 30 days, check with the Employee Benefits Department to find out how coverage can be continued during your leave.

Family Medical Leave Act (FMLA) Leave of Absence
FMLA is a Federal Law that provides "eligible" Employees the right to take up to 12 workweeks of unpaid, job-protected leave, during any 12 month period, for the birth and care of a newborn, adoption or foster care, or a serious health condition of the Employee or certain family members.

To be eligible for FMLA leave you must work an average of 24 hours or more per week (at least 1,250 hours a year); have completed 12 months of employment; and your worksite must be within a 75-mile radius of a site where 50 or more Employees work.

FMLA leaves of absence of up to 12 weeks in a rolling 12-month period, measured backwards from the date you use FMLA leave, are granted under the following situations:

- The Employee's serious health condition. "Serious" means a condition that requires Inpatient care or continuing treatment by a healthcare provider. It does not cover minor illnesses or medical procedures that are normally

handled through sick leave. It does, however, cover complications related to pregnancy, severe morning sickness, miscarriage, recovery from childbirth, and/or the need for prenatal care.

- Birth of a child, or placement of a child for adoption or foster care. Family leave must be completed within 12 months after the birth or placement.
- Caring for Your seriously ill spouse, parent, or sick child under the age of 18. The same definition of "Serious" shown above applies here. If you are planning on taking a FMLA, you should provide the Employer with 30 days advance notice, if at all possible. You will be required to complete a Family Medical Leave Request Form. In most cases you must submit medical certification or a written statement from the adoption agency to support your request for leave. If you fail to give adequate notice, your FMLA may be delayed.

During a FMLA, the Employer will continue your medical and dental insurance coverage, provided that you pay for your share of such coverage on a timely basis as if you had remained actively employed. During any paid leave, your share of the premiums will be deducted from your pay. During any unpaid portion of the leave, you will be required to pay your share. If payment is more than 30 days late, your benefits will cease until and if you return to work.

If you fail to return from your leave, the Employer may be entitled to recover from you the portions of medical insurance premiums that were paid for by the Employer. At the end of a Family Medical Leave, you will typically have the right to return to your last position before the leave or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment. All employees who take a FMLA will be subject to any pay or benefit reductions or other adverse action, including layoff that they would have experienced if they had not been on a FMLA.

The complete policy and procedures on the Employer Family and Medical Leave Policy can be obtained from your HR Representative.

Military Leave of Absence

It is the policy of the Employer to grant its Employees military leave for the induction in the Armed Forces, or participation in military reserve units and National Guard units. The Federal Law, Uniformed Services Employment and Reemployment Act (USERRA), provides reemployment rights for veterans and members of the National Guard and Reserve following qualifying military service. It also prohibits Employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

In accordance with USERRA, an Employee who goes on an unpaid military leave of absence may continue to participate in the Plan during the USERRA leave until the first of the following occurs:

- You return to work after service;
- the 24-month period beginning on the date on which your absence begins; or
- the period ending the day after the date on which you fail to apply for or return to a position with the Employer, as determined in accordance with USERRA.

If the USERRA leave is for 30 days or less, your required contributions will remain the same as similarly situated active Employees.

An Employee absent from work for more than 30 days in order to fulfill a period of duty in the uniformed services (as defined by USERRA), experiences a qualifying event as of the first day of your absence for such duty. If you elect to continue health coverage, you may pay contributions in the same amount, form and manner as provided for those who elect to continue coverage under COBRA. If you elect to continue coverage, you are generally considered to be participating in COBRA continuation coverage and USERRA continuation coverage at the same time. You and your covered dependents shall be entitled to the benefit of rights under both COBRA and USERRA and the law most beneficial to the individual taking leave for uniformed service will apply in any particular circumstance. This is important because COBRA continuation coverage may offer additional rights that are not available under USERRA. It is also important to note that COBRA and USERRA continuation coverage run concurrently.

The following leaves relating to military service are available:

1. Covered Service Member Leave: An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member, who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member.

This military caregiver leave is available during "a single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

2. Qualifying Exigency Leave: Eligible employees are entitled up to 12 weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.
3. The final rule defines qualifying exigency by referring to categories for which employees can use FMLA leave, including, short-notice deployment; military events and related activities; childcare and school activities; financial and legal arrangements; counseling; rest and recuperation; post-deployment activities; and additional activities not encompassing the other categories, but agreed to by the employer and employee.

Uniformed Service Members' Right to FMLA

USERRA requires that returning veterans receive eligibility for leave under FMLA. A service member who is absent from employment for an extended period of time due to military service and who requests FMLA leave shortly after returning to employment may not have actually worked for the Employer for a total of 12 months or may not have performed 1,250 hours of actual work with the Employer in the 12 months prior to the start of the FMLA leave.

Accordingly, a returning service member would be entitled to FMLA leave if the hours they would have worked for the Employer during the period of military service would have met the FMLA eligibility threshold. Therefore, in determining whether a veteran meets the FMLA eligibility requirement, the months employed and the hours that were actually worked for the Employer should be combined with the months and hours that would have been worked during the twelve months prior to the start of the leave requested but for the military service.

Federal Continuation Coverage (COBRA)

Introduction

You are receiving this notice because you have recently become covered under your Employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this document or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent–employee dies;
- The parent–employee's hours of employment are reduced;
- The parent–employee's employment ends for any reason other than his or her gross misconduct;
- The parent–employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides healthcare coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee's becoming entitled to Medicare benefits under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event. You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your Employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitle to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18–Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of

the 18–month period of continuation coverage. Contact your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18–Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your Plan Administrator.

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

The phone number of COBRA administration is 888-541-7107.

Healthcare Plan Benefit Summary

Medical PPO and CDHP Benefits
BCBS of Illinois

	PPO PLAN		Consumer Driven Health Plan (CDHP)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Single Single + 1 Family	 $400 $800 $1,200	 $800 $1,600 $2,400	 $1,500 n/a $3,000	 $3,000 n/a $6,000
Out-of-Pocket Single Single + 1 Family	 $4,000 $8,000 $12,000	 $8,000 $16,000 $24,000	 $6,000 n/a $12,000	 $12,000 n/a $24,000
Lifetime Maximum	Unlimited		Unlimited	
Hospital/Surgical Services (incl. mental health) Inpatient Outpatient Out of Area	 80% after ded. 80% after ded. 80% after ded.	 70% after ded. 70% after ded. 70% after ded.	 80% after ded. 80% after ded. 80% after ded.	 70% after ded. 70% after ded. 70% after ded.
Hospital Copay	$0	$300	$0	$0
Emergency Room	$100 copay then 80% after regular ded .		80% after regular ded.	
Chiropractic	$50 copay 12 visit maximum/calendar year for muscle manipulations/spinal adjustments	70% after ded.	80% after ded. 12 visit maximum/calendar year for muscle manipulations/spinal adjustments	70% after ded.
Physical Therapy	$50 copay 65 visits/calendar year/therapy maximum	70% after ded.	80% after ded. 65 visits/calendar year/therapy maximum	70% after ded.
Occupational Therapy	$50 copay 70 visits/calendar year/therapy maximum	70% after ded.	80% after ded. 70 visits/calendar year/therapy maximum	70% after ded.
Speech Therapy	$50 copay 45 visits/calendar year/therapy maximum	70% after ded.	80% after ded. 45 visits/calendar year/therapy maximum	70% after ded.
Physician Services (incl. mental health) Inpatient Outpatient Out of Area	 80% after ded. $25 copay for primary care/mental health and $50 for specialist 80% after ded.	 70% after ded. 70% after ded.	 80% after ded. 80% after ded. 80% after ded.	 70% after ded. 70% after ded.
Virtual Visits (MDLive)	$25 copay	n/a	80% after ded.	n/a

	PPO PLAN		Consumer Driven Health Plan (CDHP)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Private Duty Nursing	80% after ded. 10 visits/calendar year maximum	70% after ded.	80% after ded. 10 visits/calendar year maximum	70% after ded.
Other Services Outpatient Out of Area	80% after ded.	70% after ded. 80% after ded.	80% after ded.	70% after ded. 80% after ded.
Maternity Authorization	Only required for hospital stays longer than 48 hours for a vaginal delivery or 96 hours for a cesarean section.		Only required for hospital stays longer than 48 hours for a vaginal delivery or 96 hours for a cesarean section.	
Pre-certification Penalty**	Pre-certification is required before all hospital admissions (or within two working days following an emergency admission) and before all scheduled surgeries performed outside the doctor's office. A $200 additional deductible will be applied. Utilization Management can be reached at: 1-800-572-3089			
* Except when emergency treatment is required. You must call your Primary care Physician (PCP) for follow-up care. ** All inpatient hospital admissions or any surgeries must be pre-certified for both PPO plans.				
Wellness Benefits Well Baby/Child Care Preventive Services	 100% 100%	 90% 90%	 100% 100%	 90% 90%

Medical HMO Benefit
(Provided via fully-insured BCBS of IL Plan)

	HMOI
	In-Network
Deductible Single Single + 1 Family	 $0 $0 $0
Out-of-Pocket Single Single + 1 Family	 $1,000 n/a $2,000
Lifetime Maximum	Unlimited
Hospital/Surgical Services(incl. mental health) Inpatient Outpatient Out of Area	 100% 100% 0%*
Hospital Copay	$200/3 days
Emergency Room	100% after $75 copay
Chiropractic	100% after $40 copay referral required
Physical Therapy	100% after $20 copay
Occupational Therapy	100% after $20 copay
Speech Therapy	100% after $20 copay
Physician Services (incl. mental health) Inpatient Outpatient Out of Area	 100% 100% after $20 copay for primary care/mental health and $40 for specialist N/A
Private Duty Nursing	100% referral required
Other Services Outpatient Out of Area	 100% 0%*
Maternity Authorization	physician will authorize
Pre-certification Penalty**	physician will authorize
* Except when emergency treatment is required. You must call your Primary care Physician (PCP) for follow-up care.	
Wellness Benefits Well Baby/Child Care Preventive Services	 100% less $20 copay per visit 100% less $20 copay per visit

Prescription Drug Benefits

	PPO Plan		Consumer Driven Health Plan (CDHP)		HMOI
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
PRESCRIPTION DRUG BENEFITS (Included in all medical plans) – Advantage Pharmacy Network (excludes CVS)					
Retail (34 day supply)			Subject to deductible than copays apply*		
Generic	$10 copay	$10 copay+25%	$10 copay	$10 copay+25%	$10 copay
Brand	$25 copay	$25 copay+25%	$25 copay	$25 copay+25%	$25 copay
Non-Preferred Brand	$60 copay	$60 copay+25%	$60 copay	$60 copay+25%	$60 copay
Self-Injectables	$65 copay	$65 copay+25%	$65 copay	$65 copay+25%	$65 copay
Specialty	$60 copay	Not Covered	$60 copay	Not Covered	$60 copay
Mail Order (90 day supply)			Subject to deductible than copays apply*		
Generic	$20 copay	Not Covered	$20 copay	Not Covered	$20 copay
Brand	$50 copay	Not Covered	$50 copay	Not Covered	$50 copay
Non-Preferred Brand	$120 copay	Not Covered	$120 copay	Not Covered	$120 copay
Self-Injectables	$130 copay	Not Covered	$130 copay	Not Covered	$130 copay
Specialty	n/a	Not Covered	n/a	Not Covered	n/a
Non-Participating Pharmacy Payment Level	75% of the eligible charge, minus the applicable copay				Not Covered
Mail Order (90 day supply)			Subject to deductible than copays apply*		
Generic	$20 copay		$20 copay		$20 copay
Brand	$50 copay		$50 copay		$50 copay
Non-Preferred Brand	$120 copay		$120 copay		$120 copay
Non-Participating Pharmacy Payment Level	75% of the eligible charge, minus the applicable copay				Not Covered

*Approved preventive medications are paid prior to deductible at the listed copays. Call BCBS at the number listed on the back of your ID card for a complete list.
Note: D303 participates in Prior Authorization, Step Therapy, Mandatory Specialty Pharmacy, and Member-Pay-the-Difference programs. Compound drugs are excluded.
Call BCBS for more details on the Medical and Prescription Drug programs.

Step Therapy
Step therapy protocol means that an individual may need to use one type of medication before another. Our Plan monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help an individual access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the Pre-Certification process is applied.

Dental Expense Benefits

MetLife

(must be elected separately from medical)

	In-Network	Out-of-Network
Deductible Applies to B & C	$50 individual $150 family	$50 individual $150 family
Yearly Individual Maximum Includes Type A, Type B, and Type C covered services	$1,750	$1,750
Yearly Individual Maximum Benefit Amount for Implant Covered Services	$1,000	$1,000
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	$1,500	$1,500
Coverage A Preventive	100% of Maximum Allowed	80% of Reasonable & Customary
Coverage B Minor Restorative	80% of Maximum Allowed	70% of Reasonable & Customary
Coverage C Major Restorative	50% of Maximum Allowed	40% of Reasonable & Customary
Orthodontia	50% of Maximum Allowed	50% of Reasonable & Customary

Certain limitations and exclusions may apply to any benefit or benefit amount. It is important that You and Your Dependents refer to the provisions contained in this Program Description for details about Your benefits.

Vision Care Benefits

Vision Service Plan (VSP)
(included with all medical plans)

Eligible members and/or dependents may select any licensed provider for vision care services. Members who choose to receive services from a Non-Participating provider will be reimbursed up to the maximum allowance.

	VSP Participating Provider	Non-Participating Provider
WellVision Exam Once every 12 months	100% after $10 copay	Reimbursed up to $25
Lenses Single Vision Lined Bifocal Lined Trifocal Standard Progressive Premium Progressive Custom Progressive Once every 12 months	 100% after $25 copay 100% after $25 copay 100% after $25 copay 100% after $50 copay 100% after $80-$90 copay 100% after $120-$160 copay	 Reimbursed up to $30 Reimbursed up to $35 Reimbursed up to $45 Reimbursed up to $45 Reimbursed up to $45 Reimbursed up to $45
Frames Once every 24 months	Covered up to $130 allowance	Reimbursed up to $45
Elective Contact Lenses	Covered up to $130 allowance 15% off contact lens exam (fitting and evaluation)	Reimbursed up to $105
Non-Covered Glasses	30% off additional glasses or sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision exam. 20% off from any VSP doctor within 12 months of your last WellVision exam.	N/A
Laser Vision Correction	Average of 15% off regular price or 5% off promotional price. Discounts only available from contracted facilities.	N/A

Coordination of Benefits

Medical

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

To coordinate Benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

- The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining Eligible Charges.
- When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this ''birthday'' type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
    - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
    - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

      Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

    - If neither of the above rules applies, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount that it determines to be warranted if payments, which should have been made by the Claim Administrator, have been made by such other organization under any other group program recover any overpayment, which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

Benefits for Medicare Eligible Covered Persons

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this document (see Who is Eligible and Medicare sections).

The benefits and provisions described throughout this document apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. Determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. Deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

Subrogation Provision

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this document, you agree:

1. The Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
2. The Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

   The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury. You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. See Claim Administrator's Financial Arrangements with Providers.

If the Plan Participant(s) retains an attorney, the Plan Administrator may require that attorney to sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Plan Participant(s)'s attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Plan in his or her pursuit of recovery. The Plan will not pay the Plan Participant(s)'s attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the Plan Participant(s)'s attorneys' fees and costs.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. As a possessor of a portion of the recovery, the Plan Participant(s)'s attorney holds the recovery as a constructive trustee and fiduciary and is obligated to tender the recovery immediately over to the Plan. A Plan Participant(s)'s attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the Plan Participant(s) nor the attorney is the rightful owner of the portion of the recovery subject to the Plan's lien.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by any recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of

rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes that attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Excess Insurance

If at the time of Injury, Illness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

a. the responsible party, its insurer, or any other source on behalf of that party;

b. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c. any policy of insurance from any insurance District or guarantor of a third party;

d. worker's compensation or other liability insurance District or

e. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of the injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b) to provide the Plan with pertinent information regarding the Illness, Injury, disease, disability, including accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

If the Plan Participant(s) and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury, Illness, or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

Failure by the Plan Participant(s) and/or their attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies their obligation.

Dental

When You or a Dependent incur charges for Covered Services, there may be other Plans, as defined below, that also provide benefits for those same charges. In that case, This Plan may reduce what This Plan pays based on what the other Plans pay. This Coordination of Benefits section explains how and when This Plan does this.

Definitions

In this section, the terms set forth below have the following meanings:

Allowable Expense means a necessary dental expense for which both of the following are true:

- a covered person must pay it; and
- it is at least partly covered by one or more of the Plans that provide benefits to the covered person.

If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred), such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, This Plan treats the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

The term does not include:

- expenses for services performed because of a Job-Related Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Plans compute their benefit payments on the basis of reasonable and customary fees;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
    - second surgical opinions;
    - pre-certification of services;
    - use of providers in a Plan's network of providers; or
    - any other similar provisions.

This Plan won't use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

Custodial Parent means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the child resides more than half of the Year without regard to any temporary visitation.

HMO means a Health Maintenance Organization or Dental Health Maintenance Organization.

Job-Related Injury or Sickness means any injury or sickness:

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

Parent means a person who covers a child as a dependent under a Plan.

Plan means any of the following, if it provides benefits or services for an Allowable Expense:

- a group insurance plan;
- an HMO;
- a blanket plan;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- motor vehicle No Fault coverage if the coverage is required by law; and
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- individual or family insurance or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- a school blanket plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of This Plan, which limit benefits based on benefits or services provided under:

- Government Plans; or
- Plans which the Employer (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

This Plan means the Dental Benefits described in this Program Description, except for any provisions in this Program Description that limit coverage based on benefits for services provided under government plans, or plans which the Employer (or an affiliate) contributes to or sponsors.

Primary Plan means a Plan that pays its benefits first under the "Rules to Decide Which Plan Is Primary" section. A Primary Plan pays benefits as if the Secondary Plans do not exist.

Secondary Plan means a Plan that is not a Primary Plan. A Secondary Plan may reduce its benefits by amounts payable by the Primary Plan. If there are more than two Plans that provide coverage, a Plan may be Primary to some plans, and Secondary to others.

Rules to Decide Which Plan is Primary

When more than one Plan covers the person for whom Allowable Expenses were incurred, the Claim Administrator determines which plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- the other Plan has rules coordinating its benefits with those of This Plan; and
- this Plan is primary under This Plan's rules.

The first rule below, which will allow the Claim Administrator to determine which Plan is Primary, is the rule that the Claim Administrator will use.

Dependent or Non-Dependent: A Plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the Plan covering the person as a dependent; and
- Primary to the Plan covering the person as other than a dependent (e.g., a retired employee);

then the order of benefits between the two Plans is reversed and the Plan that covers the person as a dependent is Primary.

Child Covered Under More Than One Plan – Court Decree: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the Child's health care expenses, that Parent's Plan is Primary, if the Plan has actual knowledge of those terms. This rule applies to Claim Determination Periods that start after the Plan is given notice of the court decree.

Child Covered Under More Than One Plan – The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- the Parents are married; or
- the Parents are not separated (whether or not they have ever married); or
- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.

However, if the other Plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Child Covered Under More than One Plan – Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Plan is:

- the Plan of the Custodial Parent; then
- the Plan of the spouse of the Custodial Parent; then
- the Plan of the non-custodial Parent; and then
- the Plan of the spouse of the non-custodial Parent.

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage: The Plan that covers a person as an active employee, member or subscriber (or as that employee's Dependent) is Primary to a Plan that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan that covers the person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered: If none of the above rules determine which Plan is Primary, the Plan that has covered the person for the longer time shall be Primary to a Plan that has covered the person for a shorter time.

No Rules Apply: If none of the above rules determine which Plan is Primary, the Allowable Expenses shall be shared equally between all the Plans. In no event will This Plan pay more than it would if it were Primary.

Effect on Benefits of This Plan

If This Plan is Secondary, when the total Allowable Expenses incurred by a covered person in any Claim Determination Period are less than the sum of:

- the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
- the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

then This Plan will reduce the benefits that would otherwise be payable under This Plan. The sum of these reduced benefits, plus all benefits payable for such Allowable Expenses under all other Plans, will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been made on time.

Right to Receive and Release Needed Information

The Claim Administrator needs certain information to apply the Coordination of Benefits rules. The Claim Administrator has the right to decide which facts The Claim Administrator needs. The Claim Administrator may get facts from or give them to any other organization or person. The Claim Administrator does not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Plan which covers the person. Each person claiming benefits under This Plan must give the Claim Administrator any facts This Plan needs to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term “payment made” includes benefits provided in the form of services, in which case This Plan may pay the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount This Plan pays is more than This Plan should have paid under this Coordination of Benefits provision, This Plan may recover the excess from one or more of:

- the person This Plan has paid or for whom This Plan has paid;
- insurance companies; or
- other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

How to File a Claim

Medical Claims

In order to obtain your benefits under this Healthcare Plan, it is necessary for a claim to be filed with the Claim Administrator. To file a claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your claim for you. Remember, however, it is your responsibility to ensure that the necessary claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own claim, follow these instructions:

- Complete a claim form. These are available from your Benefits Coordinator or from the Claim Administrator's office.
- Attach copies of all bills to be considered for Benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service, a description of the service and the claim charge.
- Mail the completed claim form with attachments to:
  Blue Cross Blue Shield of Illinois
  P.O. Box 805107
  Chicago, IL 60680

In any case, claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) Claims not filed within the required time period will not be eligible for payment.

Should you have any questions about filing claims, ask your Benefits Coordinator or call the Claim Administrator's office.

Outpatient Prescription Drug Program Claims

In certain situations, you will have to file your own Claims in order to obtain Benefits under the Outpatient Prescription Drug Program. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a Claim or you received Benefits from a non–Participating Prescription Drug Provider. To do so, follow these instructions:

Complete an Outpatient Prescription Drug Program Claim Form. These forms are available from your Benefits Coordinator or from the Claim Administrator's office.

- Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
- Mail the completed claim form with attachments to:

  Prime Therapeutics

  P.O. Box 14624

  Lexington, KY 40512-4624

In any case, claims must be filed no later than one year after the date a service is received. Claims not filed within one year from the date a service is received will not be eligible for payment.

Vision Claims

When a network Doctor is used, you do not need to file a claim form – the doctor will submit the appropriate claim for you. However, if you use an Out-of-Network Provider, it is your responsibility to submit the claim for reimbursement.

Vision Claims (Out-of-Network Provider Claims)
When an Out-of-Network Provider is used, you must pay the provider in full at the time of services and submit an itemized receipt for reimbursement to the Claim Administrator. To ensure a timely reimbursement, log on to Claim Administrator's web site and access the claim form. Simply:

- Sign on to www.vsp.com
- Select the "Out-of-Network Reimbursement Form" under My Forms
- Follow the instructions
- If you do not have Internet access, send the following to VSP:
  - An itemized receipt listing the services received
  - The name, address and phone number of the Out-of-Network Provider
  - The covered member's ID number, name, address and phone number
  - The name of the organization that offers your VSP coverage
  - The patient's name, date of birth, address and phone number
  - The patient's relationship to the covered member (such as self, spouse, or child)
  - Keep a copy of the claim information and send the originals to:

    VSP
    Attention: Out-of-Network Claims
    P.O. Box 997105
    Sacramento, CA 95899-7105

You will be reimbursed up to the amount shown in the Healthcare Plan Benefit Summary for Out-of-Network Providers.

All claims must be filed within six months of the date services were completed. Reimbursement benefits are paid directly to the Covered Person and are not made payable to the doctor.

Dental Claims
If your dentist does not have a claim form, you may obtain one from your Benefits Coordinator or online at https://www.metlife.com/insurance/dental-insurance. Please be sure that the information portion of the claim form includes the following:

- the employee's full name and address;
- the employee's social security number;
- the name and date of birth of the person receiving dental treatment; and
- the group name and number.

The completed Dental Expense Claim Form can be submitted to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Fax: 1-859-389-6505

Claims Procedures

Medical Claims
The Claim Administrator will pay all claims within 30 days of receipt of all information required to process a claim. In the event that the Claim Administrator does not process a claim within this 30-day period, you or the valid assignee shall be entitled to interest at the rate of 9% per year, from the 30th day after the receipt of all claim information until the date payment is actually made. However, interest payment will not be made if the amount is $1.00 or less. The Claim Administrator will notify you or the valid assignee when all information required to pay a claim within 30 days of the claim's receipt has not been received.

If the claim is denied in whole or in part, you will receive a notice from the Claim Administrator with: (1) the reasons for denial; (2) a reference to the healthcare Plan provisions on which the denial is based; (3) a description of additional

information which may be necessary to perfect the appeal, and (4) an explanation of how you may have the claim reviewed by the Claim Administrator if you do not agree with the denial.

Vision Claims

VSP uses processes to review, approve, modify, or deny, based on medical necessity, requests by doctors for authorization of the provision of service to Covered Persons. VSP makes these decisions within at least 72 hours for urgent care claims; within 15 days for pre-service claims; and within 30 days for post-service claims after receipt of the claim by the Plan. A 15-day extension will be granted for pre and post-service claims if proper notice and delay is beyond the control of the Plan. This notice of extension shall state the special circumstances that require the extension and the date by which a final decision will be made.

Dental Claims

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to the Claim Administrator. When the Claim Administrator receives such Proof, the Claim Administrator will review the claim and if the Claim Administrator approves it, This Plan will pay the Dental Benefits in effect on the date that service was completed.

Review Procedures

Medical

Initial Claims Determinations

The Claim Administrator will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see Payment of Claims and Assignment of Benefits provisions in the Claim Administrator's Financial Arrangements with Providers section.) If you fail to follow the procedures for filing a Pre-Service Claim, you will be notified within 5 days (or within 24 hours in the case of a failure regarding an Urgent Care/Expedited Clinical Claim. Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non-urgent Pre-Service Claims, within 15 days after receipt of the claim by the Claim Administrator.
2. For post-service claims, within 30 days after receipt of the Claim by the Claim Administrator.
   If the Claim Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent Pre-Service and post-service claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information. If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:
   a. The reasons for denial;
   b. A reference to the benefit plan provisions on which the denial is based;
   c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
   d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;
   e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;

f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
j. In the case of a denial of an Urgent Care/Expedited Clinical Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care/Expedited Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within 3 days of oral notification;
k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

3. For benefit determinations relating to Urgent Care/Expedited Clinical Claims, such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
4. For benefit determinations relating to care, that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

Inquiries and Complaints

The Claim Administrator has a team available to assist you with Inquiries and Complaints (see Healthcare Plan Definitions). Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the Claim Appeal Procedures.

To pursue an Inquiry or a Complaint, you may contact Customer Service at the number on the back of your ID card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (see Healthcare Plan Definitions) or an adverse action by the Claim Administrator, its employees or a participating provider.

Claim Appeal Procedures

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrator's (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage

determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as “appeals.”

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

Claim Review Section
Health Care Service Corporation
P.O. Box 2401
Chicago, Illinois 60690

In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator, by phone or in person at a location of the Claim Administrator's choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an adverse Benefit Determination or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant much exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an Urgent Care/Expedited Clinical Claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Claim Administrator shall render a determination of the appeal within 30 days after the appeal has been received by the Claim Administrator or such other time as required or permitted by law.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois

ombudsman program at 1-877-527-9431, or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and a discussion of the decision.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the Independent External Review section below.

If an appeal is not resolved to your satisfaction, you may appeal the Claim Administrator's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the appeal. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

Some of the operations of the Claim Administrator are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

Independent External Review

Standard External Review

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO).

1. Request for external review. Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30,

because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
   a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
   b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
   c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the Exhaustion section below for additional information and exhaustion of the internal appeal process; and
   d. You or your authorized representative have provided all the information and forms required to process an external review.

   You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).
3. Referral to Independent Review Organization. When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an Independent Review Organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

   The IRO must provide the following:
   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
   c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.
   d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or

payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
   1) Your medical records;
   2) The attending health care professional's recommendation;
   3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
   4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
   5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
   6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
   7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:
   1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
   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 Claim Administrator and you or your authorized representative;
   6) A statement that judicial review may be available to you or your authorized representative; 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.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

Request for Expedited External Review.

Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Preliminary review.
Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the Standard External Review section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in Standard External Review section above.

Referral to Independent Review Organization.
Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the Standard External Review section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

Notice of Final External Review Decision.
The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the Standard External Review section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

Exhaustion
For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

<u>Vision</u>

If you ever have a question or problem, your first step is to call the Claim Administrator at 800-877-7195. They will make every effort to assist you.

If you feel the situation has not been addressed to your satisfaction, you may initiate a formal appeal within 180 days of an initial determination through our Member Appeals Department. Appeals may be submitted verbally or in writing to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

You may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial determination. Your written request must state why you think your claim should not have been denied. Your letter must include the name of the Employer, the date of the services for which benefits were denied, the name and social security number of the Employee, the name and date of birth for whom the claim was denied, a copy of the claim, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim. Upon receipt of your letter, you claim will be reviewed. An appeal determination, including specific reasons for the decision, shall be provided to you in writing within 72 hours for urgent care claims; within 30 days for pre-service claims; and within 60 days for post-service claims of the date your request for review is received.

You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

If you disagree with the resolution of this claim, you have the right to a second level appeal. Within 60 days after receipt of the Claim Administrator's final determination, you may submit your appeal along with any further documentation to the address listed above. The Claim Administrator will respond you in writing within 72 hours for urgent care claims; within 15 days for pre-service claims; and within 30 days for post-service claims of the date your request for review is received. This response will include the reasons for the decision and references of Plan provision on which the decision was based.

Dental

If you ever have a question or problem, call the Claim Administrator at the number listed on the back of your ID Card. They will make every effort to assist you.

Your rights if benefits are denied While we always process claims according to the terms of your Employee Benefit Plan, you have the right to appeal our benefits decision up to two times at no cost to you. Please send any request for review in writing within 180 days of the date on this explanation of benefits to: MetLife Group Claims Review P.O. Box 14589, Lexington, KY 40512 In your request for a review, please include: Whether this is your first or second request for a review The reason you believe the claim for benefits was improperly denied Any comments, questions, documents or information that support your reason. We'll review your claim within 30 days of receiving it and send you a clear, understandable explanation by mail or email. If we deny your first appeal in whole or in part, you may request a second-level appeal and we'll respond to that request within a 30-day time period. How we promise a full and fair review The review will be made by someone who didn't make the initial review of your benefits, including anyone who reports to that person. If you're requesting a second review, the reviewer also won't be the person who conducted the first review. You have the right to request free copies of all documents, records and other information we used to evaluate your claim. If deciding an appeal relies at all on a medical judgment, we'll consult a health care professional with appropriate training and experience. If our benefits decision is based on an internal rule, guideline or other standard, you may request a copy of the document free of charge. If we determine that a procedure or treatment was unnecessary or experimental or had a similar exclusion or limit, you may ask us to provide an explanation of the scientific or clinical judgment free of charge. What you can do after two appeals If you're not satisfied with our decision after a second level appeal, you and your plan may have other voluntary alternative dispute resolution options, such as mediation.

Disabled or Retired Public Employees

If you are a public employee and are eligible for continued coverage for accident and health insurance under Sections 367g, 367h and 367j of the Illinois Insurance Code, you may establish and maintain such continued health coverage under this Health Care Plan, if you meet the following conditions:

1. You and your eligible dependents must have been covered under this Health Care Plan on the day immediately preceding the effective date of eligibility for continued health coverage.
2. Once properly established, continued health coverage under this Health Care Plan may be maintained by you or your surviving spouse, until the loss of eligibility as specified in Sections 367g, 367h and 367j of the Insurance Code. It shall be your responsibility to inform the Claim Administrator of the loss of eligibility.
3. If you or your surviving spouse is continuing coverage under this Health Care Plan and becomes eligible for Medicare, the benefits under this Health Care Plan shall be reduced in accordance with the benefit provisions for Medicare Eligible stated in this document.
4. If a timely and valid election of continued health coverage has been made, you must remit the total monthly premium payment required to establish and maintain such coverage, whether such total monthly premium is contributed by you, deducted from a pension payment or paid directly to your Employer by you.

Flexible Spending Account Plan

Community Unit School District 303, (the "Employer") sponsors the Community Unit School District 303 Cafeteria Plan (with Premium Payment, Health FSA, and DCAP Components) (the "Cafeteria Plan") that allows Eligible Employees to choose from a menu of different benefits to suit their needs and to pay for those benefits with pre-tax dollars. Alternatively, Eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

This document describes the basic features of the Cafeteria Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the Cafeteria Plan and is not meant to interpret or change the provisions of your Plan. A copy of your Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time.

Who is Eligible

Any Employee of the employer regularly performing services shall become eligible to participate at the time of open enrollment, effective January 1st following 30 days of employment.

Employee Assistance Program

The Employee Assistance Program (EAP) through Central DuPage Hospital is a free, voluntary and confidential service designed to help you or a member of your immediate family seek solutions to personal problems you can't handle alone. A phone call puts you in touch with a professional counselor who will evaluate your situation and help you work out the best way to handle the problem. While we recognize that not all problems have immediate or apparent solutions, the EAP can assist by providing confidential assessment, short-term counseling and/or referral services.

Who Can Benefit

Problems at home can affect your health, well-being and job performance just as much as job-related problems. You and the people in your household have access to the program.

What Kinds of Problems Can the EAP Handle?

EAP counselors can assist you in addressing many different problems you or your family may encounter. These include:

- Marital/family/relationship issues
- Stress
- Depression/anxiety
- Addiction or substance abuse problems
- Work-related conflicts
- Grief and loss

- Financial problems
- Legal difficulties
- Child care or elder care needs

Where to Go for Help

You can reach a counselor at 888-933-1327. The EAP telephone number is available to you and your family on a 24-hour, 7-day-a-week basis. Once you've made the call, an appointment will be arranged for a convenient time and location. For specific information about counseling locations, call the EAP directly.

Plan Benefits

Listed below are the names, addresses, and phone numbers of the organizations that provide insurance and/or administrative services, including as Contract/Claim Administrators. These services include administering claims and providing customer service

Type of Plan	Policy Number	Type of Funding	Contribution
Medical PPO, CDHP Plan BCBS of IL (Contract/Claims Administrator) 300 E. Randolph Street Chicago, IL 60601 800-828-3116	016201/P22270 016201/PC0390	Self-funded	Employer & Employee Contributions
Medical HMO Plan BCBS of IL 300 E. Randolph Street Chicago, IL 60601 800-892-2803	016201/H22260	Fully-insured	Employer & Employee Contributions
Dental MetLife (Contract/Claims Administrator) 10 LaSalle St , Ste. 3350 Chicago, IL 60603 1-800-638-5000	166506	Self-funded	Employer & Employee Contributions
Vision VSP (Contract/Claims Administrator) 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195	12198663	Self-funded	Employer Contributions
Section 125 Plan (Health Care and Dependent Care FSA) SelectAccount (Contract/Claims Administrator) One Pierce Place, Suite 250C Itasca, IL 60143 800-859-2144	011633	Self-funded	Employee Contributions