

**Lincolnway Area Affiliation of Participating School
Districts dba Illinois School Insurance Network
Summary Plan Description***

**This document, together with the Certificate(s) and SPD Booklet(s) for the Benefit Program(s) in which you are enrolled, constitutes your Summary Plan Description for the Lincolnway Area Affiliation of Participating School Districts dba Illinois School Insurance Network.*

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Introduction

The **Lincolnway Area Affiliation of Participating School Districts dba Illinois School Insurance Network** (“Plan”) sponsored by Lincolnway Area Affiliation of Participating School Districts dba Illinois School Insurance Network C/O Marsh & McLennan Agency, LLC (“Plan”) is designed to help you and your covered family members by offering the types of coverage listed below. The Plan provides benefits to employees of employers who have agreed to aggregate for purposes of offering such benefits (the “Participating Employers”). The various types of coverages available under the Plan are referred to in this Summary Plan Description (“SPD”) as “Benefit Programs.”

Summary Plan Description

This SPD contains key administrative information about the Plan and Benefit Programs as in effect on January 1, 2026. If you have any questions about the information in this SPD, contact the Plan Administrator, whose contact information appears in the “**Administrative Information**” section.

This SPD supplements each certificate of insurance (or evidence of coverage) produced by the Insurer (the “Certificates”) and each summary plan description booklet (“SPD Booklet”) provided by the Plan for each Benefit Program, and the current annual enrollment materials—***together, these documents constitute your SPD for the Plan.*** This SPD provides details about the administration of the Plan and your rights under applicable laws. Please read the SPD carefully and keep it with other information about your Plan welfare benefits. In the event that there is a conflict between this SPD and the underlying Certificate, SPD Booklet or annual enrollment materials, the underlying Certificate, SPD Booklet or annual enrollment materials will control.

Certain Illinois insurance mandates apply to insurance policies and managed care plans regulated by the Illinois Department of Insurance. To the extent any such mandate applies to Certificate or SPD Booklet incorporated into this Plan or is otherwise applicable to the Plan by law, benefits will be administered in accordance with applicable law and the applicable Certificate or SPD Booklet(s). To the extent a mandate does not apply to a self-funded benefit, the Plan may nevertheless adopt comparable provisions by Plan amendment or administrative practice as determined by the Administrator.

Benefit Programs

You may not be eligible for all of the Benefit Programs available under the Plan -- eligibility for a particular Benefit Program may depend on certain factors, such as where you live. The Benefit Programs which may be available to you under the Plan include:

- Medical Program
- Dental Program
- Vision Program
- Employee Assistance Program

- Life Insurance Program
- Accidental Death and Dismemberment Program
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance

Keep in mind that you and your doctor always make the final decision regarding your healthcare and treatment. This Plan only determines whether benefits will be paid by the Plan, not whether care or treatment is appropriate for you or your dependents.

The dental and vision Benefit Programs use provider networks. Therefore, a provider listing will be furnished to you, without charge. For information regarding the provider network(s) for a particular Benefit Program, refer to the applicable Certificate or SPD Booklet and/or contact the Insurer or Plan Administrator, whose contact information appears in the “**Administrative Information**” section.

The Benefit Programs

Complete details about each of the Benefit Programs, such as eligibility, coverage details and schedules, claims and appeals procedures, etc., can be found in the Certificates, SPD Booklets, and the annual enrollment materials.

If you have any questions about a Certificate, SPD Booklet or the Benefit Program in which you are enrolled, you should contact the applicable Insurer or the Plan Administrator, whose contact information appears in the “**Administrative Information**” section and in the applicable Certificate or SPD Booklet.

Amendment or termination of the Plan

The Plan reserves the right to amend or terminate the Plan or any Benefit Program available under the Plan at any time. Refer to the “**Administrative Information**” section for more information.

Who Is Eligible

You

Please refer to the applicable Certificate or SPD Booklet for specific eligibility requirements, enrollment requirements (including deadlines) and entry dates that apply for each Benefit Program under the Plan. Generally, coverage is extended to full-time employees working or expected to work more than 20 hours per week, although specific eligibility criteria may vary by Participating Employer.

Your eligible dependents

Eligible dependents are described in detail in the applicable Certificates and SPD Booklets. Generally, eligible dependents includes:

- Your spouse (including a same-sex spouse who is considered your spouse for Federal tax purposes pursuant to applicable Internal Revenue Service guidance).
- Your domestic partner or civil union partner (as recognized under applicable state law).
- Your (or your spouse's/civil union partner's) dependent children until they turn age 26. Your eligible children include your natural children, legally adopted children or children who are placed with you for adoption, stepchild, foster child, and children who reside in your household under your legal guardianship.
- Your unmarried incapacitated dependent children (refer to the applicable Certificate or SPD Booklet for details).
- Your dependents eligible under the applicable Certificates and SPD Booklets or required by law.
- In addition, a court order could require you as a parent to provide for your child's group health plan coverage. If this is the case and the court order is determined by the Plan Administrator to satisfy all applicable legal requirements (and is therefore a *qualified medical child support order*, or "QMCSO"), the Plan will offer coverage to the extent required by law and under the Plan. To obtain a copy of the Plan's QMCSO procedures, free of charge, contact the Plan Administrator whose contact information appears in the "**Administrative Information**" section.
- For avoidance of doubt, parents and stepparents are not eligible dependents under the Plan unless expressly provided in the applicable Certificate or SPD Booklet, required by law for a particular insured Benefit Program, or adopted by written Plan amendment.

You may be required to provide proof of your dependent's eligibility from time to time and your dependent will not be considered eligible for coverage unless and until satisfactory proof of such eligibility is submitted to the Plan Administrator or the Insurer. The Plan Administrator reserves the right (in its sole discretion) to establish rules regarding the time, form, and manner in which

such proof must be submitted. Failure to submit the required proof according to those rules may result in ineligibility. If you attempt to intentionally or fraudulently misrepresent your dependent's eligibility, the Plan (and the Insurer) reserve the right to retroactively rescind your coverage and to seek to recoup any benefits that you (or your dependents) received.

Taxation of Civil Union Partner Coverage

The cost of a Plan subsidy (if any) associated with providing benefits to a civil union partner, where the civil union partner is not your dependent for purposes of Section 152 of the Code, as modified by Code Section 105(b), shall be treated for withholding purposes as taxable compensation to you. You should speak with your tax advisor or legal counsel if you have questions regarding the tax implications of coverage for your civil union partner.

Enrollment and Cost of Coverage

When you are first hired, and each year before the annual enrollment period, you will receive information about enrolling for benefits.

New employee

To elect coverage as a new employee:

- Review the new hire enrollment information you receive carefully. Be sure to note the deadline for making your enrollment elections.
- Decide whom you want to cover under the elective Benefit Programs of the Plan.
- Timely complete the Plan's enrollment form (and any other forms required by the Insurer(s)).

If you don't complete an election form within the timeframe established by your Participating Employer after you are first eligible that failure will constitute an election not to participate in the elective Benefit Programs and an election to receive your full compensation in cash, except that the Plan Administrator reserves the right to select a default enrollment option and deem you have elected coverage in that default option.

You generally may not change your coverage elections until the next annual enrollment period unless you experience an event described in the “**Changing Your Coverage Elections**” section.

Annual enrollment

You may change your coverage elections once each year during the annual enrollment period. Information about the Benefit Program options available to you will be provided to you during annual enrollment period.

Your failure to make an election during annual enrollment will constitute (i) a re-election of the same Benefit Program benefits and coverage, if any, immediately before the end of the preceding plan year; except for any default enrollment option as communicated in your annual open enrollment materials.

Mid-year enrollment

If you previously declined coverage because you were covered under another health plan and you then lose that coverage, special enrollment rules may apply. See the “**Special Enrollment Rules**” section below for more information.

Cost of coverage and cost sharing—*Elective Benefit Programs*

The Plan pays a portion of your elective coverages. You pay your portion of the cost through payroll deductions. Your costs for elective coverage are based on the Plan option and coverage level you select. Your contributions are generally deducted from your pay on a pre-tax basis. Information regarding the applicable benefits, pricing, and whether the benefit premiums are payable on a pre-tax or after-tax basis will be available during the annual enrollment period.

The elective Benefit Program options contain certain cost sharing features, such as deductibles and co-payments. These are the responsibility of the Plan participant or dependent, and are described in detail in the Certificates and SPD Booklets.

Cost of coverage and cost sharing—*Non-Elective Benefit Programs*

The Plan pays the cost of your non-elective insurance coverages.

Changing Your Coverage Elections

The circumstances under which you may change your Benefit Program coverage elections during the year are described below. If none of these circumstances apply, you may not change your coverage elections during the year. In order to make a mid-year change to your coverage elections, you must meet the requirements of the Plan and of the applicable Benefit Program, as described in the Certificate for that Benefit Program.

Changing your coverage

Under certain circumstances, you may enroll in coverage, add or remove dependents, or change coverage that is paid for on a pre-tax basis during the year. For example, you may make a prospective change to your coverage (and/or the coverage of your dependents, if applicable), if:

- You experience a “change in status” (as described below) that affects your or your dependents’ eligibility for a Benefit Program;
- You qualify for a special enrollment during the year (as described below);
- The Plan Administrator or Insurer receives a QMCSO or other court order, judgment or decree requiring you to enroll a dependent child;
- You, your spouse, or your dependent becomes entitled to or loses Medicare or Medicaid coverage;
- You, your spouse, or your dependent experiences a significant, unexpected and unforeseen increase (or decrease) in the cost of coverage;
- You, your spouse, or your dependent child experience a significant reduction in coverage or a total loss of coverage;
- The Plan adds a benefit package option or significantly improves coverage under an existing option;
- You experience a reduction in hours from more than 30 hours per week, on average, to less than 30 hours per week, on average, followed by enrollment in Health Insurance Marketplace coverage or other qualifying coverage no later than the start of the second full month following the reduction;*
- You qualify for annual or special enrollment in Health Insurance Marketplace coverage, with Marketplace coverage to begin no later than the day following the termination of your coverage under this Plan; and*
- Any other event recognized for purpose of changing Plan elections under applicable law and regulation, in the sole discretion of the Plan Administrator.

*These events only permit election changes to your medical coverage election.

Coverage election changes must be consistent with the event and generally must be made within 30 days of the event, or within such other timeframe provided in the applicable Certificate. The Plan Administrator will determine, in its sole discretion, if an event has occurred that permits a change under these rules.

Change in status

You may change certain coverage elections under the Plan during the year if you experience a change in status. Depending on the event that you experience, you may change your coverage elections. You also may change your pre-tax salary reduction amount, and you may be able to add or remove dependents from coverage. Changes in status include:

- You get married, divorced, or legally separated or you have your marriage annulled;
- Your spouse or dependent dies;
- Your dependent becomes eligible for coverage or ineligible for coverage (e.g., he or she reaches the eligibility age limit);
- You or your spouse has a baby, you adopt or you have a child placed with you for adoption;
- You, your spouse, or your dependents experience a change in employment status that leads to a loss of or gain in eligibility for coverage; or
- Your home residence changes and your previous coverage is no longer available or new coverage options become available.

Regardless of what type of change in status you have, any coverage election change you make under the Plan must be because of and consistent with the change in status. The Plan Administrator will determine (in its sole discretion) whether a particular event constitutes a change in status. The change must also be permitted by the Insurer, if applicable. If you experience a change in status or any other event described in this section, you must notify the Plan Administrator within 30 days after the event, or within such other timeframe provided in the applicable Certificate, to change your Benefit Program coverage election. In addition, you may be required to provide proof of your change in status or the other event. If you do not, you cannot change your coverage until the next annual enrollment period, unless you once again experience a change in status.

Effective date of coverage change

Except as otherwise provided in the applicable Certificate (and except for a change in status based on birth, adoption, or placement for adoption), your coverage change will generally be effective on the date you timely file a completed election form with the Plan Administrator or Insurer. For birth, adoption, or placement for adoption, your change will be effective as of the date of birth, adoption, or placement for adoption provided you enroll your child within 30 days of the event date, or within such other timeframe specified in the applicable Certificate.

Special enrollment rules

If you decline enrollment in the Plan for yourself or your dependents because of other health coverage and you later lose that other coverage or the employer providing other coverage stops making contributions, you may be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends, or within such other timeframe provided in the applicable Certificate.

Your loss of other health coverage qualifies for special enrollment treatment only if you satisfy both of the following conditions:

- You (or your dependents) were covered under another group health plan or health insurance coverage when coverage under the Plan was originally offered to you; and
- You (or your dependents) lost your other coverage either because you exhausted your rights under COBRA continuation coverage or you were no longer eligible under that plan.

If you gain a dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependent(s), provided that you request enrollment within 30 days after the event, or within such other timeframe provided in the applicable Certificate.

If you and/or your dependents are eligible for health coverage under the Plan but do not elect such coverage during a regular enrollment period, and either:

- Your and/or your dependent's Medicaid or State Children's Health Insurance Program ("CHIP") coverage is terminated due to a loss of eligibility; or
- You and/or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP,

then you may enroll yourself and/or your dependents in health care coverage under the Plan, provided you request enrollment within 60 days after the occurrence of either of these events.

Coverage under the Plan will become effective on the date of the birth, adoption, or placement for adoption. For all other events, except as otherwise provided in the applicable Certificate, coverage under the Plan will become effective on the first day of the calendar month following the date the enrollment request is timely received by the Plan Administrator.

Circumstances Which May Affect Benefits

Your and your dependents' eligibility for Plan benefits will terminate upon the occurrence of any of the events described under “**When coverage ends**,” section below, or described in the applicable Certificate or SPD Booklet.

Other circumstances may result in the termination, reduction, loss, offset, or denial of benefits including, but not limited to, exclusions for certain medical procedures, limitations on coverage for new drugs, and rights of recovery of benefits paid by a particular Benefit Program (for example, the Benefit Program's rights of reimbursement and/or subrogation). Benefits under a particular Benefit Program may also be subject to coordination of benefits if you have coverage under another plan.

Refer to the applicable Certificate or SPD Booklet for specific information regarding the circumstances which may affect your benefits under the particular Benefit Program.

Preexisting conditions

Some of the Benefit Programs include limitations on preexisting limitations. Notwithstanding the foregoing, no “group health plan” (as that term is defined under the Affordable Care Act) will impose a pre-existing condition exclusion. *Refer to the applicable Certificate or SPD Booklet for information about that Benefit Program's preexisting condition rules and how they apply to your coverage.*

When coverage ends

Your coverage generally ends when:

- your employment with a Participating Employer ends;
- you no longer meet the eligibility rules of the Plan or a Benefit Program;
- the Plan or Benefit Program terminates;
- you stop making any required contributions;
- you commit fraud against the Plan;
- you fail to repay overpayments, amounts subject to reimbursement under any Benefit Program, or mistaken payments from a Benefit Program within 90 days after the Plan Administrator requests repayment or according to a repayment schedule approved by the Plan Administrator; or
- you go on strike or are locked out to the extent not prohibited by the applicable collective bargaining agreement.

Except where otherwise provided in the applicable Certificate or SPD Booklet, in the event that coverage terminates upon one of the events identified above, such termination will be effective at

the end of the month in which such event occurs. Notwithstanding the foregoing, for purposes of the medical Benefit Program, dependent coverage will continue through the last day of the month in which the dependent turns 26.

Your dependent's coverage ends on the date your coverage ends, or on the last day of the month in which your dependent no longer meets the Plan's definition of an eligible dependent.

Refer to the applicable Certificate or SPD Booklet for information about when coverage under a particular Benefit Program ends. (The Certificates and SPD Booklets also contain information about converting to an individual policy when your coverage under the group program ends, if applicable.)

Rights Under Federal Law

Your rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a normal vaginal delivery; or
- 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. *For more information and coverage details, refer to the applicable medical Certificate or SPD Booklet.*

Your rights under the Women's Health and Cancer Rights Act of 1998

The Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, and the complications resulting from a mastectomy (including lymphedema). These benefits include reconstruction and surgery to achieve breast symmetry, and prostheses. *For more information and coverage details, refer to the applicable medical Certificate or SPD Booklet.*

Military leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your health coverage for up to 24 months as long as you give the Plan advance notice (with certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from the Employer, does not exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (including both the Plan and your contributions) necessary to cover a similarly-situated employee who does not go on military leave.

If you are on military leave for less than 18 months and you do not return to work at the end of your leave or you do not elect to continue coverage during your leave, you may be entitled to purchase COBRA continuation coverage for the remaining months, up to a total of 18 months from the commencement of the military leave. Refer to page 24 for information about COBRA continuation coverage.

HIPAA Privacy

As a participant in the Plan, your “protected health information” is subject to safeguard under the privacy provisions of the Health Insurance Portability and Accountability Act (“HIPAA”). As a Benefit Program participant, you will receive or have received a “privacy notice” that describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a copy of this notice, you should contact your Insurer or the Plan Administrator.

Children’s Health Insurance Program (CHIP) Notice

If you or your children are eligible for Medicaid or the Children’s Health Insurance Program (“CHIP”) but are unable to afford the premiums, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs but who also have access to health insurance through their employer. If you or your children are NOT eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, or if you think you might be eligible for Medicaid or CHIP, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS-NOW (543-7669)**, or go to **www.insurekidsnow.gov** to find out if premium assistance is available. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Mental Health Parity

The Plan may not, under federal law, impose any limits or restrictions on mental health coverage that are less favorable than the other hospital/medical/surgical coverages.

Continuation of Coverage During FMLA Leave

For any Participating Employer-approved leave of absence, paid or unpaid, you may continue the same benefits that you were receiving immediately before the start of your leave, if permitted under the applicable insurance policies and appropriate payment arrangements are made for unpaid leaves. If your leave qualifies under the Family and Medical Leave Act of 1993, as amended (“FMLA”), you will be entitled to receive the same medical, vision and dental Benefit Program benefits that you were receiving immediately before the start of your FMLA leave. The Plan also intends to allow you to continue to receive all other Plan benefits during your FMLA leave, to the extent possible. For a leave of absence that does not qualify for the FMLA, you may continue to participate in the Benefit Programs you elected, if permitted in the applicable Certificate or SPD Booklet, provided you make the appropriate Benefit Contributions.

- If you do not wish to receive some or all of the coverage during your leave that you were receiving just prior to your leave, you must inform the Plan before the start of your leave. Benefits under the Plan will terminate at the end of the month when you start your leave of absence.

- If you wish to continue your participation in the Plan, and you are currently required to contribute a certain amount for your coverage, you must make arrangements with your Local HR Department to pay for the coverage you wish to maintain during the course of your leave. If your leave is a paid leave, you may continue making contributions during your leave. If your leave is unpaid, you can pay your benefit contributions before you go on leave, during your leave by sending a check to the Participant Employer or when you return to work.
- Your eligibility to continue any coverage that requires payments from you may be cancelled if you do not make the required payments in a timely fashion.
- If the Participating Employer advances money by making contributions for you during your leave, in whole or in part, it can recoup the amounts advanced to you upon the end of your leave, whether or not you return to employment following your leave. If you return to employment following your leave, the Plan may recoup those amounts through payroll deductions. If you do not return from a leave of absence, you are responsible for reimbursing the Plan for the entire cost to the Plan (i.e., the Participating Employer's contribution) for providing any benefits under this Plan during your leave, unless the leave was an FMLA qualified leave of absence, and you do not return due to the continuation of a serious health condition or circumstances beyond your control.

If you are on an approved disability leave from your Participating Employer, you may continue the same benefits that you were receiving immediately before the start of your leave if permitted by the applicable Certificate or SPD Booklet. Your Benefit Contributions will be automatically deducted from your paycheck.

For additional information about FMLA leaves, contact your Local HR Department.

Filing a Claim for Benefits Under the Plan

Even though it does not happen often, occasionally disagreements about benefit eligibility or amounts arise. In most cases, they are resolved quickly. However, if you are unable to resolve the disagreement, formal appeals processes are in place to help you (or your authorized representative acting on your behalf) file a claim and appeal a denied claim.

In this section you will find the timeframes for responding to initial claims, as well as the appeals process. The timeframes for responding to claims depend on the type of claim (eligibility claim or claim for benefits, described below).

In no event can you (or any other person) challenge a decision in court until the applicable claims procedures have been complied with and exhausted. The decision of the Plan Administrator or the Claims Administrator, as applicable, on the final level of mandatory appeal will be final and binding on you, your dependents and any other interested party.

To the extent that the Plan Administrator properly delegates its claims authority to a Claims Administrator, the Claims Administrator may apply alternative timeframes than those set forth below, as described in the applicable Certificate or SPD Booklet. To the extent that an Insurer (or other Claims Administrator) administers claims under a Benefit Program, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company. Insurers will determine claims related to eligibility only to the extent eligibility depends on an insurance requirement, such as evidence of insurability.

The Claims Administrators for the various benefits provided by the Plan are listed in the “**Administrative Information**” section. The Claims Administrators do not guarantee the payment of benefits under the Plan.

Procedures Regarding Eligibility

These procedures apply to claims for eligibility for coverage or enrollment in the Plan, to the extent those determinations have not been delegated to a Claims Administrator.

Filing a Claim

If you believe that you or your dependent is eligible for coverage under the Plan, you may file a claim in writing with the Plan Administrator at the following address:

111 North Canal, Suite 550
Chicago, IL 60606

Initial Claim Decision

When an eligibility or enrollment claim is received, the Plan Administrator must notify you of its benefit determination within 90 days of the receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. You will be given notice

of any such extension. The notice will state the special circumstances involved and the date a decision is expected.

The Plan Administrator will send you a written notice of an adverse benefit determination. A denial of a claim will include:

- The reason(s) for the denial;
- References to the specific Plan provisions on which the decision was based;
- A description of any additional material or information you should supply in support of your claim and an explanation of why it is necessary, if any;
- A description of the Plan's appeal procedures and the time limits applicable to the appeal process; and
- Information regarding the availability of any applicable office of health insurance consumer assistance or ombudsman.

Appealing an Eligibility or Enrollment Claim Denial

If you (or your duly authorized representative) believe that a denial is incorrect, you may request a full review by the Plan Administrator (at the address above) within 60 days after your receipt of the denial of your claim. In connection with your appeal, you or your representative may submit written comments, documents, records and other information relating to the claim. You also have the right to request copies of all relevant documents (free of charge).

The Plan Administrator will furnish you with a written decision providing the final determination of the appeal. The Plan Administrator's decision on appeal usually will be made within 60 days after receiving your appeal, unless special circumstances require an extension of an additional 60 days. If the period is extended, the Plan Administrator will notify you in writing of the extension within 60 days of receiving your appeal. The Plan Administrator's decision on review will be final and binding on you, your dependents and any other interested party. Your appeal notice will include:

- The specific reason or reasons for the appeal decision;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you have the right to request access to and copies of all relevant Plan documents free of charge; and
- Information regarding the availability of any applicable office of health insurance consumer assistance or ombudsman.

Procedures Regarding Adverse Benefit Determinations

How Claims for Benefits Are Processed

How a claim for benefits is processed depends on the type of claim it is. There are several categories of claims:

- **Concurrent Care Claim** -- A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. When possible, this type of claim should be filed at least 24 hours before the expiration of the course of treatment for which an extension is being sought.
- **Pre-Service Claim** -- A Pre-Service Claim is a claim for a benefit with respect to which the terms of Health Coverage require approval of the benefit in advance of obtaining medical care.
- **Post-Service Claim** -- A Post-Service Claim is a claim for a benefit that is not a Pre-Service Claim. Most claims are Post-Service Claims.
- **Urgent Care Claim** -- An Urgent Care Claim is any Pre-Service Claim for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize the life or health of you or your Dependent or subject you or your Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

Submitting a Benefit Claim

You must report claims to the address appearing in “**Administrative Information**” section promptly but no later than one year after the date of the service. If you do not provide this information to us within one year of the date of service, benefits for that health service will be denied or reduced, at the Claim Administrator’s discretion. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits, you may be required to provide all of the following information:

- Employee’s name and address.
- The patient’s name, age and relationship to the employee.
- The member number stated on your ID card.
- An itemized bill from your provider that includes the following:
 - Patient diagnosis;
 - Date(s) of service;

- Procedure code(s) and descriptions of service(s) rendered;
- Charge for each service rendered;
- Provider of service name, address and Tax Identification Number;
- The date the injury or sickness began; and
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you re-enrolled for other coverage you must include the name of the other carrier(s).

Submit your claims to the address “**Administrative Information**” section.

Benefit Determinations

The Claims Administrator will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider (assuming the Plan Administrator, in its sole discretion, chooses to recognize the assignment).
- You make a written request for the out-of-network provider to be paid directly at the time you submit your claim.

Pre-Service Urgent Care

Urgent Care Claims are those for medical care or treatment with respect to which the failure to process the claim immediately could seriously jeopardize: (i) the life or health of you or your dependent; (ii) the ability of you or your dependent to regain maximum function; or (iii) subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

This type of claim generally includes those situations commonly treated as emergencies. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator’s receipt of the requested information; or

- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will set forth the specific reason or reasons for the denial, refer to specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted (if applicable) an explanation of why such information is necessary. This letter will also describe the process for filing a formal appeal and the time limits for filing an appeal, including your right to bring a civil action following an adverse determination upon appeal. If the denial is based on medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post service or pre-service timeframes, whichever applies.

Pre-Service Claims

Pre-service claims are those claims that require certification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day timeframe, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted and an explanation of why such information is necessary, and describe the process and time limits for filing a formal appeal including your rights to bring a civil action following an adverse determination upon appeal. If the denial is based on the medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical

judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day timeframe and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be granted and an explanation of why such information is necessary, and describe the process and time limits for filing a formal appeal including your right to bring a civil action following an adverse determination upon appeal. If the denial is based on the medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

Appeals

If your question or concern is about a benefit determination you may informally contact the appropriate Claims Administrator before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in “**Submitting a Claim**” section, you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact customer service and later wish to request a formal appeal in writing, you should contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address of the claims administrator.

If you are appealing an Urgent Care Claim denial, please refer to the “**Urgent Claim Appeals that Require Immediate Action**” section below and contact customer service immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your request may be required to include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

You will be provided notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from the receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.
- For procedures associated with urgent claims, see “**Urgent Claim Appeals that Require Immediate Action**” below.

Notice of Decision on Appeal

If your appeal is denied, you will receive a notice explaining the following: the reason for the denial, specific references to the part of the Plan on which the denial is based, a statement that you are entitled by law to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim, a statement regarding any voluntary appeal procedures offered by the Plan and your right to bring a civil action after an adverse determination on appeal, information about the internal rule, guideline or protocol that was relied on, if applicable, information on the scientific or clinical judgment for the determination if the adverse decision is based on medical necessity or experimental treatment, and a description

of the external review process, including how to initiate an external review and the time limits that apply.

Please note that the Claims Administrators' decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

External Review Process

For purposes of any Benefit Program considered a "Group Health Plan," if your claim involving medical judgment or involving a rescission of coverage is denied by the Plan, you can request an external review. In the case of an urgent care claim, you can file a request for an expedited external review at the same time you file an internal appeal.

If the Plan denies Your appeal, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or Your authorized representative may file a second level (external) appeal of the Final Internal Adverse Benefit Determination by filing a written application with the Illinois Department of Insurance. (However, You may not file a second level appeal of the Final Internal Adverse Benefit Determination to the extent that determination related to a failure to meet the requirements for eligibility under the terms of the Plan.)

To request a second level appeal, or for further information, contact the Director of the Illinois Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 (toll-free phone number)
(217) 557-8495 (fax)
DOI.externalreview@illinois.gov

For a copy of the second level appeal claims procedures, contact the Plan Administrator.

Reversal of the Second Appeal decision.

Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim.

For questions about Your appeal rights or for assistance, You can contact the Illinois Office of Consumer Health Insurance at 877-527-9431.

Exhaustion of Administrative Remedies

In no event can you (or any other person) challenge a decision in court until this claims procedure has been complied with and exhausted. If you have complied with and exhausted the appropriate claims procedures and intend to bring civil action, you must bring the civil action within two years after your initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the Benefit Program.

Your Legal Right to Continue Coverage Under COBRA

This section 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. Although not required by Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, the Plan will extend continuation coverage that is similar to COBRA to civil union partners in accordance with the terms of this section. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

For purposes of any Benefit Program administered by an Insurer, you may have additional continuation rights under state law. Refer to the Certificate or contact the Insurer at the address listed at the end of this Plan for more information.

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 a Participating Employer 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 entitled to 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 happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B, or both);
- You and your spouse divorce or legally separate; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

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, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your Participating 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. *You must provide this notice in writing to the Plan at the contact address under “**Plan contact information**” below.*

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 a total of 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 eight (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 eight (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. You must make sure that the Plan Administrator is notified 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. *You must provide this notice in writing to the Plan at the contact address under "Plan contact information" below.*

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 any 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. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. *You must provide this notice in writing to the Plan at the contact address under "Plan contact information" below.*

Termination of continuation coverage

Other events will cause COBRA continuation coverage to end sooner. Coverage will end short of the maximum period on the earliest of the following:

- The Plan no longer provides group health plan coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- You or your dependents become entitled to Medicare;

- With respect to the disability extension, the Social Security Administration no longer considers you or your dependent to be disabled; or
- You become covered under another group health plan (provided preexisting condition exclusions or limitations under the group healthcare plan do not apply).

How much does COBRA coverage cost?

Generally, qualified beneficiaries may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated participant or beneficiary who is not receiving continuation coverage. You will have 45 days from the date of electing continuation coverage to start paying for that coverage. The first payment must include the cost of coverage for the entire period from the date coverage was lost because of the qualifying event at least through the date of payment. Each other payment is due by the first day of the month for which continuation coverage is provided. A 30-day grace period will apply for making each month's payment.

A qualified beneficiary who is disabled may be required to pay up to 150% of the cost of his or her COBRA continuation coverage during the disability extension.

If you have questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator, whose contact information appears below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the state insurance commissioner at www.idoi.illinois.gov.

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.

COBRA Administrator contact information

(888) 862-6272

Jennifer.Schwichow@asuresoftware.com

www.AsureSoftware.com

Administrative Information

This section provides important legal and administrative information you may need such as:

- how to contact the Plan Administrator;
- information about the Insurers that insure and administer the Benefit Programs of the Plan and how to contact them.

If you have any questions about any of the information contained in this SPD, contact the Plan Administrator.

Plan identification

This Plan is named the Lincolnway Area Affiliation of Participating School Districts dba Illinois School Insurance Network. The Plan number is 501.

Plan sponsor

The Plan is sponsored by Lincolnway Area Affiliation of Participating School Districts dba Illinois School Insurance Network C/O Marsh & McLennan Agency, LLC (“Plan”).

The Plan’s address is:

111 North Canal, Suite 550
Chicago, IL 60606

The employer identification number (EIN) assigned to the Plan sponsor by the Internal Revenue Service is 36-3734432.

Plan Administrator

The Plan Administrator is the Board of Directors, other entity or individual designated by the Board of Directors of the Plan to supervise the administration of the Plan. The Plan Administrator is your primary source of information about the Plan. The Plan Administrator’s business address is:

111 North Canal, Suite 550
Chicago, IL 60606

The Plan Administrator (or its designee) has sole discretionary authority to interpret and construe the provisions of the Plan, to grant or deny benefits, to determine eligibility for benefits under the Plan, and to resolve any disputes that arise under the Plan. Benefits under this Plan will be paid only if the Plan Administrator (or its designee) decides in its sole discretion that the applicant is entitled to them. Decisions of the Plan Administrator (or its designee) shall be final and binding.

Participating Employers

Participating Employers include:

- Manhattan School District 114
- Chaney-Monge School District 88
- Lemont Township High School District 210
- Elwood Community Consolidated School District 203
- Laraway Community Consolidated School District #70-C
- Lockport Elementary School District 91
- Union School District 81
- Lincoln-Way Area Special Education District 843
- Wilco Area Career Center
- Chicago Ridge School District 127.5
- Richland Grade School District 88A
- Southern Will County Cooperative for Special Education
- Will County School District 92
- Peotone Community Unit School District 207U
- Gower Elementary School District 62
- Dixon Public Schools 170
- Community Consolidated School District 181

Plan year

The Plan year is January 1 to December 31.

Plan type, funding, and administration

The Plan is a benefit plan. The Benefit Programs of the Plan may be fully-insured by the Insurers pursuant to group insurance contracts entered into between Plan and the Insurers or self-funded by the Plan. For fully-insured benefits, premiums are paid to the Insurers from Participating Employer's general assets. The Insurers are responsible for paying benefit claims incurred while the applicable group insurance contracts are in effect. For self-fund benefits, Participating Employers are responsible for paying benefit claims for its general assets.

Insured Benefit Programs

The following Insurers insure and administer the applicable Benefit Programs under the Plan:

BENEFIT PROGRAM	CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE
VISION	VSP 1-800-877-7195 www.vsp.com	Except where noted by your Employer, the Plan pays part of the cost for coverage. You pay the rest through your pre-tax benefit contributions.
LIFE INSURANCE	Blue Cross and Blue Shield of Illinois Attn: Life Claims Department • P.O. Box 7070 • Downers Grove, IL 60515 800-367-6401 https://www.bcbsil.com/	The Plan pays for the cost of basic coverage.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	Blue Cross and Blue Shield of Illinois Attn: AD&D Claims Department • P.O. Box 7070 • Downers Grove, IL 60515 800-367-6401 https://www.bcbsil.com/	The Plan pays for the cost of basic coverage.
DENTAL	BCBS-IL 800-323-7201 (HMO) 800-367-6401 (PPO) https://www.bcbsil.com/	Except where noted by your Employer, the Plan pays part of the cost for coverage. You pay the rest through your pre-tax benefit contributions.
EMPLOYEE ASSISTANCE PROGRAM	Perspectives, perspectivesltd.com/login 800-456-6327	The Plan pays for the cost of basic coverage.
ACCIDENT INSURANCE	Blue Cross and Blue Shield of Illinois Attention: Claims Department P.O. Box 7070 Downers Grove, IL 60515 (800) 367-6401 groupsupplementalClaimsIL@BCBSIL.com	You pay for the cost of coverage.
CRITICAL ILLNESS INSURANCE	Blue Cross and Blue Shield of Illinois Attention: Claims Department P.O. Box 7070 Downers Grove, IL 60515 (800) 367-6401	You pay for the cost of coverage.

BENEFIT PROGRAM	CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE
	groupsupplementalClaimsIL@BCBSIL.com	
HOSPITAL INDEMNITY INSURANCE	Blue Cross and Blue Shield of Illinois Attention: Claims Department P.O. Box 7070 Downers Grove, IL 60515 (800) 367-6401 groupsupplementalClaimsIL@BCBSIL.com	You pay for the cost of coverage.

Third-Party Administrators

The following organizations administer the applicable Benefit Programs under the Plan:

BENEFIT PROGRAM	THIRD-PARTY ADMINISTRATOR/CLAIMS ADMINISTRATOR	WHO PAYS FOR COVERAGE
MEDICAL	BCBS-IL 800-892-2830 (HMO) 800-548-1686 (PPO) https://www.bcbsil.com/	Except where noted by your Employer, the Plan pays part of the cost for coverage. You pay the rest through your pre-tax benefit contributions.

Agent for service of legal process

The agent for service of legal process on the Plan is the Plan Administrator.

Amendment or termination of the Plan

The Plan reserves the right to amend or terminate the Plan or any Benefit Program at any time. Any such amendment or termination may be made by proper action of the Board of Directors or their designee. Alternatively, in certain instances, the Plan Administrator may amend the Plan through the issuance of revised SPD Booklets, enrollment materials, brochures, or Certificates.

Subrogation

General Principle

When you or your eligible dependent receives benefits under the Plan which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your eligible dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your eligible dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your eligible dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, even if you or your eligible dependent has not been paid or fully reimbursed for all damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole"

doctrine, the “fund” doctrine, the “common fund” doctrine, comparative/contributory negligence, “collateral source” rule, “attorney’s fund” doctrine, regulatory diligence or any other equitable defenses that may affect the Plan’s right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your eligible dependent to assert a claim to any of the benefits to which you or your eligible dependent may be entitled. The Plan will not pay attorneys’ fees or costs associated with the claim or lawsuit without express written authorization from Plan.

If the Plan should become aware that you or your eligible dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your eligible dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your eligible dependents.

Participant Duties and Actions

By participating in the Plan you and your eligible dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your eligible dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your eligible dependent has any reason to believe that you or your eligible dependent may be entitled to recovery from any third party, you or your eligible dependent must notify the Plan. At that time, you and your eligible dependent (and your or your eligible dependent’s attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan’s subrogation rights and the Plan’s right to be reimbursed for expenses arising from circumstances that entitle you or your eligible dependent to any payment, amount or recovery from a third party.

If you or your eligible dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your eligible dependents until the agreement is signed. Alternatively, if you or your eligible dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your eligible dependent, your or your eligible dependent’s acceptance of such benefits shall constitute agreement to the Plan’s right to subrogation or reimbursement.

You and your eligible dependent consent and agree that you or your eligible dependent shall not assign your or your eligible dependent’s rights to settlement or recovery against a third person or party to any other party, including your eligible dependent’s attorneys, without the Plan’s consent. As such, the Plan’s reimbursement will not be reduced by attorneys’ fees and expenses without express written authorization from the Plan.

Coordination of Medical Benefits

The Plan has a coordination of benefits feature with respect to medical benefits. This prevents duplication of benefits if you or an eligible dependent is covered by more than one medical plan. When a claim is made, the “primary” plan pays benefits first, without regard to the other plan. When the Plan is secondary, the Plan calculates what it would have paid if it were primary and reduces benefits by what the other plan has paid.

The Plan will not supplement the other plan to bring reimbursement up to 100%, but will coordinate with the other plan to bring your reimbursement up to the Plan’s benefit level. Generally, the plan covering a person as an employee is the “primary” plan while the plan covering the same person as a dependent is the “secondary” plan.

Coordination of benefits rules apply whenever you or your eligible dependent is covered by more than one insurance plan. Plans include any other type of coverage for persons in a group—whether the plan is fully-insured or self-funded. No-fault auto insurance that is required by law is also included, even if it is not provided on a group basis. The level of benefits required by law will be considered when benefits are coordinated.

Coordination with other Plans

The Plan describes the coordination of benefits rules in greater detail. Generally, primary and secondary plans are determined as follows:

- The plan covering a person as an employee is the primary plan, and the plan covering the same person as a dependent is the secondary plan.
- For dependent children, the plan of the parent whose birthday occurs earlier in the calendar year is primary (regardless of the year of birth). If both parents have the same birthday, the plan that has covered a parent for the longer period is primary. If the other plan follows a gender rule (i.e., male’s plan pays first) instead of the birthday rule to determine order of benefits, the other plan’s provision will apply.

In the case of separated or divorced parents, primary and secondary plans are determined as follows:

- If a court decree awards joint custody but does not specify which parent is responsible for healthcare expenses, the rules above apply.
- If a court decree has given financial responsibility for medical care for eligible dependent children to one parent, the plan of this parent is primary.
- If there is not a court decree establishing financial responsibility for medical care for eligible dependent children,
 - the plan that covers the parent with custody pays first;
 - if the parent with custody has remarried, the plan of the custodial parent pays first, then the plan of the stepparent and last, the plan of the parent without custody.

- In the case of a stepchild or the child of a civil union partner the plan of the parent will be primary.

If none of these rules apply, the plan that has covered the individual for the longest period of time is primary.

Coordination with Medicare

If you are a Participant or an eligible dependent and you become eligible for Medicare, the Plan will be your primary source of coverage (with Medicare secondary), unless you elect otherwise. If you choose to be covered under both plans, your Plan coverage will be primary and Medicare secondary. If you also cover your spouse (and he or she is not covered as an employee under another employer's plan), your Plan coverage is primary for your spouse as well, regardless of whether your spouse is under or over age 65.

If you are receiving long-term disability benefits from the your Participating Employer and become Medicare-eligible, you may no longer be eligible for group-sponsored medical coverage through the Plan. Your eligible dependents who are not Medicare-eligible continue to be covered by the Plan Medical Benefit Program, assuming they continue to satisfy the dependent eligibility requirements.

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void, unless otherwise agreed to, in the sole discretion of the Plan Administrator. The assignment of rights or benefits, as well as the assignment of the right to file a lawsuit, are prohibited, except that a participant may assign covered benefits to an appropriate medical service provider solely for the purpose of allowing the provider to submit a claim and allowing the Plan to pay covered benefits directly to the provider. The payment of benefits directly to a provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

Recovery of Excess Payments

You will be required to return to the Plan any benefits, or portion thereof, paid under the Plan by a mistake of fact or law.

NO SUPPRISES ACT

The No Surprises Act of the Consolidated Appropriations Act, 2021 (the "CAA"), protects you from "surprise billing" or "balance billing" when you get emergency care at an out-of-network hospital or when you receive care from an out-of-network provider who is working at a hospital or ambulatory surgical center in your health plan's network.

A "balance bill" is a bill charged to you by an out-of-network provider or facility to make up the difference between what your health plan pays and the provider charges for the items or services rendered. "Surprise billing" is an unexpected balance bill you receive from a provider or facility. This can happen when you receive care from a facility that is in-network but one of the providers at the facility is out-of-network.

Under the No Surprises Act, you are protected from balance billing for emergency services provided by out-of-network providers, including services you may get after you are in stable condition (unless you give written consent and give up your protections against balanced billing for post-stabilization services). You are also protected from surprise bills from services you receive from out-of-network providers while at an in-network hospital or ambulatory surgery center, such as services for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services. The most the providers can bill you is your in-network cost-sharing amount, and they can't ask you to give up your protections from being balance billed. If you receive other services at in-network facilities, out-of-network providers cannot balance bill you unless you provide written consent. Written consent can never be required. Further, you can always choose to get care at an in-network facility or from an in-network provider instead of getting care from an out-of-network provider or facility.

The Plan covers emergency services without requiring you to get approval for such services in advance, which is known as prior authorization. Further, the Plan covers emergency services even if those services are provided by providers who are outside the plan's network. Your required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received by an out-of-network provider or facility will be the same as what you pay a provider or facility in the Plan's network. That amount will be included in your explanation of benefits. Finally, the amount of any cost-sharing you pay for emergency services or out-of-network services will count towards your applicable maximum annual deductible and out-of-pocket limits under the Plan.

Contact the Plan Administrator for more information.