PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

FOR

COMMUNITY HIGH SCHOOL DISTRICT 155
MEDICAL REIMBURSEMENT PLAN

October 1, 2011

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INTRODUCTION

This document is a description of the **Community High School District 155 Medical Reimbursement Plan (MRP)** (the "Plan"). No oral interpretations or representations can change this Plan. The Plan described is designed to protect Covered Persons against certain catastrophic health expenses. This booklet contains a summary in English of your rights and benefits under this health care plan. If you have difficulty understanding any part of this booklet, contact the Plan Administrator identified in the General Plan Information section of this booklet.

Nota: *Este libro contiene un sumario en Ingles de sus derechos y beneficios bajo este Plan de salud. Si usted tiene algun problema o no entiende caul quier parte de los beneficios por su lenguaje, o por cual quier razon, por favor de comunicarse con el Administrador del Plan identificado atras de este libro.*

Coverage under the Plan will take effect when all of the eligibility requirements of the Plan have been satisfied.

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

Changes in the Plan may occur in any or all parts of the Plan, including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like. Failure to follow the eligibility or enrollment requirements of the Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, failure to establish Medical Necessity, failure to timely file a claim or lack of coverage. These provisions are explained in summary fashion in this Plan Document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated, even if the expenses were Incurred as a result of an accident, Injury or disease that occurred, began or existed while coverage was in force.

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

This Plan Document summarizes the rights and benefits of Covered Persons and is divided into the following parts:

Eligibility, Funding, Effective Date, Termination and Pre-Existing Condition Limitations – Explains eligibility for coverage under the Plan, funding of the Plan and when coverage takes effect and terminates.

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

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

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

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

COBRA Continuation Options – Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Privacy and Security Information – *THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

Note: *The Plan Administrator may condition enrollment into the Plan or eligibility for benefits on you providing authorization to disclose* ***Protected Health Information (PHI)*** *when the authorization is requested by the Plan prior to your enrollment in the Plan if (1) the authorization sought is for the Plan's eligibility or enrollment determinations relating to you or for the Plan's underwriting or risk rating determinations and (2) the authorization is not for use of disclosure of psychotherapy notes.*

PHI may be accessed by the Plan Administrator, privacy officer, or their designee, and business associates who perform administrative functions on behalf of the Plan, such as, but not limited to, benefit management, claim processing, utilization review, disease management programs, managed care programs, billing, data analysis, legal, actuarial, consulting, accounting or other related services. Business associates will safeguard this information in the same manner as the Plan Administrator.

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Standards") protect medical records and other confidential health information that identifies (or could reasonably be used to identify) an individual, and relate to a past, present or future physical or mental condition of the individual or the provision of health care to an individual, or the payment for the provision of health care to the individual. This individually identifiable health information can be in any form (including electronic, written, or oral) that is created or received by a health plan (or other Covered Entity, as defined in the Privacy Standards) or employer.

1. **Disclosure of Summary Health Information to the Plan Sponsor**

   In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

   "Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. **Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes**

   In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

   a) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

   b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

   c) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

   d) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

   e) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

   f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

   g) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

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

j) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

   (i) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

   Human Resource Manager and Staff member(s) designated by the Human Resources Manager.

   (ii) The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

   (iii) In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

6. HIPAA Security Standards

The Plan shall comply with the HIPAA Security rules (45 C.F.R. parts 160, 162 and 164) as they apply to electronic protected health information. The Plan Administrator shall implement administrative, physical, and technical safeguards that reasonably protect the confidentiality, integrity, and availability of EPHI that is created, received, maintained or transmitted by or on behalf of the Plan. The Plan shall ensure that any independent contractor, agent or subcontractor with which the Plan enters into services agreements that involve EPHI shall implement reasonable and appropriate safeguards to protect such information. Any security incident (as defined in 45 CFR Section 164.304) relating to EPHI of which the Plan Administrator becomes aware shall be reported to the Plan and appropriate action shall be taken in conformance with applicable regulations.

ELIGIBILITY, FUNDING, EFFECTIVE DATE, TERMINATION PROVISIONS

ELIGIBLE CLASS

An employee's legal spouse or recognized partner under the Illinois Civil Union Act who is employed and eligible for health insurance coverage under his/her employer's group health insurance, unless Community High School District 155 believes it is in the best interest to cover them under Community High School District 155's health plan.

ENROLLMENT

Enrollment Requirements – An Employee spouse or recognized partner must enroll for coverage by filling out and signing an enrollment application.

EFFECTIVE DATE

Effective Date of Employee Coverage – An Employee's covered spouse or recognized partner will be covered under this Plan as of the **first** day of the calendar month following the date that the Employee satisfied all of the Enrollment requirements.

FUNDING

COST OF THE PLAN

Community High School District 155 pays the full cost of this Medical Reimbursement Plan (MPP).

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TERMINATION PROVISIONS

When Coverage Terminates – Coverage will terminate when the Employee's Spouse or recognized partner is no longer employed or eligible for coverage under their employer's plan, unless Community High School District 155 believes it is in the best interest to cover them under Community High School District 155's health plan.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT AMOUNT	UNLIMITED	

This MRP plan will reimburse the covered person 100% of the difference between what the covered person's primary plan paid and what Community High School District 155's health plan would have paid for in-network PPO deductible, coinsurance and co-pays if it was the primary coverage. If no payment would have been made by Community High School District 155's health plan as the primary payor and the primary plan does pay, then no reimbursement is due under this MRP plan. The MRP plan will reimburse employees any greater amount their spouse or recognized partner has to pay for his/her coverage versus the cost of covering their spouse or recognized partner under Community High School District 155's health plan."

DEFINED TERMS

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

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

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

Covered Person means the Spouse of an Employee who is employed and eligible for coverage under their employer's plan. Covered person shall include partners of Employees who are recognized under the Illinois Civil Union Act.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual insurance policy, Medicaid, Medicare, and a State Children's Health Insurance Program (SCHIP). Creditable Coverage also includes coverage under a public health plan of a State, city, county or other government subdivision, or of the U.S. or of any foreign country. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Employer means **Community High School District 155.**

Enrollment Date means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Maximum Lifetime Benefit means the total amount of money this Plan will pay in a Covered Person's Lifetime.

Plan means **Community High School District 155 Medical Reimbursement Plan (MRP)**, which is a benefit plan and is described in this Plan Document.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year that is a short Plan Year.

Qualified Medical Child Support Orders are a judgment or decree by a court of "competent jurisdiction" that requires a group health plan to provide coverage to the dependent children of a Covered Employee pursuant to a state domestic relations law, or an administrative order in the form of a National Medical Child Support Order issued by a State agency. A person who is an alternate recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan for purposes of the Act. "Alternate Recipient" means any child of a Covered Employee who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. A Covered Employee may obtain without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

Women's Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy (including lymphedema).

HOW TO SUBMIT A CLAIM AND CLAIM APPEAL PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan. "Health benefits" includes *medical and prescription drug claims.*

When a Covered Person has a claim to submit for payment, that person must:

1. Obtain a claim form from the Personnel Office or the Plan Administrator.
2. Complete the Employee portion of the form. ***All questions must be answered.***
3. Have the Physician or Dentist complete the provider's portion of the form.
4. For Plan reimbursements, attach bills for services rendered. ***All bills must show the following information:***
   a) Name of Plan;
   b) Employee's name;
   c) Name of patient;
   d) Name, address, telephone number of the provider of care;
   e) Diagnosis;
   f) Type of services rendered, with diagnosis and/or procedure codes;
   g) Date of services; and
   h) Charges.
5. Send the above to the Claims Administrator at this address:

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
847-519-1880

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are *four* types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Pre-service Claims:

A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his or her life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims:

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims:

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Claims Administrator by July 1st of the following calendar year of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;

5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

TIMING OF CLAIM DECISIONS

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the claimant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant

submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

- **Notification of an Adverse Benefit Determination**

The Plan Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;

2. Specific reason(s) for a denial;

3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

5. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

6. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);

7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and

8. In a claim involving Urgent Care, a description of the Plan's expedited review process.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

- **Full and Fair Review of All Claims**

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;

2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits in the possession of the Plan Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and

8. In an Urgent Care Claim, for an expedited review process pursuant to which:

   A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

FIRST APPEAL LEVEL

- **Requirements for First Appeal**

The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, the claimant may telephone 847-519-1880 and ask for the Claim Manager. To file an appeal in writing, the claimant's appeal must be addressed as follows and faxed to the following number:

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
Attention: Claim Manager
Phone: 847-519-1880
Fax: 847-519-1979

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/claimant;
2. The Employee/claimant's identification number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

- **Timing of Notification of Benefit Determination on First Appeal**

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

Calculating Time Periods: The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

- **Manner and Content of Notification of Adverse Benefit Determination on First Appeal**

The Plan Administrator shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
7. A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information regarding any such procedures;
8. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
9. A description of the Plan's review procedures and the time limits applicable to the procedures;
10. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims and;
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

- **Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

SECOND APPEAL LEVEL

- **Adverse Decision on First Appeal; Requirements for Second Appeal**

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

- **Timing of Notification of Benefit Determination on Second Appeal**

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.

Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

Calculating Time Periods: The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

- **Manner and Content of Notification of Adverse Benefit Determination on Second Appeal**

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; (ii) a description of the Plan's review procedures and the time limits applicable to the procedures; and (iii) for Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

- **Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide the Covered Person such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

- **Decision on Second Appeal to be Plan Administrator's Final Decision**

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied.

External Review Procedure Under Patient Protection and Affordable Care Act (PPACA)

If the health plan is NOT a grandfathered plan and the claim is denied in whole or in part because the information provided does not meet the Plan requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or because the treatment is experimental the Covered Person may have a right to a review by an Independent Review Organization (IRO). The

Covered Person may also request an IRO review if the Plan retroactively rescinds coverage back to his or her enrollment date for a reason other than the person not being eligible for coverage under Plan rules. The Covered Person must first exhaust the Plan's internal appeal requirements. The IRO review request must be in writing and filed within 4 months of receiving a final denial of an internal Plan appeal.

The Plan will have 5 business days after receiving the written request to review the claim and verify the Covered Person is eligible for an IRO review. The Plan will verify whether (a) the person was an eligible Covered Person at the time the claim was incurred; (b) the Plan's internal appeal requirements have been exhausted; and (c) all of the information and forms required to process an external IRO review have been provided.

Within 1 business day after completing its review the Plan will send the Covered Person written notice of eligibility for an IRO review. If the Plan's notice asks for additional information it must be provided within the original 4-month IRO review request period. If the original 4-month IRO review request period ended, the Covered Person must provide the information within 48 hours of receipt of the Plan's notice.

If the Covered Person is eligible for an IRO review, the Plan will assign one of three unrelated IROs to review the claim. The IRO will conduct its review independently under the requirements of the U.S. Department of Labor Technical Release 2011-02. If the Covered Person receives communications from the IRO during the review, he or she is responsible for responding to the IRO in the time period set by the IRO. The IRO will issue its decision to the Covered Person within 45 days after receiving an eligible request for external review. The IRO determination will be final and binding on the Plan and the Covered Person. However, there may be additional state or federal remedies available.

Special rules apply under an expedited IRO. The covered Person may request an expedited IRO where any delay in issuing a benefit determination would seriously jeopardize the Covered Person's life, health or ability to regain maximum function, or the claim involved emergency treatment and the Covered Person has not yet been released from the treating facility. On receipt of a request for an expedited IRO, the Covered Person will be notified immediately whether the request is complete and eligible for external review. If the request is eligible for an expedited external review it will be referred to an IRO by the quickest means available. The IRO will assume responsibility for completed the review as soon as possible but no later than 72 hours after the IRO receives a complete review request.

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

- **Appointment of Authorized Representative**

The Employee or Covered Person is permitted to appoint an Authorized Representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a medical provider will not constitute appointment of that provider as an Authorized Representative. To appoint such a representative, the Employee or Covered Person must complete a form which can be obtained from the Claims Administrator. However, in connection with Pre-Service Urgent Care claims only, the Plan will permit a health care professional with knowledge of the claimant's medical condition to act as the Authorized Representative without completion of this form. In the event a claimant designates an Authorized Representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Claim Administrator, in writing, to the contrary.

ASSIGNMENT

As a courtesy, the Plan Administrator will permit benefits for medical expenses covered under this Plan to be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid.

No Covered Person shall at any time, either during the time in which he is covered under the Plan, or following his termination as a Covered Person, in any manner, have any right to assign his right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he may have against the Plan or its fiduciaries.

COBRA CONTINUATION OPTIONS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

As a participant in the **School District 155 Medical Reimbursement Plan (MRP)**(the Plan) you are entitled to certain rights and protections. This Plan Section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you or they would otherwise lose Plan coverage. You, your enrolled spouse or enrolled dependents will be required to pay for COBRA continuation coverage. This information is included as part of the Summary Plan Description/Plan document. For additional information, you should contact the Plan Administrator.

The Plan Administrator is **Community High School District 155, One South Virginia Road, Crystal Lake, IL 60014 815-455-8505.** COBRA continuation coverage for the Plan is administered by a COBRA Administrator designated by the Plan Administrator. The name of the COBRA Administrator can be found in the General Information Section at the end of this Plan Document/Summary Plan Description.

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. COBRA continuation coverage must be offered to each person who is listed as a “qualified beneficiary.” A qualified beneficiary is an enrolled individual (you, your spouse, and your dependent child) who will lose coverage under the Plan because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (the full cost means the employee and employer cost of 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:

1. Your hours of employment are reduced, or
2. 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:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
5. 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 happens:

1. The parent-employee dies;
2. The parent-employee’s hours of employment are reduced;

3. The parent-employee's employment ends for any reason other then his or her gross misconduct;

4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event, but only if the Plan offers retiree coverage. If a proceeding in bankruptcy is filed with respect to the Plan Administrator, and that bankruptcy results in the loss of retiree coverage, if available under the Plan, the Retired Employee becomes a qualified beneficiary with respect to the bankruptcy. The covered spouse and covered dependent children of the covered retiree also will be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA 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, or entitlement of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

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. The Plan requires you to notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You or your spouse must send this written notice to: Community High School District 155 One South Virginia Road, Crystal Lake, IL 60014 815-455-8505. Your written notice should include the date of the qualifying event. If you or your spouse are notifying the Plan Administrator of a divorce or legal separation, you or your spouse should provide a copy of the legal separation papers or divorce decree. If you fail to give written notice within the 60-day time period, the spouse and/or dependent child will lose the right to elect COBRA continuation.

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 has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA on behalf of their covered spouses, and parents may elect COBRA on behalf of their covered children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, entitlement of the employee to Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage can last 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 entitled 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 equals 28 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 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 at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in writing in a timely manner, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This written notice should be sent to: Community High School District 155 One South Virginia Road, Crystal Lake, IL 60014 815-455-8505. You should include a copy of the Social Security Administration's letter which gives the effective date of the disability.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your COBRA covered family members experience another COBRA qualifying event within the first 18 months of COBRA continuation, COBRA continuation coverage for up to an additional 18 months is available. The total months of COBRA coverage, including the COBRA extension, cannot exceed a maximum of 36 months from the original COBRA qualifying event. A COBRA extension is available to the spouse and dependent children if the former employee dies, or is divorced or legally separated. The COBRA extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In certain limited instances, the extension may be available if the former employee becomes Medicare entitled after loss of coverage due to termination of employment or reduction in hours. **In all cases, the 18-month extension occurs only if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event never occurred.**

The following example shows how the second qualifying event rule works. Former employee A elects 18 months of COBRA continuation for the entire family. After the first six months of COBRA continuation, former employee A becomes entitled to Medicare (Part A, Part B, or both). If former employee A were still actively employed, entitlement to Medicare would **not** result in a loss of coverage under the Employer's health plan. The additional 18-month extension is not available for the former employee's spouse and dependents, because if Medicare entitlement had occurred during active employment there would have been no loss of employer health plan coverage.

In all of these cases, you must make sure that the Plan Administrator is notified within 60 days of the second qualifying event. This notice must be sent to: Community High School District 155 One South Virginia Road, Crystal Lake, IL 60014 815-455-8505.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation will end early if the employer's group health plan terminates and the employer does not provide replacement medical coverage. COBRA continuation will also end on the first to occur of the following events.

- The qualified beneficiary first becomes covered under another group health plan after the date of the COBRA election, unless the new group coverage is limited due to a Pre-Existing Condition exclusion. COBRA continuation will be primary for the Pre-Existing Condition and secondary for all other eligible health care expenses, only if contributions for COBRA coverage continue to be paid. COBRA coverage may continue only for the remainder of the COBRA period.

- The qualified beneficiary fails to make required contributions when due.

- The qualified beneficiary becomes entitled to Medicare Part A or Part B (or both) after electing COBRA continuation coverage.

- The qualified beneficiary is extending the 18-month coverage because of Social Security disability and is no longer disabled under the COBRA Disability Extension rules described above. In this case the qualified beneficiary is required to notify the Plan Administrator of the loss of Social Security disability status within 30 days of receipt of notice from the Social Security Administration.

IMPORTANT INFORMATION WHEN CONSIDERING A COBRA COVERAGE ELECTION

When considering whether to elect COBRA continuation, the eligible person should understand that a failure to elect COBRA will affect future rights under federal law. First, failure to elect COBRA, or failure to give notice of a COBRA event to the Plan Administrator within 60 days, can result in loss of the right to avoid having Pre-Existing Condition exclusions applied by other group health plans where there is a 63-day health coverage gap. Election of COBRA continuation may help to avoid a 63-day gap in health coverage.

Second, in order to qualify for individual health insurance policies sold by insurance companies that do not have Pre-Existing Condition exclusion provisions, a person has to exhaust the maximum COBRA continuation period. Failure to elect COBRA, or to give the Plan Administrator notice within 60 days of a COBRA event, can make it difficult to purchase an individual insurance policy if the person does not have other group health coverage.

Finally, the federal law provides certain special enrollment rights when a COBRA-covered person becomes eligible for another group health plan (such as a plan sponsored by a spouse's employer, or the plan of a new employer). Coverage can be elected under the other group health plan within the first 30 days of eligibility.

COST OF COBRA CONTINUATION COVERAGE

The COBRA beneficiary must pay the entire cost of health coverage (the employer's contribution portion and the active employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation.

If COBRA benefits are extended under the COBRA SSA Disability Extension Rules described above, the cost of COBRA is 102% for the first 18 months, and 150% from the 19th through the 29th month of coverage.

The Trade Act of 2002 created a new tax credit for certain employees who become eligible for trade adjustment assistance due to loss of their jobs because of trade-related reasons. Under the Trade Act, eligible individuals can either take a tax credit or receive advance payment of 65% of premiums for qualified health insurance, including COBRA provided the individual is eligible for COBRA. If you have questions about the Trade Act, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282; TTD/TTY callers may call toll-free at 1-866-626-4282.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

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.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

School District 155 Medical Reimbursement Plan (MRP) is the benefit plan of **School District 155**, the Plan Sponsor. An individual may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to: a) construe and interpret the terms and provisions of the Plan; b) to make determinations regarding issues which related to eligibility for benefits; c) to decide disputes which may arise relative to a Covered Person's rights; and d) to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

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

Plan Administrator Compensation – The Plan Administrator serves without compensation; however all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary – A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties – A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties that must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the Plan (if any) so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.

The Named Fiduciary – A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These

other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either.

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator is not a Fiduciary – A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded by **Community High School District 155.**

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

If, due to a clerical error, an overpayment occurs in the Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination.

The Plan Sponsor intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part, in its sole discretion. This includes amending the benefits under the Plan or the Trust agreement (if any).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

COMPLIANCE WITH APPLICABLE LAWS

The Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under

this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

FRAUD

The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;

2. Attempting to file a claim for a Covered Person for services which were not rendered or Prescription Drugs or other items which were not provided; or

3. Providing false or misleading information to the Plan.

LIMITATIONS ON LEGAL ACTIONS

All claims review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of benefits or for a fiduciary's breach of duty must be commenced within one year after the Plan's claim review procedures have been exhausted.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded health plan and the administration is provided through a third party claims administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME **Community High District 155 Medical Reimbursement Plan (MRP)**

TAX ID NUMBER 36-6005124

PLAN EFFECTIVE DATE January 1st

PLAN YEAR ENDS December 31st

EMPLOYER INFORMATION

Community High School District 155
One South Virginia Road
Crystal Lake, IL 60014
815-455-8505

AGENT FOR SERVICE OF LEGAL PROCESS

Community High School District 155
One South Virginia Road
Crystal Lake, IL 60014
815-455-8505

PLAN ADMINISTRATOR

Community High School District 155
One South Virginia Road
Crystal Lake, IL 60014
815-455-8505

CLAIMS ADMINISTRATOR

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
847-519-1880
www.groupadministrators.com

NAMED FIDUCIARY

Community High School District 155
One South Virginia Road
Crystal Lake, IL 60014
815-455-8505

COBRA ADMINISTRATOR

Benefit Advantage
3431 Commodity Lane
Green bay, WI 54304
920-339-0351

The Plan Sponsor hereby adopts this Plan Document as the written description of the Plan.

IN WITNESS WHEREOF, this instrument is executed for **School District 155** on or as of the day and year first being written.

By: _____
Community High School District 155

Date: _____

Witness: _____

Date: _____