

**EGYPTIAN AREA SCHOOLS
EMPLOYEE MEDICAL BENEFIT PLAN**

**PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION
FOR THE
BRONZE PLAN**

An HSA-Qualified High Deductible Health Plan

Plan No.: 009

Revised: September 1, 2011

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HOW TO USE YOUR BENEFITS

HealthLink Open Access III Program

This Plan offers the HealthLink Open Access III Program. Under this program, both you and the Plan save money when you use hospitals, physicians and other health care providers that have agreed to join the HealthLink networks and provide services to Plan members for reduced or discounted fees.

The Plan provides four basic levels of benefits:

Tier 1 – Tier 1 provides the highest level of benefits. Your benefits are paid at this level when you use the services of providers in the **HealthLink HMO network**.

Tier 2 – Tier 2 is the second level of benefits in Open Access III. Your benefits are paid at this level when you use the services of providers in the **HealthLink PPO network**.

The providers described in Tiers 1 and 2 are sometimes referred to in this booklet as Network Providers or HMO or PPO providers.

Tier 3 – Your benefits are paid at Tier 3 when you use providers located **outside the Metro St. Louis Area** (defined below) that do not participate in the HealthLink HMO network or PPO network.

Tier 4 – Your benefits are paid at Tier 4 when you use providers located **within the Metro St. Louis Area** that do not participate in the HealthLink HMO network or PPO network.

The **Metro St. Louis Area** means the counties of St. Charles County, St. Louis County and St. Louis City in Missouri, and Madison County, St. Clair County and Monroe County in Illinois. The Tier 3 or Tier 4 benefit levels are determined by the location of the provider (doctor or hospital), not by where you live.

The providers described in Tiers 3 and 4 are sometimes referred to in this booklet as Non-Network Providers.

Note: Certain limits apply when you use Non-Network Providers outside the States of Illinois, Missouri, Indiana, Kentucky and Arkansas. See page 13.

This Plan Is Not An HMO. The Plan simply has a contract with HealthLink which allows Plan members to receive services from Network Providers for reduced or discounted fees. You do not have to select a primary care physician. You do not have to obtain referrals from a primary care physician in order to see specialists. You do not have to choose to be in an HMO or PPO. You are free to use any provider at any time. Your benefits for each service are determined by whether the provider for that service falls within Tier 1, Tier 2, Tier 3 or Tier 4, as described above.

You will receive the highest benefits when you use providers in Tier 1, the HMO network. Please note that if a provider in the HMO or PPO network refers you for services to a Non-Network Provider, the services performed by the Non-Network Provider will be considered at the Tier 3 or Tier 4 level of benefits, depending on the provider's location.

If you have questions about whether a provider participates in the HealthLink HMO or PPO network, please contact HealthLink directly. The most current information about providers may be found on HealthLink's website at www.healthlink.com or call (800) 624-2356.

If You Need Hospital Care

All hospital admissions must be pre-certified through HealthLink. Present your Plan Identification Card when you enter the hospital. You may or may not need to fill out claim forms or report any hospital charges to the Claim Services Administrator. Most hospitals will bill the Claim Services Administrator directly. The Claim Services Administrator will determine the appropriate payment to the hospital. You will receive a Member Statement from the Claim Services Administrator

explaining how the payment, if any, was determined. You may also visit www.myMERITAIN.com to retrieve copies of your individual Explanation of Benefits (EOB).

If You Need Physician Care

Present your Plan Identification Card to the physician. Ask the physician's office to submit a claim for all services that may be payable under this Plan. The bill must indicate the date of service, type of service, diagnosis and fee(s). You will receive a Member Statement from the Claim Services Administrator explaining how the payment, if any, was determined. You may also visit www.myMERITAIN.com to retrieve copies of your individual Explanation of Benefits (EOB).

Pre-certification

*****The pre-certification requirements of the Plan changed effective September 1, 2011.***
Please review pages 10 – 11 carefully.**

Pre-certification is required for all hospital and facility admissions and for certain outpatient surgical procedures, ancillary services, including services for Autism Spectrum Disorders, durable medical equipment, outpatient diagnostic imaging services and certain specialty infusion drugs.

To obtain pre-certification please contact:

**HealthLink
Phone: (877) 284-0102
Fax: (800) 510-2162**

IMPORTANT! If your physician wants to write instead of call to request pre-certification, the letter must be addressed to:

**HealthLink
Attn: Utilization Management
233 S. Wacker Drive, Suite 38
Chicago, IL 60606**

Please see pages 10 - 11 for more detailed information about pre-certification requirements.

For questions regarding eligibility or benefits, contact Meritain Health, the Claim Services Administrator.

Consult A Doctor™ Program

The Plan provides full coverage for telephone or e-mail consults through the Consult A Doctor program. Physicians are available 24/7 by telephone or e-mail for non-emergency medical consultations. Common examples of when to use Consult A Doctor include but are not limited to:

- care after office hours;
- care while on vacation;
- to refill a short term (non-DEA controlled) prescription;
- second opinions; and
- research and advice on a particular health condition.

To use this service, please visit: www.myMeritain.com or www.MyDrConsult.com.

If you do not have internet service available, please call: (800) 362-2667.

If you request a prescription you will be required to complete an electronic medical record prior to receiving a consult. This electronic medical record is confidential and will be maintained by Consult A Doctor. For questions about the Consult A Doctor benefit please contact Meritain Health. This benefit does not include telephone or e-mail consults with your regular Physician outside Consult A Doctor. It only covers telephone or e-mail consults with Physicians reached through Consult A Doctor. This benefit is not available in the State of Oklahoma.

File all Medical Claims with:

HealthLink
P.O. Box 419104
St. Louis, MO 63141-9104

Or for Electronic Submission:
ELECTRONIC VENDOR #90001
EDI Clearinghouses
WebMD

www.healthlink.com

The Prescription Drug Card and Mail Order program is administered by:

Express Scripts, Inc. and Scrip World, LLC

One Express Way
St. Louis, MO 63121
Pharmacy Help Desk: (800) 235-4357
Member Customer Services: (800) 451-6245
Prior Authorization: (800) 830-2310

www.express-scripts.com

Egyptian Area Schools Employee Benefit Trust Website:

You may access the Egyptian Area Schools Employee Benefit Trust website at:

www.eqtrust.org

This site gives you a brief description of the Trust and includes copies of the Plan documents, updated Schedules of Benefits, and other notices and important information about the Plan. It also provides hyperlinks to the Meritain Health, HealthLink, Express Scripts and UniView websites.

Meritain Health Website:

You may access information about your own enrollment information and claims on the Meritain Health website at:

www.myMeritain.com

To access your own enrollment and claim information and print copies of your Explanation of Benefits (EOB) you must register at www.myMERITAIN.com. Contact the Customer Service Department at (800) 844-7979 if you have questions about the website.

ABOUT THE SCHEDULE OF BENEFITS

The Egyptian Area Schools Employee Benefit Trust offers five benefit Plans with different Schedules of Benefits. The five Plans are the **Platinum Plan**, the **Gold Plan**, the **Silver Plan**, the **Bronze Plan** and the **Copper Plan**. Your Employer may offer only one Plan to its Employees or may offer more than one Plan and allow each Employee to choose a Plan. If your Employer selects the Copper Plan it cannot offer any other Plan. Otherwise, your Employer may offer any of the other Plans alone or may offer any two, three or all four of the other Plans. Please refer to "Changing Plans" in the Eligibility section of this booklet.

This Plan Document is specific to the **Bronze Plan** which is an "HSA-Qualified" High Deductible Health Plan. There is a separate Plan Document for the **Platinum, Gold, Silver and Copper Plans**. Those Plans all have the same basic plan design, but different levels of benefits.

You will receive a separate Schedule of Benefits for the Plan in which you are enrolled. You and your covered dependents must all be enrolled in the same Plan. The Schedule of Benefits for each Plan is printed on colored paper, as follows:

Platinum Plan	Blue
Gold Plan	Yellow
Silver Plan	Green
Bronze Plan	Tan
Copper Plan	Pink

Please keep your Schedule of Benefits with this booklet. You may also print a copy of the Schedule of Benefits from the Trust's website at www.egtrust.org.

ABOUT THE BRONZE PLAN

The **Bronze Plan** is different from the other Plans in that it is designed to meet requirements set forth in the Internal Revenue Code to qualify as a High Deductible Health Plan (HDHP). Under IRS rules, an eligible individual who has health coverage only under an HDHP can make tax deductible contributions to a Health Savings Account (HSA).

Under the Bronze Plan, each Covered Person must satisfy the Individual Calendar Year Deductible before the Plan will pay any expenses other than expenses for Preventive Care and Preventive Drugs. If an Employee elects coverage for one or more dependents, the family must satisfy the Family Calendar Year Deductible before the Plan will pay any expenses other than expenses for Preventive Care and Preventive Drugs. Once the Deductible is satisfied, the Covered Person will be required to pay copayments and/or coinsurance as described in the Schedule of Benefits until the Calendar Year Out-of-Pocket Maximum is satisfied. Once the Calendar Year Out-of-Pocket Maximum is satisfied the Plan will pay 100% of covered expenses, except as otherwise stated in this Plan.

Like the other plans, the Bronze Plan uses the HealthLink Open Access III Program described at the beginning of this booklet, with four different benefit levels (Tiers) depending on whether services are provided by HealthLink Network Providers or by Non-Network Providers. Benefits are greatest in Tier 1 and lowest in Tier 4.

In this booklet the terms Plan and Schedule of Benefits refer to the Bronze Plan and the Schedule of Benefits for the Bronze Plan. Benefits under the Plan apply to all Covered Persons, both Employees and dependents, enrolled for coverage. All benefits, unless otherwise specified, are based on Usual, Customary and Reasonable (UCR) charges, or the network contracted amounts, and are subject to the deductibles, benefit percentages and maximum amounts shown in the Schedule of Benefits. Please read the more detailed description of benefits, the description of covered expenses, and the Plan limitations and exclusions provided in this booklet.

If you have questions, please call the Claim Services Administrator, Meritain Health, at (800) 844-7979.

ABOUT HEALTH SAVINGS ACCOUNTS

If you are enrolled in the Bronze Plan you may contribute to a Health Savings Account (HSA) provided that you meet requirements set forth in the Internal Revenue Code. You are not required to have an HSA. You may enroll in the Bronze Plan without establishing an HSA, but you may not contribute to an HSA unless you are enrolled in a qualified HDHP such as the Bronze Plan and meet other IRS requirements. One of the key requirements is that you may not be enrolled for coverage under any other comprehensive health plan (including but not limited to Medicare) that is not a qualified HDHP.

An HSA is a trust account established by an eligible individual at a bank, insurance company or other qualified financial institution. Funds can be contributed to, invested and accumulated in the HSA on a tax-free basis and used to pay for uninsured health care costs. HSA contributions may be made by an eligible individual's employer, by the individual or both. Under federal law, employer contributions are not taxable to the employee. An individual may make contributions to an HSA pre-tax through a Section 125 cafeteria plan or after-tax and then claim a deduction on the individual's federal tax return.

For 2011, up to \$3,050 may be contributed to an HSA on behalf of an eligible individual for individual coverage and up to \$6,150 for family coverage. An account owner may contribute an additional \$1,000 for 2011 if the account owner will reach at least age 55 in 2011.

Contributions and investment earnings belong to the HSA account owner and can never be forfeited. The account owner may move the funds at any time to a different qualified HSA trustee. Funds may be withdrawn from the HSA tax free to pay qualified medical expenses for the individual and his or her tax dependents. For example, if you establish an HSA you may withdraw funds from your HSA to pay medical expenses you are required to pay before you meet the Calendar Year Deductible under the Bronze Plan. You may instead pay those expenses from other funds and continue to accumulate funds tax-free in the HSA to be used for qualified medical expenses in a later year.

Funds withdrawn from an HSA for any purpose other than payment for qualified medical expenses will be subject to income and excise taxes. The account owner is responsible for maintaining documentation to verify that withdrawals are made for qualified medical expenses. The account owner is also responsible for reporting all HSA contributions and distributions to IRS by filing IRS Form 8889 with his or her individual tax return (IRS Form 1040) each year.

The laws governing HSAs are complex and may be changed from time to time. You should talk with your own tax advisor or an HSA provider before deciding to establish an HSA to make sure you meet the legal requirements and understand your obligations as the account owner.

For more information about HSAs, including who is eligible, other health coverage that might disqualify you from being eligible, contribution limits and other rules, see IRS Publication 969 (Health Savings Accounts and Other Tax-Favored Health Plans) at www.irs.gov.

RECENT FEDERAL LAWS

The Patient Protection And Affordable Care Act Of 2010

In 2010 Congress enacted the Patient Protection and Affordable Care Act (the "Affordable Care Act") which established several new requirements for group health plans. The Plan has been amended to comply with the requirements of this new law effective September 1, 2011. Some of the key changes include:

- An employee's children are eligible for coverage to age 26, regardless whether they are married or students or dependent on the employee for support.
- Additional benefits for preventive health care are covered at 100% with no deductibles, co-pays or coinsurance when provided by HealthLink Network providers.
- All pre-existing condition limitations and exclusions have been eliminated.
- The overall lifetime dollar limit on all benefits has been eliminated.
- New procedures for external review are available if your claim is denied.

The Mental Health Parity And Addiction Equity Act Of 2008

In 2008 Congress enacted the Mental Health Parity and Addiction Equity Act of 2008 (the "2008 Mental Health Parity Act"). Group health plans sponsored by State and local governmental employers such as public school districts may elect to be exempted from the requirements of the 2008 Mental Health Parity Act if the plans are self-funded rather than provided through health insurance policies.

The Egyptian Area Schools Employee Benefit Trust has elected to exempt the Plan from some requirements of the 2008 Mental Health Parity Act. The Plan complies with all requirements of the 1996 Mental Health Parity Act. The exemption from the new requirements was first in effect for the Plan year beginning September 1, 2010 and will continue in effect for the Plan year beginning September 1, 2011 and ending August 31, 2012. This election may be renewed for subsequent years.

PRESCRIPTION DRUG CARD BENEFIT

Deductible. Under the Bronze Plan most prescription drug charges are subject to the Calendar Year Deductible. Until you satisfy the Calendar Year Deductible you must pay 100% of the discounted cost for your prescription drugs, except drugs that are considered "Preventive Drugs". Preventive Drugs are drugs that are prescribed to help keep you from developing a health condition instead of to treat an existing medical condition. (See the definition of Preventive Drugs in the Definitions Section of this booklet.) A list of the most common drugs that are often prescribed as Preventive Drugs is attached to your Bronze Plan Schedule of Benefits. This list may also be found on the Express Scripts website at www.express-scripts.com or the Trust's website at www.egtrust.org. For some patients these drugs may be prescribed to treat an illness. When prescribed for that purpose they are not considered Preventive Drugs. Your physician may be asked to verify that a given drug has been prescribed for prevention instead of treatment.

Copayments. For most Preventive Drugs you will pay a copayment. Once you satisfy the Calendar Year Deductible you will pay a copayment for other covered prescription drugs. Refer to the Prescription Drug Card Benefit in your Schedule of Benefits for the copayment amounts. In the Bronze Plan, prescription drug copayments count toward the Calendar Year Deductible and Out-of-Pocket Maximum. If your medical and drug expenses for a year exceed the Out-of-Pocket Maximum, the Bronze Plan will pay the entire cost of your covered prescription drug expenses for the remainder of the year.

Preferred And Non-Preferred Drugs. The Plan uses a formulary of "preferred" drugs in different therapeutic classes. The formulary was developed by a national committee of physicians and is updated regularly. Drugs may be added or deleted from the formulary at any time. You can find a current list of formulary drugs at www.express-scripts.com. This Plan uses an "open" formulary which means the Plan provides benefits for both preferred and non-preferred drugs, but your copayments are lower when you use preferred drugs. (Note: Some drugs may not be covered at all. Refer to Exclusions below.)

Generic Equivalents. If your physician prescribes or you request a brand name drug when a generic equivalent is available, you must pay the difference between the full price of the brand name drug and the full price of the generic drug. The pharmacy will inform you of the price difference and you must pay that amount to the pharmacy in addition to the copayment. Only medically documented reasons for not using the generic equivalent will be considered as an exception. Your physician must provide the documentation to the Claim Services Administrator for approval.

Days' Supply. Generally, you may purchase up to a 30 day supply of any prescription drug at any retail pharmacy, except as described below for medications classified as maintenance drugs or specialty drugs. To purchase more than a 30 day supply of any drug you must use a pharmacy in Express Scripts' Maintenance Drug Network (MDN) or Express Scripts' Home Delivery program.

Maintenance Drugs. Certain drugs that patients take for chronic medical conditions are classified by Express Scripts as maintenance drugs. A list with the most common maintenance drugs is available on the Express Scripts website at www.express-scripts.com and on the Trust's website at www.egtrust.org. You may buy up to two 30-day fills of a maintenance drug at any retail pharmacy. After the first two fills, you can only buy maintenance drugs through Home Delivery or from an MDN pharmacy. You cannot use other retail pharmacies for a maintenance drug after the first two fills. When you purchase a new maintenance drug you will receive a notice informing you of the MDN and Home Delivery options for maintenance drugs. You will pay higher copayments if you choose to use MDN pharmacies instead of Home Delivery.

Injectables. For covered injectable drugs other than insulin, you will be required to pay the copayment and an additional 3% of the drug cost. The extra 3% does not apply to insulin.

Specialty Drugs. Certain very high cost oral, injectable and infused medications are classified as specialty drugs. Specialty drugs are generally limited to a 30-day supply. After the first 30-day fill, specialty drugs can only be purchased from **CuraScript Specialty Pharmacy**, a specialty pharmacy which provides patient education and assistance with the use of these drugs. If you attempt to fill a script for a specialty drug at a retail pharmacy, you will be notified that the drug must be ordered from CuraScript. Self-administered injectable drugs available under the prescription drug card program will not be reimbursed under the Major Medical provisions of the Plan.

Over the Counter (OTC) Drugs. The following over-the-counter (OTC) drugs for heartburn/reflux are covered by the Plan at 100% under the prescription card benefit with no member copayment; famotidine (Pepcid), omezaprole OTC (Prilosec OTC), lansoprazole OTC (Prevacid OTC); ranitidine (Zantac). You must submit a prescription written specifically for the OTC drug.

Preventive OTC and Generic Drugs. The following over-the-counter (OTC) and generic legend drugs are covered by the Plan at 100% with no member copayment if the patient meets the stated conditions. You must submit a prescription written for the OTC or generic drug.

- OTC aspirin when prescribed to reduce the risk of cardiovascular disease, heart attack or stroke for men age 45 to 79 and women age 55 to 79.
- Generic oral fluoride supplements when prescribed for children from birth to age 5.
- OTC and generic iron supplements when prescribed for children from birth to 12 months of age.
- OTC generic folic acid supplements when prescribed for women of child bearing age.

Step-Therapy. The Plan uses step-therapy programs for certain classes of medications. For new prescriptions in these drug classes, you must try a “step-one” drug (generally a generic drug) first. If the step-one drug does not work for you, you may obtain a step-two drug in the same class. Your pharmacist will notify you if a new prescription is subject to step-therapy. A list of drugs in the step-therapy program is available on the Express scripts website. You may also contact Express Scripts with questions about step-therapy.

Express Scripts Network. The Plan uses the Express Scripts Pharmacy Network with more than 50,000 participating retail pharmacies. Most, but not all, of these retail pharmacies also participate in MDN, the Maintenance Drug Network. A list of the MDN pharmacies is on the Express Scripts website.

If you buy covered medications with your prescription drug card at any participating retail or MDN pharmacy or use Home Delivery from Express Scripts or CuraScript, no further action on your part is required. The pharmacy will handle your claims. Even when you are required to pay the full cost of a drug you must show your prescription drug card to the pharmacist to receive Network discounts and to have your payments counted toward the Calendar Year Deductible and Out-of-Pocket Maximum.

If you buy covered medications from a **non-participating pharmacy**, you must pay the pharmacy the full price of the drug. You must then complete a medical claim form, attach the itemized receipt for the medication (cash register receipts are not acceptable), and file the claim with Express Scripts. Express Scripts will reimburse an amount no greater than the amount paid to participating retail pharmacies (less the copayment and any additional charge for a brand name when a generic substitute is available), regardless of the actual amount charged by the non-participating pharmacy.

Prior Authorization. Certain drugs require prior authorization which must be obtained prior to filling your prescription. You will be notified by the pharmacy or Express Scripts if your drug requires prior authorization.

Covered Prescription Medications

- Legend drugs.
- Over the Counter (OTC) drugs for heartburn/reflux (requires a prescription written specifically for the OTC drug).

- Insulin and insulin syringes.
- Compound prescriptions of which at least one ingredient is a legend drug in a therapeutic amount.
- Diabetic supplies (test strips).
- Injectable medications and syringes.
- Growth hormones.
- Fluoride products.
- Imitrex.
- Bee sting kits.
- Acne treatments.
- Prenatal vitamins.
- Fertility drugs (with prior authorization only).
- Birth control pills and other prescription contraceptives (excluding IUDs and implants which are covered under the medical benefit).
- Diet control/weight management drugs.
- Retin-A/Differin (prior authorization required after age 24).
- Prescription strength vitamins (with prior authorization only).
- Preventive Over the Counter (OTC) and generic drugs for patients who meet the requirements stated above.
- Smoking cessation products limited to:
 - nicotine gum - \$850 lifetime maximum benefit.
 - nicotine patch - \$1,100 lifetime maximum benefit.
 - nicotine nasal spray - \$1,300 lifetime maximum benefit.
 - nicotine inhaler - \$1,500 lifetime maximum benefit.
 - Zyban tablets - \$250 lifetime maximum benefit.

Exclusions

- Biological serums (immunological vaccines).
- Cosmetic agents.
- Non-Drug items, such as stockings or devices, even if a prescription is required.
- Experimental drugs or drugs required to be labeled “Caution – Limited by Federal Law to Investigational Use”.
- Over the Counter (OTC) drugs (except as stated above).
- Hair growth stimulants.
- Refills obtained more than one year after the original prescription date or prior to 75% of completion of the projected usage.
- Medical devices/supplies (unless listed as covered).
- Diagnostic agents (test kits).
- Syringes and needles (except for insulin and other covered injectables).
- Impotence treatments.*
- Vitamins, except prescription strength vitamins for which the patient has obtained prior authorization.

* Certain drugs that are not covered under the Prescription Drug Card Program may be covered under the Major Medical Expense provisions of the Plan.

MAJOR MEDICAL EXPENSE PROVISIONS

All charges allowable under your Major Medical Expense Benefits are based on Usual, Customary and Reasonable (UCR) charges, as defined in the Definitions section, or the network provider contracted amount, and limited to any Lifetime and Calendar Year Maximum Benefits as shown on the Schedule of Benefits.

Pre-Certification/Utilization Review Program

Utilization Review is for the purpose of determining the medical need for an inpatient hospital or facility stay or for certain outpatient surgeries, ancillary services, including services for Autism Spectrum Disorders, durable medical equipment, diagnostic imaging and specialty infusion drugs. Pre-certification does not guarantee benefits for the service if any limitations or exclusions of the Plan apply to that service.

Inpatient Admissions: All inpatient admissions (Network and Non-Network) must be pre-certified with HealthLink.

- ***You must contact HealthLink to pre-certify any non-emergency hospital admission within 5 to 7 days BEFORE the admission.***
- If you are admitted to a hospital on an emergency basis for any reason other than childbirth, you must contact **HealthLink** within 24 hours or by the next business day.
- If you need a hospital stay for childbirth of more than 48 hours following a normal delivery or more than 96 hours following a cesarean section, you must contact **HealthLink** to certify the extra days.

Specific Services: The following procedures, services and supplies must be pre-certified with HealthLink BEFORE services are rendered by any Network or Non-Network Provider:

Inpatient Services (Medical, Surgical, Behavioral)

- | | |
|------------------------|---------------------------------------|
| • Bariatric surgery | • Lumbar Spine Surgery |
| • Elective Admissions | • Rehabilitation Facility Admissions |
| • Emergency Admissions | • Skilled Nursing Facility Admissions |
| • Hospice | • Transplants |
| • LTAC Admissions | |

Surgical Procedures – Ambulatory

- | | |
|-----------------------------|---|
| • Bariatric Surgery | • Rhinoplasty |
| • Cartilage Transplant Knee | • Sinus Endoscopy |
| • Lumbar Spine Surgery | • Sleep Apnea Surgery – LAUP/UPPP, Nasal, and Uvulopalatoplasty |
| • Nasal Septoplasty | |

Ancillary Services

- | | |
|--------------------------|--|
| • Home Infusion Services | • Physical Therapy |
| • Home Health Services | • Speech therapy |
| • Home Hospice | • Services/treatment for Autism Spectrum Disorders |
| • Occupational Therapy | |

Durable Medical Equipment

- | | |
|--|-----------------------------|
| • Bone Stimulator | • Limb Prosthetics |
| • Cardio/External Defibrillator | • Myoelectric prosthetics |
| • Cochlear Implant | • Neuromuscular Stimulators |
| • Cooling Devices (i.e. Polar Care) | • TENS Units |
| • CPAP/BIPAP | • Wheelchairs (Custom) |
| • Electric Scooters | • Wheelchairs (Power) |
| • Functional Electrical Stimulator Bikes | • Wound Vacs |

Diagnostic Imaging – Ambulatory

- MRA of the Head and/or Neck
- MRI of the Brain
- MRI of Spine – Cervical, Thoracic, Lumbar, Sacral
- PET Scans

Specialty Infusion Drugs (covered under Medical Benefit)

- Alemtuzumab (Campath)
- Azatidine (Vidaza)
- Bevacizumab (Avastin)
- Bortezomib (Velcade)
- Fulvestrant (Faslodex)
- Mitaxantrone (Novantrone)
- Oxaliplatin (Eloxatin)
- Paclitaxel (Taxol and Abraxane)
- Panitumubab (Vectibix)
- Pemetrexed (Alimta)
- Rituximab (RituXan)
- Trastuzumab (Herceptin)
- Zoledronic Acid (Zometa)

Failure to obtain pre-certification from HealthLink for the listed procedures, services and equipment will result in a 50% reduction in benefits up to a maximum reduction of \$250 per inpatient confinement or per course of treatment or therapy. This reduction in benefits does not apply toward the Out-of-Pocket Maximum. Generally, no benefits will be paid for hospital days or services for which HealthLink has denied certification.

Other Services: If you have questions about services, procedures or equipment not listed in this section, please contact the Claim Services Administrator, Meritain Health.

Appeals: If HealthLink makes an adverse Medical Necessity determination on any request for pre-certification, you and/or your physician may request a peer-to-peer discussion or appeal the determination in accordance with HealthLink's Appeal/Grievance Process. This process is outlined in Appendix A, printed at the end of this booklet. You may also request review using the Plan's Appeal Procedures and External Review Procedures.

REMEMBER, the ultimate responsibility for pre-certification is yours. Please refer to your I.D. Card for the name and telephone number for HealthLink. **Certification by HealthLink does not assure that proposed admissions or services are covered under the Plan. Please read the Plan booklet carefully, or call the Claim Services Administrator for assistance with benefit questions.**

Advance Determination Of Medical Necessity

This Plan generally provides benefits only for services, procedures and pharmaceuticals that are Medically Necessary and are not Experimental and Investigational. (These terms are defined in the Definitions section of this Plan.) In addition, the Plan generally does not cover cosmetic services or procedures. Even if the Plan does not require pre-certification for a particular service or procedure, you may want to know whether a service or procedure that has been recommended for you is a covered expense and whether the service or procedure will be considered by the Plan to be Medically Necessary for your medical condition, or will be considered cosmetic or Experimental and Investigational for your condition, so you will know in advance whether the Plan will provide benefits in your individual case.

To request an advance determination for a particular service or procedure, you or your provider must contact the Claims Department at Meritain Health, the Claim Services Administrator. Written requests may be sent to:

**Attn: Egyptian Trust Claims Supervisor
Meritain Health
300 Corporate Parkway
Amherst, NY 14226**

If appropriate, the Claim Services Administrator will authorize a clinical consultation by HealthLink's Utilization Management Department. A medical reviewer will evaluate the

information you submit to determine whether the service or procedure is considered Medically Necessary, or cosmetic, or Experimental and Investigational, as applicable, for your condition. HealthLink will notify you of the result of the review in writing.

Appeals: If you disagree with the determination, you may request a peer-to-peer discussion or file an appeal in accordance with HealthLink's Appeal/Grievance Process outlined in Appendix A, printed at the end of this booklet. You may also request review using the Plan's Appeal Procedures and External Review Procedures.

Alternative Care/Case Management

A Case Manager may be assigned to help manage the care of patients who have catastrophic or extended care illnesses or injuries. The objective of case management is to identify and coordinate cost effective medical care alternatives meeting accepted standards of medical practice. The Case Manager will monitor the patient's care and coordinate communication among providers, the patient and family members. If a Case Manager is assigned, the patient must cooperate with the Case Manager and participate in the case management process as a condition of receiving benefits from the Plan.

The objectives of case management can usually be met with normal Plan benefits. In certain circumstances the Plan may pay benefits not normally provided under the Plan, on an exception basis. This will only apply when care covered by the Plan would otherwise be required, the patient agrees to the alternative care and the HealthLink Medical Director or his/her designee approves the alternative care. For example, a referring physician may recommend treatment outside the Designated Area or that a transplant should be performed at a Non-Network facility. If the alternative care is approved by the HealthLink Medical Director or his/her designee, the Non-Network Out-of-Pocket Maximum will apply even though the treatment is out of the Designated Area or a transplant is performed outside the network.

Calendar Year Deductible

Before the Plan will pay any charges other than expenses for Preventive Care and Preventive Drugs, the Calendar Year Deductible amount shown on the Schedule of Benefits must be met. The Deductible amount must be satisfied only one time each calendar year regardless of the illness or injury, type of services or treatment provided.

The Family Calendar Year Deductible is the amount of eligible expenses incurred in a calendar year for all covered family members cumulatively that you must pay before most benefits become payable under the Plan. If any dependents are covered, the Family Calendar Year Deductible must be satisfied before the Plan will pay covered expenses for any covered family member, except expenses for Preventive Care and Preventive Drugs.

Penalties and other non-covered expenses cannot be used to satisfy the Calendar Year Deductible amount. However, copayments, including prescription drug copayments, will count toward satisfying the Calendar Year Deductible.

Out-Of-Pocket Maximum

The Out-of-Pocket Maximum assures you that you and your family will not be responsible for paying covered Major Medical Expenses for any year in excess of the amount indicated on the Schedule of Benefits.

Eligible expenses applied toward the satisfaction of the Out-of-Pocket Maximum amount consist of the Calendar Year Deductible and most copayment and coinsurance amounts that are not paid by the Plan. After the Out-of-Pocket Maximum is reached the Plan will pay 100% of covered expenses incurred during the remainder of that calendar year, subject to the exceptions stated below.

The following expenses do not apply toward satisfaction of the Out-of-Pocket Maximum: Coinsurance for all mental/nervous, alcohol and/or substance abuse treatment; coinsurance for certain treatment outside the Designated Area (defined below); charges for services by Tier 4 providers; charges for transplants performed outside the network; charges for surgical procedures

for morbid obesity performed outside the network; spinal adjustment charges; penalties for failure to pre-certify; ineligible or non-covered expenses or expenses in excess of Lifetime or Calendar Year Maximum benefits. You will be responsible for paying these amounts even if you have satisfied the Out-of-Pocket Maximum.

Travel For Treatment Outside The Designated Area: If you choose to travel outside the Designated Area for the purpose of receiving medical treatment, the Out-of-Pocket Maximum will not apply. You will be required to pay the Non-Network coinsurance percentage on all covered charges, without any limit. This rule applies only when you travel outside the area for the purpose of obtaining medical treatment. It does not apply to treatment received in the community or state in which a retiree or dependent resides or attends school outside the area or to emergency medical treatment required while traveling outside the area for purposes other than to receive medical treatment.

Designated Area means the states of Illinois, Missouri, Indiana, Kentucky, and Arkansas.

Copayment For Hospital Admissions And Outpatient Surgery

You must pay a copayment for each new hospital admission and each outpatient surgical procedure performed at a hospital or ambulatory surgical facility, but not more than 3 copayments per person per year. The amount of the copayment is shown on the Schedule of Benefits. If you are discharged from the hospital and readmitted for any reason within 7 days, you will not be charged another copayment for readmission. If a person has 3 or more hospital admissions and/or surgical procedures in the same calendar year, the copayment will be waived for any additional hospital admissions or surgical procedures in the same year. You must contact the Claim Services Administrator to request this waiver. These copayments can be used to satisfy the annual Out-of-Pocket Maximum.

Benefit Levels

The Plan has a contract with HealthLink which offers you and the Plan the benefit of reduced or discounted fees HealthLink has negotiated with many hospitals, physicians and other service providers. HealthLink has two provider networks, one called the HMO network and the other called the PPO network. For most services, your benefits are greater when you use HealthLink Network Providers.

Your benefits are paid at the highest level, Tier 1, when you use providers that belong to the HealthLink HMO network. You also save the Plan money when you use HMO providers, thereby helping to keep premium costs as low as possible. Your benefits are paid at Tier 2 when you use providers in the HealthLink PPO network.

The Plan also has two levels of benefits for Non-Network Providers. Your benefits are paid at Tier 3 when you use Non-Network Providers outside the Metro St. Louis Area. Your benefits are paid at Tier 4 when you use Non-Network Providers within the Metro St. Louis Area. The Metro St. Louis Area includes St. Charles County, St. Louis County and St. Louis City in Missouri, and Madison County, St. Clair County and Monroe County in Illinois. Charges from Tier 4 providers do not apply to the Out-of-Pocket Maximum.

For information about providers in the HMO and PPO networks, refer to HealthLink's website. The website is updated weekly and will provide the most current information. Healthlink's telephone numbers and website are listed on your I.D. card and at the beginning of this booklet.

Forced Providers

"Forced Providers" are hospital-based providers that the patient cannot choose. The charges of certain forced providers will be considered at the same benefit level as the hospital facility in which services are rendered. The forced provider benefit applies only to the following inpatient or outpatient hospital facility charges:

- Emergency room physicians;
- Inpatient hospital professional fees for radiology, pathology or anesthesiology;
- Outpatient hospital professional fees for radiology, pathology or anesthesiology.

Note: This provision *does not* apply to providers in an office visit setting or any setting other than inpatient or outpatient hospital facilities.

Benefit Period

Your Benefit Period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage your first Benefit Period begins on the date your coverage is effective and ends on December 31st of the same year or the day your coverage terminates, whichever is earlier.

Pre-Admission Testing

This benefit allows you to have laboratory and x-ray testing performed on an outpatient basis within 72 hours before a proposed covered hospitalization. Covered expenses for those tests will be considered at normal coinsurance rates after you satisfy the Calendar Year Deductible.

Second Surgical Opinion

In order to reduce unnecessary surgery and its related costs to you and the Plan, a Second Surgical Opinion Program is available. You may use this program for any elective (non-emergency) surgery. Covered expenses for a second opinion (and third opinion if necessary) will be considered at normal coinsurance rates after you satisfy the Calendar Year Deductible.

To take advantage of this benefit you may, prior to surgery, obtain the second opinion from a Board Certified Specialist who is not part of the medical or surgical group as your surgeon. If the second opinion differs from your surgeon's opinion, you may obtain a third opinion.

Hospital Self Audit Program

This program will save the Plan money and can earn you a **cash reward**. Here's how it works:

If you, upon review of your (or a covered family member's) hospital bill for covered hospital services, identify an overcharge in the amount billed, you may receive a cash reward from the Plan of 50% of the amount of the overcharge which would have been paid by the Plan, provided that you document the error by submitting a corrected bill from the hospital to the Claim Services Administrator. The reward may not exceed \$250 per hospital stay or visit.

Lab Card Program

This voluntary program will save you and the Plan money. When your physician orders lab work for you, show your ID card and advise your physician you would like to use the Lab Card program. When your physician uses Lab Card, your covered lab services will be reimbursed at 100% after you meet the Calendar Year Deductible. If you choose not to use your Lab Card benefit, normal Plan benefits will apply.

How the LabCard Program Works:

1. When your doctor orders lab work for you, show your Meritain Health ID Card with the Lab Card logo. Tell your doctor and staff you would like to use your Lab Card benefit. Your lab work will need to be analyzed at a Quest Diagnostics facility. If your doctor or staff are not familiar with the Lab Card program, ask them to call the phone number listed on your member ID card.
2. Your doctor's office collects your specimens and calls a participating testing facility for pick-up. If your doctor does not collect specimens in his or her office, approved collection sites are also available. You can get more information by calling the toll-free number listed on your member ID card.
3. The testing facility performs the tests and sends the results to your doctor (usually within 24 hours).

For questions about the Lab Card program and Quest Diagnostics, please contact the Meritain Health Customer Service Department.

COVERED MAJOR MEDICAL EXPENSES

Subject to all Plan limitations and exclusions, the following are eligible expenses under your Plan. No expense will be considered eligible if the service is provided to any covered family member by you, a close family member of the Covered Person or by a person residing with the Covered Person. The term "Close Family Member" is defined in the Definitions section of this booklet.

1. **Hospital services** and supplies including room and board charges for approved hospital days. Room and board charges are limited to the most common semi-private rate except that the actual charge made for an intensive/coronary care unit accommodation shall be an eligible expense. **Please note the pre-certification requirements and penalties.**
2. Charges made by a licensed free standing **ambulatory surgical center** for medically necessary services and supplies incurred in the performance of covered surgical procedures. **Please note the pre-certification requirements and penalties.**
3. Medically necessary charges for room and board made by a **Skilled Nursing Facility or Extended Care Facility or Rehabilitation Facility**, but only while confined as a registered bed patient undergoing the continuous care of a physician. Charges for medically necessary services and supplies made by the facility during the confinement will be considered eligible expense. The attending physician must personally supervise the care in such facility. **Please note the pre-certification requirements and penalties.**
4. **Home Health Care** stated in a Home Health Care Plan, performed while the individual is under the care of the physician approving the Home Health Care Plan, provided treatment is not performed by a close family member as defined in the Definitions section of this booklet, or someone who resides with the individual. **Please note the pre-certification requirements and penalties.**

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

The following medically necessary services and supplies are eligible, when provided through a Home Health Agency:

- part-time or intermittent nursing care by or under the supervision of a registered graduate nurse (R.N.);
- part-time or intermittent home health aide services consisting primarily of caring for the patient;
- physical therapy, occupational therapy and speech therapy;
- social services counseling;
- drugs, medicines, dressings, laboratory tests ordered by a physician; and dietary guidance by a qualified nutritionist.

The following are NOT covered under the Home Health Care provisions:

- food, food supplements, home delivered meals;
 - transportation expenses;
 - private duty nursing;
 - housekeeping services;
 - custodial care.
5. **Doctor's professional services**, including additional surgical opinions, surgery and other covered medical services.
 6. **Anesthetics and oxygen**, including the services of an anesthesiologist or CRNA, but only when the anesthesiologist is not the physician performing the surgery.
 7. **Ambulance**. Emergency transportation by professional ground ambulance to a local hospital when determined to be medically necessary. Ground ambulance shall be considered an

eligible expense between hospitals when medically necessary services cannot be provided by the first hospital and the patient cannot be transported other than in an ambulance for medical reasons. *NOTE: Local ground ambulance transportation from a Non-Network hospital to a network hospital when the Covered Person is stabilized shall be considered an eligible expense.* Benefits for air ambulance to the nearest facility which is equipped to provide the services required are available only if this type of ambulance service is requested by the policing or medical authorities at the site of an emergency situation or the Covered Person is in a location that cannot be reached by ground ambulance. In a non-emergency situation, air ambulance service is not eligible for benefits unless the Covered Person requests and receives written approval from the Administrator prior to services being rendered.

8. **Physical therapy** by a Registered Physical Therapist on the written orders of a physician for therapeutic treatment of a covered illness or injury which is subject to significant improvement through short-term therapy. **Please note the pre-certification requirements and penalties.**
9. **Occupational therapy** by a Registered Occupational Therapist on the written orders of a physician for therapeutic treatment of a covered illness or injury which will improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. **Please note the pre-certification requirements and penalties.**
10. **Speech therapy** by a certified Speech Therapist, if recommended by a physician as medically necessary to restore loss or impairment of normal speech caused by stroke or other medical accident, an accidental injury, a surgical procedure, an illness that is other than a learning or Mental Disorder, or to treat a diagnosed Autism Spectrum Disorder. **Please note the pre-certification requirements and penalties.**
11. **X-ray and laboratory** charges and professional fees. **Please note the pre-certification requirements and penalties for certain diagnostic imaging procedures.**
12. **Prescription Drugs** that are not covered under the Prescription Drug Card Benefit. Prescription Drugs must be FDA approved and determined to be medically necessary and appropriate treatment. Prescriptions for male impotency medications are limited to a maximum of 6 tablets per month and must be submitted with a statement of medical necessity from the prescribing physician. **Please note the pre-certification requirements and penalties for certain specialty infusion drugs.**
13. Rental (not to exceed the full purchase price) of **durable medical equipment** prescribed by a physician and required for temporary therapeutic use in treatment of an active illness or injury. Equipment will not be covered if it can be useful in the absence of an illness or injury or if you are purchasing the equipment without a physician's prescription. **Please note the pre-certification requirements and penalties.**

Repair and maintenance of purchased durable medical equipment will be considered an eligible expense to the extent that the repairs do not exceed the purchase price of new, similar equipment.
14. **Oxygen** and/or rental of equipment required for its administration.
15. **Initial prosthetics** such as artificial limbs, eyes (including contact lenses following cataract surgery) or other prosthetic devices required to replace natural limbs, eyes, or other bodily parts. Expenses for a replacement prosthetic shall be considered eligible if determined to be medically necessary and the replacement is due to physiological changes or normal growth or deterioration from normal wear, but no more often than once every 5 years for normal wear. Covered expenses for the initial or a replacement prosthetic shall be limited to the least costly alternative (based on the Usual, Customary and Reasonable charge) for the prosthesis or appliance. **Please note the pre-certification requirements for certain prosthetics.**

16. **Chemotherapy and radiation therapy**, except high-dose chemotherapy related to a non-covered transplant procedure. **Please note the pre-certification requirements for certain chemotherapy drugs.**
17. **Braces, crutches, splints, casts, orthotics** and custom made orthopedic shoes are also included when recommended by a physician as medically necessary.
18. **Blood** and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
19. **Hospice Care.** Usual, Customary and Reasonable charges for the following services, when approved as part of a hospice program provided by a qualified hospice. **Please note the pre-certification requirements and penalties.**
- Physician's services;
 - Nursing care by or under the supervision of an R.N.;
 - Physical therapy or speech-language pathology services by an individual licensed to perform such services;
 - Medical social services under the direction of a physician;
 - Home health care by a trained aide and homemaker services;
 - Medical supplies, including drugs and biologicals, and use of medical appliances;
 - Short-term, inpatient care, including respite care. Respite care will be covered only if treatment is provided on an intermittent non-routine and occasional basis over a period no longer than ten consecutive days;
 - Procedures necessary for pain control and acute and chronic symptom management;
 - Nursing care and home health care may be provided on a 24-hour continuous basis during periods of crisis, if necessary to maintain the patient at home.
20. Services of a **Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), or Licensed Practical Nurse (L.P.N.)**, provided such services are certified as medically necessary by the attending physician, and are not rendered by a close family member as defined in the Definitions section of this booklet. Such services shall include **Registered Nurse Midwives** acting within the scope of their license. Nurse's services are covered in the hospital, convalescent hospital, extended care facility, skilled nursing facility or in the patient's home.
21. **Treatment of temporomandibular joint syndrome (TMJ)**, limited to surgical or other treatment specifically of the temporomandibular joint.
22. **Wellness Benefit / Preventive Services.** The Plan covers expenses for routine health care and preventive services that are not provided to treat an illness or injury only as stated on the Wellness Benefit pages in the Schedule of Benefits or as required by law. Covered preventive services include routine physical exams, certain screening tests and immunizations and some types of counseling to promote health or prevent illness or health problems.
- 100% Benefit for Recommended Preventive Services. The Plan will pay 100% of the cost of services that are "recommended preventive services" (as defined below) provided by HealthLink Network physicians or other HealthLink providers. You are not required to pay any deductible, copayment or coinsurance that would otherwise apply for a service provided In-Network that is designated as a recommended preventive service based on your age, gender and health risk factors. The 100% benefit applies only to the recommended preventive service and not to any additional treatment or further services that may be recommended or provided as a result of a preventive service. Any additional treatment or further services will be covered as provided in the Plan, subject to all applicable deductibles, copayments and coinsurance.
- Recommended Preventive Services. Federal law defines recommended preventive services by reference to guidelines published by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and

Prevention (CDC) and the Health Resources and Services Administration (HRSA) (collectively, the Guidelines). Recommended preventive services include:

- Evidence-based preventive items or services that have in effect a rating of “A” or “B” in the current recommendations of the USPSTF for individuals of the patient’s age, gender and health risk factors.
- Routine vaccines and immunizations recommended by the CDC for individuals of the patient’s age, gender and health risk factors.
- For infants, children and adolescents, evidence-informed preventive care and screenings recommended by the HRSA.
- For women, additional preventive care and screenings, not otherwise addressed by the USPSTF guidelines, recommended by the HRSA.

These Guidelines will change from time to time. Any new service added to the Guidelines will be covered by the Plan as a recommended preventive service no later than the first Plan Year that begins one year after the new service is added. A complete list of the current Guidelines can be found at:

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.

You may also contact the Claim Services Administrator for a paper copy of the current Guidelines. The Plan also covers some wellness services that are not included in the Guidelines. A summary list of services covered by the Plan under the Wellness Benefit is included with the Schedule of Benefits. A more comprehensive list is posted on the Trust’s website at www.egtrust.org.

Preventive Services Provided Out-of-Network. Routine preventive services provided by physicians or other providers that are not in the HealthLink Network are covered only if the Plan specifically provides that such services are covered outside the Network. You will be required to pay the applicable deductible, copayment and coinsurance amounts stated in the Plan for any covered Non-Network services, including recommended preventive services. Refer to the Wellness Benefit pages in the Schedule of Benefits.

Frequency and Setting. If the Guidelines do not specify the frequency for a recommended preventive service the Plan may impose reasonable frequency limits for a service to be covered at 100%. To the extent medically appropriate, all screening and counseling services recommended by the Guidelines should be provided in connection with your annual routine physical exam (more frequent routine exams are covered for infants and children up to age 2). If a recommended preventive service is provided during any other office visit and is billed separately from the office visit, you will be charged the normal office visit copayment. If a recommended preventive service is provided at another visit and is not billed separately, you will be charged the normal office visit copayment unless the claim clearly shows that the primary purpose of the visit was for the recommended preventive service.

The Plan may also use reasonable medical management techniques to ensure that care is provided in an appropriate setting. If you have questions about whether a service will be treated by the Plan as a recommended preventive service, contact the Claim Services Administrator.

23. **Maternity** charges are considered as any other illness under the Plan for covered Employees and covered spouses or civil union partners of Employees. The charges incurred by a newborn while confined at the time of birth will be considered under the newborn’s own coverage as long as the newborn has been enrolled for coverage under this Plan. No benefits are payable on behalf of the newborn if the newborn is not enrolled in the Plan within the required period. See the Eligibility section of this booklet. There are no benefits available for charges related to the pregnancy of a dependent child or complications of pregnancy of a dependent child.

Under federal law, health plans generally may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the

Plan will pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). The Plan's pre-certification requirements apply only if a longer hospital stay is required.

24. Organ And Tissue Transplant Coverage. Charges for cornea, bone, homografts and skin transplants will be considered in the same manner as any other covered surgical expense.

All other non-experimental transplant procedures that have been approved as medically appropriate for the patient's condition under the guidelines established by Medicare will be considered subject to the limitations and requirements stated below. This includes kidney, kidney/pancreas, liver, heart, lung, heart/lung, bone marrow and stem cell transplants, and other transplant procedures approved by Medicare.

Transplant procedures that are medically approved and appropriate under the guidelines established by Medicare will be considered as follows:

- **HMO or PPO Facility:** Transplant services rendered at an HMO or PPO Network hospital with organ/tissue transplant facilities will be considered at the benefit levels stated in the Schedule of Benefits, plus transportation costs and room and meals for one designated support person not to exceed \$50.00 per day. Please contact HealthLink for a list of available transplant facilities.
- **Non-Network Facility:** Transplant services rendered at a Non-Network hospital will be considered at 50%, limited to a maximum benefit per procurement of \$50,000 (including all related therapy, treatment and drugs). (Note: If the HealthLink Medical Director determines that it is medically necessary for the patient to obtain a transplant outside the network, the \$50,000 benefit limit will not apply. Charges will be considered at 50% and the applicable Calendar Year Out-of-Pocket Maximum for Non-Network treatment will apply.) No transportation costs or room and meal benefits are payable.

ALL TRANSPLANT EXPENSES ARE SUBJECT TO THE FOLLOWING:

- A second opinion is not required prior to undergoing any transplant procedure. If the patient chooses to obtain a second surgical opinion, the second opinion must concur with the attending physician's findings regarding the medical necessity of such procedure. The physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria. The second opinion must be rendered by a Board Certified Surgeon who is not professionally or financially associated with the physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second opinion may not perform the surgery.
- In the event of a direct organ or tissue transplant from a living person to a covered person, the covered medical expenses for the donor of such organ(s) or tissue which are incurred as the direct result of and within 3 months of the transplant will be considered expenses incurred by the recipient to the extent that benefits for the donor are not provided under any other group benefit plan. This includes expenses for testing up to 5 potential donors to find a suitable match. Any fee or charge made by the donor for such organ(s) will not be considered a covered medical expense.
- If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits.
- If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately.

- The reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and the hospital's charge for storage or transportation of the organ, will be considered a covered expense.

The following are non-covered transplant expenses:

- Charges for services relating to obtaining or implanting non-human or artificial organs;
- Experimental or Investigational transplant procedures;
- High-dose chemotherapy related to a non-covered transplant procedure;
- With respect to heart transplant, expenses of the donor shall not be covered.

25. **Treatment Of Infertility.** Diagnostic procedures, surgical procedures and drug therapies for the treatment of infertility will be considered as any other covered expenses, provided that the covered person has been diagnosed by a physician as requiring treatment for infertility. Infertility is defined as the inability to conceive after 12 months of unprotected sexual intercourse or the inability to sustain a successful pregnancy by a woman of normal child-bearing age.

In addition, the Assisted Reproduction Techniques listed below will be considered as covered expenses up to the Lifetime Maximum Benefit stated on the Schedule of Benefits, provided that the following conditions are satisfied:

- The covered person has attempted but has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments;
- The treatment conforms to the guidelines of the American College of Obstetrics and Gynecology or according to the standards of the American Society of Reproductive Medicine.

Subject to these conditions, the following Assisted Reproduction Techniques are covered up to the Lifetime Maximum Benefit:

- Medical costs of oocyte or invasive sperm retrieval
- In vitro fertilization
- Uterine embryo lavage
- Embryo transfer
- Artificial insemination
- Gamete intrafallopian tube transfer
- Zygote intrafallopial tube transfer
- Low tubal ovum transfer
- Other medically recognized techniques that are not considered Experimental or Investigational at the time the treatment is provided.

The following are non-covered expenses:

- Costs associated with cryopreservation and storage of egg, sperm or embryo
- Experimental treatments
- Fertility treatment for a person who has undergone a voluntary sterilization procedure
- Fertility treatment for a person who is beyond normal child-bearing age.

26. **Reconstructive Surgery Following Mastectomy.** Expenses for breast reconstruction in connection with a mastectomy will be considered as all other covered surgical expenses. Covered expenses include:

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

27. **Surgical Treatment Of Morbid Obesity.** Surgical procedures for treatment of obesity (including gastric stapling, gastric pouching, surgical resection and any other surgical treatment of obesity) will be considered as eligible medical expenses only if all of the following requirements are satisfied and subject to the limitations stated below.

Requirements:

- The Covered Person meets the requirements for morbid obesity stated in the Definitions;
- the Covered Person has another serious medical condition such as degenerative joint disease, pulmonary and circulatory insufficiency, diabetes or heart disease which is aggravated or caused by the excess weight; and
- the patient or physician provides evidence that conventional weight reduction methods have failed.

Limitations on Benefits:

- HMO or PPO Provider: Considered as all other covered surgical procedures.
- Non-Network Provider: Considered at 50%, not subject to the Calendar Year Out-of-Pocket Maximum, and limited to a maximum benefit of \$50,000 (including all related therapy, treatment and drugs). (Note: If the HealthLink Medical Director determines it is medically necessary for the patient to obtain the procedure outside the network, the \$50,000 maximum benefit will not apply and the applicable Calendar Year Out-of-Pocket Maximum for Non-Network treatment will apply.)

28. **Taxes And Surcharges.** Taxes and/or surcharges applied to a covered expense are considered covered expenses when the tax or surcharge is mandated by state or federal law.

29. **Sterilization Procedures,** including tubal ligation or vasectomy.

30. **Nutritional Counseling.** Nutritional Counseling will include nutritional evaluation and counseling as medically necessary for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when prescribed by a physician and provided by a licensed health care professional (e.g., a registered/clinical dietician). A letter of medical necessity from the prescribing physician is required. Coverage shall be limited to one nutritional counseling session per primary medical condition per lifetime not to exceed 10 classes per session. Conditions for which nutritional evaluation and counseling may be considered medically necessary include, but are not limited to, the following:

Anorexia Nervosa/Bulimia	Hyperlipidemia	Multiple or Severe Food Allergies
Celiac Disease	Hypertension	Nutritional Deficiencies
Cardiovascular Disease	Liver Disease	Obesity
Crohn's Disease	Malabsorption Syndrome	Renal Failure
Diabetes Mellitus	Metabolic Syndrome	Ulcerative Colitis

Specifically excluded is Nutritional Counseling solely for the management of the following conditions:

- Attention-Deficit/Hyperactivity Disorder
- Chronic Fatigue Syndrome
- Idiopathic Environmental Intolerance (casual connection between environmental chemicals, foods and/or drugs)

31. **Total Parenteral Nutrition (TPN)** for pre or post-surgical patients, or when determined to be medically necessary in order to safe guard the Covered Person's life. A statement of medical

necessity from the attending physician must be submitted prior to receiving services in cases that are other than pre or post-surgical related.

32. **Wigs.** Charges associated with the initial purchase of a wig after chemotherapy.
33. **Clinical Trials.** Expenses for routine patient care provided in connection with a covered person's participation in an approved phase I, phase II or phase III clinical trial are considered eligible expenses and covered in the same manner as when such expenses are incurred for non-investigational purposes, provided that the covered person has a diagnosed life-threatening disease and the clinical trial is designed with therapeutic intent to improve participants' health outcomes (not simply to test toxicity or disease pathophysiology). Covered routine patient care includes:
- Items or services that are typically provided in the absence of a clinical trial (e.g., medically necessary conventional care, including but not limited to office visits, consultations, diagnostic tests, hospital charges, non-experimental drugs);
 - Items or services required for the provision of the investigational item or service (such as administration of a non-covered chemotherapy drug);
 - Items and services required for the clinically appropriate monitoring of the effects of the treatment, or the prevention of complications, but not services provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient;
 - Items and services that are medically necessary for the diagnosis or treatment of complications arising from the provision of the investigational treatment.

The Plan does not cover the cost of the Investigational therapy, drug, device or procedure that is the subject of the clinical trial or any associated research costs or any other services or items that would not be covered in the absence of a clinical trial. The Plan does not cover expenses for routine patient care provided in connection with any Experimental or Investigational therapy, drug, device or procedure that is not the subject of an approved clinical trial. Whether a clinical trial is approved is determined under Medicare guidelines.

Routine patient care to be provided in connection with a clinical trial must be pre-certified as medically necessary. The provider must submit a detailed treatment plan designating all proposed treatment as routine patient care or Investigational and/or research-related care.

34. **Autism Spectrum Disorders.** For dependents up to age 21, expenses for medically necessary diagnosis and treatment of Autism Spectrum Disorders will be considered as eligible expenses covered on the same basis as such services are covered for other medical conditions, up to the maximum annual benefit determined each year by the Director of the Illinois Division of Insurance and stated in the Schedule of Benefits. **All services for treatment of Autism Spectrum Disorders must be pre-certified as medically necessary.** The Plan may require the provider to submit a treatment plan, including diagnosis, proposed treatment by type, frequency, anticipated duration and anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

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

Diagnosis of Autism Spectrum Disorders means one or more tests, evaluations, or assessments to diagnose whether an individual has Autism Spectrum Disorders that is prescribed, performed or ordered by a physician licensed to practice medicine in all its branches or a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders.

Treatment for Autism Spectrum Disorders includes the following care prescribed, provided or ordered for a dependent diagnosed with an Autism Spectrum Disorder by a physician licensed to practice medicine in all its branches or by a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the

care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

- Psychiatric care.
- Psychological care.
- Habilitative or rehabilitative care, meaning professional, counseling and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain and restore the functioning of an individual. Applied behavior analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in behavior.
- Therapeutic care, including behavioral, speech, occupational and physical therapies that provide treatment in the following areas: self care and feeding; pragmatic, receptive and expressive language; cognitive functioning; applied behavior analysis, intervention and modification; motor planning; and sensory processing.

Medically Necessary, when used in connection with treatment of Autism Spectrum Disorders, means any care, treatment, intervention, service or item which is reasonably expected to do any of the following: prevent the onset of an illness, condition, injury, disease or disability; reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or assist to achieve or maintain maximum functional activity in performing daily activities.

35. **Genetic Testing.** Diagnostic testing of Genetic Information and counseling when medically appropriate, including but not limited to:

- Diagnostic testing where the patient is showing symptoms of disease, and those symptoms correspond to a medically recognized genetic disorder;
- Diagnostic testing when testing is performed on the DNA of an invading virus or bacterium for the purpose of identifying and treating a specific contagious disease;
- Predictive testing if the Covered Person's family history establishes the patient is at risk for a genetic disease, but only if there are accepted treatment alternatives for that condition;
- Prenatal testing when the pregnancy is categorized as high-risk, including cases where the mother or father has a family history that establishes that parent is at risk for having a hereditary genetic disorder.

The patient should request an Advance Determination of Medical Necessity prior to receiving services.

36. **Urgent Care Center/Facility.** Charges made by an Urgent Care Center/Facility for treatment of accidental injuries, emergency conditions and/or other non-routine care.

37. **Hospital Emergency Room Services.** Eligible charges for services provided by a Hospital Emergency Room for Emergency Medical Conditions, as defined in the Plan, will be covered by the Plan at the same benefit level (copayment and coinsurance) at both Network and Non-Network Hospitals. The Plan will determine the benefit it will pay for such services provided by a Non-Network Hospital Emergency Room based on an allowed amount that is not less than the greatest of:

- The median negotiated amount the Plan allows Network Hospitals for the same services;
- The amount Medicare allows for such services; or
- The Usual, Customary and Reasonable amount the Plan would normally allow for such services from a Non-Network Hospital.

38. **Outpatient Skeletal Adjustment (includes services performed by a D.C., D.O. or M.D.).** Benefits payable for a physician's charges while not confined to a hospital for skeletal adjustment, adjunctive therapy, vertebral manipulation, diagnostic testing and services for the care or treatment of dislocation or subluxations of the vertebrae are considered at 50% after the deductible and limited to the Calendar Year Maximum Benefit shown in the Schedule of Benefits.

39. **Mental/Nervous, Alcohol and/or Substance Abuse Conditions.** Treatment of Mental/Nervous disorders of any type, regardless of cause or origin, including but not limited to ICD-9 codes 290-299 and 300-316, may be provided by an M.D. or Ph.D. Clinical Psychologist, or by a master's level counselor (M.A.) or Master of Social Work (M.S.W.), provided they are licensed in the political jurisdiction where practicing, acting within the scope of their licenses and performing services ordered by an M.D., D.O. or a Ph.D. clinical psychologist.

Mental/Nervous, Alcohol and/or Substance Abuse disorders include services and treatment related to alcoholism, chemical addiction or abuse or drug addiction or abuse.

Benefits include services for the following:

- inpatient and outpatient services, limited to the lifetime maximum day limits for inpatient services and the lifetime maximum visit limits for outpatient services stated in the Schedule of Benefits;
- partial confinements or day programs provided the physician has recommended such care as an alternative or in lieu of inpatient confinement (two partial day confinements will be treated as one inpatient day for purposes of the lifetime inpatient day limit);
- both in and outpatient physicians visits are limited to one per day;
- services must be rendered by a provider covered under the Plan.

All inpatient services, including treatment in a Rehabilitation Facility, must be pre-certified by HealthLink.

The following services will be considered as any other illness and are not limited to the Mental/Nervous, Alcohol and/or Substance Abuse provisions:

- prescription drugs (considered under the prescription drug benefit);
- laboratory tests for prescribed drug levels when performed by an independent lab;
- surgical procedures and related expenses;
- electroshock therapy and related anesthesia provided by an independent anesthesiologist;
- charges readily identified as relating to the treatment of an acute medical condition caused by alcoholism, chemical addiction or abuse or drug addiction or abuse;
- charges for diagnosis and treatment of Autism Spectrum Disorders (subject to the annual limit stated in the Schedule of Benefits).

LIMITATIONS AND EXCLUSIONS

In order to avoid confusion or misunderstanding, please review carefully the limitations, exclusions and conditions listed below. If there is anything in this section that you do not fully understand, you are encouraged to contact the Claim Services Administrator.

Expenses Which Are Not Eligible For Benefits Under This Plan

Covered expenses **SHALL NOT** include:

1. Services or expenses incurred prior to the effective date or after the termination of coverage under the Plan.
2. Any services, supplies, charges or expenses which are not included under Covered Major Medical Expenses.
3. Any charge or portion of a charge which is in excess of the Usual, Customary and Reasonable charge, except to the extent the charge is covered by a contract with a network provider.
4. Any services not Medically Necessary for diagnosis or treatment of an active illness or injury, except that newborn care, mammograms, PSA tests, colonoscopies, routine physical examinations and other recommended preventive services are covered as described in the Wellness Benefit pages in the Schedule of Benefits and the Wellness Benefit/Preventive Services section under Covered Major Medical Expenses; circumcisions, abortions, vasectomies and tubal ligations are covered as any other illness.
5. Vaccinations, inoculations and immunizations, unless they are recommended preventive services. See the Wellness Benefit pages in the Schedule of Benefits and the Wellness Benefit/Preventive Services section under Covered Major Medical Expenses.
6. Any treatment or service not prescribed or recommended by a physician.
7. Charges for Experimental or Investigational treatment or procedures, including surgery, therapy, drugs, devices and supplies and related hospital charges, except charges for routine patient care provided in connection with an approved clinical trial. See the Clinical Trials section under Covered Major Medical Expenses and the Definitions section of this booklet.)
8. Any charges for: hearing aids, glasses, eye examinations (except routine vision screening for children), radial keratotomy surgery or any type of surgery to correct refractive error, testing, training, or correction of vision or fitting of glasses, other than the first pair of glasses or contact lenses following cataract surgery.
9. Any services or supplies for which the patient is entitled to benefits under the Workers' Compensation Act or similar legislation, or any illness or injury for which coverage under the Workers' Compensation Act or similar legislation is required by applicable law, whether or not such coverage is actually in force for the patient.
10. Expenses for any care or treatment of teeth, gums or alveolar process unless such expenses are for:
 - reduction of fractures of the jaw or facial bones;
 - surgical correction of harelip, cleft palate or protruding mandible;
 - removal of stones from salivary ducts;
 - bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;
 - freeing of muscle attachments;
 - hospital outpatient or inpatient charges in connection with oral surgery, extractions or other non-cosmetic dental procedures, but only if treatment in a hospital setting is medically necessary for the patient's condition (this includes only hospital facility charges and does not include charges of a dentist or oral surgeon for non-covered dental procedures, anesthesia or other charges);

- emergency medical services related to an injury to sound, natural teeth.
11. Unless specifically covered under Covered Major Medical Expenses and not resulting in changes to permanent structure of the teeth, treatment by any method of jaw joint problems, including temporomandibular joint syndrome.
 12. Vitamins and nutritional supplements, except as specifically covered under the Prescription Drug Card Benefit; educational training or testing.
 13. Expenses incurred for the treatment of corns, calluses or toenails, unless charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral-vascular disease.
 14. Any charges for cosmetic surgery unless the charges relate to surgery: (a) to correct a congenital defect in a newborn; (b) to repair the effects of an injury provided such surgery is performed within one year of the injury or the treatment plan is approved by the Administrator within one year of the injury; or (c) for reconstructive breast surgery after a mastectomy.
 15. Any condition, disability or expense resulting from or sustained while engaged in an illegal occupation or commission of or attempted commission of an assault or a felonious act; provided that these exclusions will not apply if the injury resulted from an act of domestic violence or a medical condition (including both physical and/or mental health conditions).
 16. Any condition, disability or expense resulting from or sustained as a result of duty as a member of the armed forces of any state or country; war or act of war declared or undeclared; an atomic explosion, or the release of nuclear energy other than when being used solely for medical treatment of an illness or injury.
 17. Any condition, disability or expense resulting from an injury caused by participating in a civil insurrection or riot.
 18. Any charges for care or treatment provided or furnished by the United States government or the government of any country, except to the extent that United States federal law requires the Plan to provide benefits for such care or treatment. (For treatment in VA facilities, the law generally requires the Plan to provide benefits for a covered individual who does not have a service-connected disability.)
 19. Any services for which a charge would not have been made in the absence of coverage, except to the extent that United States law requires the Plan to provide benefits for such services.
 20. Except as specifically covered under hospice care, services or expenses that cannot reasonably be expected to lessen the patient's disability and to enable the patient to live outside of an institution.
 21. Charges for services or supplies that were provided more than 12 months prior to the date the charges are submitted to the Plan for payment.
 22. Any charges for services or supplies related to the treatment of intentionally self-inflicted injuries; provided that this exclusion will not apply if the injury resulted from a medical condition (including both physical and/or mental health conditions).
 23. Any charges for treatment, services or supplies related to the pregnancy (including complications of pregnancy) or maternity care of dependent children.
 24. Any charges relating to organ or tissue transplants except as provided in the Organ and Tissue Transplant Coverage section under Covered Major Medical Expenses.
 25. Any charges related to reversal of a prior sterilization; or any charges related to sex transformation.
 26. Any charges related to weight control programs or weight reduction programs.

27. Any charges for surgical treatment of obesity, except as provided in the Surgical Treatment of Morbid Obesity section under Covered Major Medical Expenses.
28. Any charges related to rhinoplasty, blepharoplasty or brow lift performed for non-cosmetic reasons, unless such charges are incurred after the individual has been covered under the Plan at least 12 consecutive months or, in the case of rhinoplasty, the procedure is necessary to correct the results of an accidental injury. Any such surgical procedures performed for cosmetic reasons shall not be covered.
29. Any charges for services performed by a person who ordinarily resides in the Covered Person's household, or who is a close family member as defined in the Definitions section of this booklet.
30. Any charges for services received or supplies purchased outside the United States, unless the Covered Person is a resident of the United States, and the charges are incurred while traveling on business or for pleasure.
31. Any charges for artificial insemination, in vitro fertilization or embryo or fetal implants, or other assisted reproduction techniques, except as provided in the Treatment of Infertility section under Covered Major Medical Expenses.
32. Any charges incurred by any person not covered under the Plan as an Employee or dependent, including, but not limited to, charges for services provided to a surrogate mother or to the biological mother of a child adopted by an Employee. This shall not preclude payment of covered donor expenses for covered transplant procedures.
33. Expenses incurred for custodial care. For the purpose of this limitation, expenses incurred for care comprised of accommodations including room and board and other institutional services, nursing services provided to a covered person because of age or other mental or physical conditions, or services primarily to assist the covered person in the activities of daily living, shall be deemed custodial care. The fact that the covered person is concurrently receiving medical services that are merely maintenance care and cannot reasonably be expected to contribute substantially to the improvement of a medical condition shall not preclude the application of this limitation.
34. Any charges intentionally incurred by a covered person for the benefit of an unrelated person, including but not limited to charges relating to surrogate pregnancy and charges relating to removal of an organ or tissue for transplant into an unrelated person.

ELIGIBILITY

You and your dependents are eligible for coverage provided you are an eligible Employee as defined below and have completed any applicable waiting periods as designated by your Participating Employer. **You will have 31 days from the date you are first eligible to enroll for coverage.** If proper application is made within 31 days of the date eligible, coverage will be effective on the date eligible.

If you acquire a new dependent (other than a newborn child) after your enrollment in the Plan, you must apply for new dependent coverage within 31 days. Coverage for the new dependent will then be effective on the date the dependent first qualified as a dependent. If you do not enroll a new dependent within 31 days from the date the dependent first became your dependent, you will not be permitted to enroll the dependent until the next annual open enrollment period, unless you have a qualifying change in status or special enrollment event.

Newborn Children: The Plan allows you more time to enroll a newborn child, including a newborn adopted child:

- **Full Family or Employee Plus Child(ren) Coverage:** If you are already enrolled for full family coverage (Employee plus spouse or civil union partner and at least one child) or Employee Plus Child(ren) coverage (Employee plus at least one child) your newborn child will be covered under your family coverage or Employee Plus Child(ren) coverage from birth. There is no time limit on enrollment in this case, but you must enroll the child before claims for the child can be considered.
- **Single or Employee Plus Spouse Coverage:** If you are enrolled for single coverage or Employee plus spouse or civil union partner coverage, you must enroll your newborn child within 90 days of birth and pay the additional premium to add the child. If you do not enroll your newborn within 90 days after birth, you will not be permitted to enroll the child until the next annual open enrollment period, unless you have a qualifying change in status or special enrollment event.

If, in anticipation of adoption, an Employee is awarded physical or legal custody of a newborn child within 10 days of the date of birth, the child will be considered an eligible dependent of the Employee from the date of birth. Otherwise, an adopted child will be considered an eligible dependent when the Employee is awarded physical or legal custody. Newborn adopted children must be enrolled within the same periods as other newborns, as described above.

REMEMBER: If you do not enroll yourself and/or your dependents when first eligible you cannot enroll in the Plan before the next annual open enrollment period unless you have a qualifying change in status or special enrollment event.

If you enroll in the Plan you cannot drop coverage for yourself or any dependent until the next annual open enrollment period unless you have a qualifying change in status. See “Annual Open Enrollment” and “Qualifying Change in Status” below.

NOTE: If you transfer your employment from one Participating Employer to another Participating Employer, you must enroll with your new Employer within 31 days. Transfer of coverage in this case is not automatic. Also, because special rules apply in such cases, please contact your Personnel Department or the Claim Services Administrator for additional information.

Eligible Employee

An eligible Employee is any Employee (averaging 20 or more hours of work per week or such minimum hours per week as may be required by the Employer) of a Participating Employer who is eligible for, and enrolled for, benefits under this Plan; or a retiree who immediately prior to retirement was considered an Employee and was covered under the Plan.

An Employee who otherwise qualifies as an eligible Employee who is on an approved leave of absence under the leave policy of the Participating Employer will also be considered an eligible Employee during the approved leave period up to a maximum of 12 months from the end of the

month in which the Employee was last actively at work. Any period for which the Employee receives vacation pay or sick pay and any other period of paid or unpaid leave, including FMLA leave, will be included in the maximum 12-month leave period.. An Employee who is on an approved leave of absence that exceeds 12 months is deemed to be covered under the Continuation of Coverage section of the Plan up to the maximum coverage period. In this circumstance, the last day of the approved leave or the end of the first 12-month period, which ever occurs first, will be the first day of the continuation of coverage period.

An Employee shall be classified as one of the following:

- a. **Certified Personnel:** a person required to have a teaching certificate for the position of employment that the person holds with the Employer;
- b. **Educational Support Personnel:** a person not required to have a teaching certificate for the position of employment that the person holds with the Employer; or
- c. **Retiree:** a former Employee (either Certified Personnel or Educational Support Personnel) who retired from employment as an eligible Employee of the Employer, was covered by the Plan (or the prior plan of the Employer) at the time of retirement and has maintained continuous coverage under the Plan (or the prior plan of the Employer) since retirement. A retired person will only qualify for coverage as a Retiree under the Plan if the person is eligible for a pension benefit or a disability pension benefit from either the Illinois Municipal Retirement Fund (IMRF) or the Teachers Retirement System (TRS), as determined by IMRF or TRS.

Eligible Dependents

The following are considered eligible dependents:

- a. The legal spouse of the Employee or the legal civil union partner of the Employee (as determined under Illinois law);
- b. The Employee's children between the ages of birth and age 26, whether or not they are married or students or dependent on the Employee for support. The term "children" shall include an Employee's natural children, adopted children (including children in the physical and legal custody of the Employee prior to finalization of adoption), foster children, step-children (including children of the Employee's civil union partner), and other children in the legal custody of the Employee by court order, and any child who is required to be covered in accordance with the requirements of a Qualified Medical Child Support Order. A child for whom an Employee obtained legal custody by court order before the child reached age 18 will continue to be considered the child of the Employee after the child reaches age 18 and is no longer in legal custody provided the child otherwise meets the requirements to qualify as a dependent child.
- c. The Employee's unmarried child age 26 to 30 if the child is an Illinois resident and has been discharged from service in the active or reserve components of the U.S. Armed Forces or National Guard.
- d. The Employee's unmarried dependent child age 26 or older who is incapable of self-sustaining employment by reason of mental or physical disability, is chiefly dependent upon the child's parent(s) for support and maintenance, and was covered under this Plan immediately before the child reached the applicable maximum age for coverage as a dependent child (age 26 or 30). Proof of such incapacity and dependency must be furnished to the Plan by the Employee within 31 days of the child's 26th or 30th birthday, as applicable. The Administrator may require, at reasonable intervals, subsequent proof of the child's continuing disability and dependency. The Plan reserves the right to have such dependent examined by a physician of the Plan's choice to determine the existence of such incapacity.

Excluded as dependents are:

- a. a spouse legally separated or divorced from the Employee;
- b. a civil union partner after the civil union with the Employee has legally terminated; and
- c. any person while on active duty in any military service of any country.

A child may be covered under this Plan by only one Employee.

NOTE: Each Participating Employer is responsible for verifying that its Employees, retired Employees and their dependents satisfy the eligibility requirements to participate in the Plan. The Employer may be required to submit evidence of eligibility to the Claim Services Administrator at any time.

Annual Open Enrollment

The Plan has one open enrollment period each year. The open enrollment period is from August 1 through September 30 each year, with an effective date of September 1 or October 1, as determined by each Participating Employer. You may add or drop coverage for yourself or your dependents during the open enrollment period.

The coverage elections you make for yourself and your dependents during the open enrollment period will be **irrevocable** for the next 12 months unless you have a qualifying change in status, as described below. If you and/or your dependents choose not to enroll in the Plan for the following year or when first eligible, you will not be permitted to enroll before the next open enrollment period unless you have a qualifying change in status. Conversely, if you elect coverage under the Plan, you may not drop your coverage before the next open enrollment period unless you have a qualifying change in status.

Retired Employees and dependents must be covered by the Plan at the time the Employee retires. Retirees and their dependents are not permitted to enroll in the Plan after retirement. A covered Retiree is not permitted to enroll new dependents acquired after retirement.

Changing Plans

The Trust offers five benefit Plans with different Schedules of Benefits. The five Plans are the Platinum Plan, the Gold Plan, the Silver Plan, the Bronze Plan and the Copper Plan. Each Participating Employer will decide which Plan or Plans will be available to its Employees. An Employer may offer only one Plan or may offer up to four Plans. If an Employer selects the Copper Plan it cannot offer any other Plan to its Employees.

If your Employer offers more than one Plan, you must select and enroll in the Plan you want during an open enrollment period. All covered family members must enroll in the same Plan. You cannot change between Plans outside of the annual open enrollment period, even if you have a qualifying change in status that allows you to add or drop coverage for yourself or for your dependents.

If your Employer offers more than one Plan, you may move from a higher Plan to a lower Plan (from Platinum to Gold, Silver or Bronze, or from Gold to Silver or Bronze, or from Silver to Bronze) by making an election during any open enrollment period. The change to the lower Plan will be effective as of September 1 or October 1 of the same year.

If your Employer offers more than one Plan and you want to move to a higher Plan (from Gold to Platinum, or from Silver to Gold or Platinum, or from Bronze to Silver, Gold or Platinum) you must give one year advance notice that you intend to change Plans. This notice must be given in writing to your Employer during an open enrollment period. The change to the higher Plan will then become effective September 1 or October 1 of the following year. This notice is irrevocable. You will be required to enroll in the higher Plan for 12 months before you can change to a different Plan.

Exceptions: There are two exceptions to the rule that changes between Plans may not be made outside the annual open enrollment period.

- (1) An Employer may elect to offer the Bronze Plan as the only Plan for its Employees effective as of January 1 of any year. If an Employer which previously offered one or more other Plans makes the decision to offer the Bronze Plan as its only Plan effective as of any January 1, Employees of that Employer will be permitted to enroll in or drop coverage for themselves and their eligible dependents as of the initial January 1 effective date. Thereafter, decisions to enroll in or drop coverage can only be made during the normal annual open enrollment period unless there is a qualifying change in status.
- (2) An Employer may elect to offer only the Gold Plan or only the Silver Plan as the only Plan option for its Employees effective as of January 1 of any year, provided that the sole Plan offered is not richer than the richest Plan previously offered by the Employer. If an Employer which previously offered one or more other Plans makes the decision to offer only the Gold Plan or only the Silver Plan effective as of any January 1, all enrolled Employees of that Employer and their enrolled eligible dependents will be automatically transferred to such Plan as of the January 1 effective date. Employees will not be permitted to enroll in or drop coverage for themselves or their eligible dependents until the next annual open enrollment period unless there is a qualifying change in status.

Qualifying Change In Status

During a school year you may change your elections to enroll or drop coverage for yourself or one or more dependents only if the change is on account of and consistent with one of the events listed below:

- a. a Family Status Change;
- b. an Employment Status Change;
- c. a Special Enrollment Rights event; or
- d. entitlement to coverage under Medicare, Medicaid, a state children's health insurance program (CHIP) or any other government health insurance program.

A qualifying change in status does not allow you to change to a different Plan (the Platinum Plan, Gold Plan, Silver Plan or Bronze Plan) outside the annual open enrollment period.

A **Family Status Change** means any of the following:

- a change in legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment;
- a change relating to a civil union, including an Employee entering into a civil union, death of a civil union partner, or termination of a civil union;
- a change in the number of dependents, including birth, death, adoption and placement for adoption;
- an event that causes an eligible dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of age, marriage or other circumstance;
- a change in place of residence to a location outside the Plan's Designated Area;
- a change that makes an Employee or dependent eligible for Special Enrollment Rights, as described below;
- a judgment, decree or order, including a Qualified Medical Child Support Order, that requires you to provide coverage for a child under this Plan or requires your current or former spouse or civil union partner to provide coverage for the child under another plan.

An **Employment Status Change** means any of the following events that changes your employment status or the employment or coverage status of your spouse, civil union partner or other dependent:

- commencement or termination of employment;
- a strike or lockout;
- commencement of or return from an approved leave of absence;
- a change in work location or other change in employment status with the consequence that you and/or your dependents become (or cease to be) eligible to participate in this Plan or in a plan sponsored by the employer of your dependent (e.g., a spouse or civil union partner changes from full-time to part-time or from salaried to hourly paid with the consequence that the spouse or partner and/or dependents cease to be eligible to participate in an employer-sponsored plan);
- the open enrollment period for the health benefit plan of your dependent if that period does not coincide with the open enrollment period in this Plan;
- the annual TRS insurance plan open enrollment period for retired employees and their dependents.

Special Enrollment Rights

Loss Of Other Coverage: If you (an Employee or dependent) declined coverage when you were first eligible because you had coverage under another medical plan, you may enroll in this Plan within 31 days after you lose the other coverage, if the reason you lose the other coverage is one of the following reasons:

- the other coverage was COBRA continuation coverage and your period of COBRA coverage was exhausted;
- the other coverage was terminated as a result of loss of eligibility, including loss of eligibility due to separation, divorce, termination of a civil union, death, termination of employment, or reduction in the number of hours worked; or
- the other coverage was terminated because the employer ceased making contributions for the coverage.

Only individuals who lose coverage under the circumstances described above are eligible to enroll under this rule. This does not allow you to enroll other family members who have not lost coverage.

New Dependents: You (an Employee or dependent) may enroll in this Plan within 31 days after the Employee acquires a new dependent by marriage, entering into a civil union or by birth or adoption. All eligible family members may enroll when the Employee acquires a new dependent.

Note: As explained above, you are allowed more than 31 days to enroll a newborn child. However, to take advantage of these Special Enrollment Rights to enroll yourself or other dependents due to birth of a child, you must enroll yourself and/or the other dependents within 31 days of the birth.

Loss of Coverage under Medicaid or CHIP or Eligibility for Premium Assistance: You (an Employee or dependent) may enroll in this Plan within 60 days after you lose your eligibility for coverage under Medicaid or a state children's health insurance program (CHIP) or within 60 days after you become eligible to receive state assistance with the cost of your premiums for coverage under this Plan. Information about States that offer premium assistance and contact information is available from the U.S. Department of Labor at 1 (866) 444-3272 or at:

<http://www.dol.gov/ebsa/chipmodelnotice.doc>.

You will be required to provide your Employer with written evidence of the applicable qualifying change in status in order to change your coverage elections outside the annual open enrollment period. Generally notice must be provided with 31 days of the applicable change in status, but if the change in status event is loss of coverage under Medicaid or CHIP or entitlement to state assistance with premiums for coverage under this Plan, notice must be provided within 60 days of such event.

Retired Employees and their dependents must be covered by the Plan at the time of the Employee's retirement. Enrollment is not permitted after retirement.

Reinstatement After Lapse In Coverage Due To Approved Family Or Medical Leave Of Absence

The normal rules that preclude mid-year enrollment are waived for any Employee and eligible dependents who were previously covered under the Plan and resume coverage following a brief lapse in coverage, provided that ALL of the following requirements are satisfied:

- a. coverage lapsed during a period the Employee was on an approved leave of absence from the Employer;
- b. the reason for the leave is a reason that would qualify as family or medical leave under the Family and Leave Act (FMLA)* (whether or not the Employee is actually entitled to leave under the FMLA); and
- c. the lapse in coverage does not exceed the shorter of the actual period of leave taken by the Employee or 12 weeks (26 weeks for military caregiver leave).

* Under the FMLA a leave of absence may be taken for any of the following reasons:

- a. the birth of a child of the Employee;
- b. placement of a child with the Employee for adoption or foster care;
- c. a serious health condition that makes the Employee unable to perform his or her job;
- d. to permit the Employee to care for a spouse or civil union partner, a child or parent if the family member has a serious health condition;
- e. "qualifying exigency leave" if the Employee's spouse or civil union partner, child or parent (i) is a retired member of the Armed Forces or Reserves or in the Reserves or National Guard and (ii) is on active duty or ordered to active duty in the U.S. Armed Forces in support of a contingency operation (as designated by the Secretary of Defense and stated in the service member's active duty orders) to permit the Employee to make childcare, legal or financial arrangements or for other activities prescribed in the FMLA regulations; or
- f. "military caregiver leave" to permit the Employee to care for a spouse or civil union partner, child, parent or next of kin who is a current member of the Armed Forces or National Guard or Reserves who has a serious injury or illness incurred in the line of active duty for which the service member is undergoing outpatient medical treatment, recuperation or therapy.

Multiple Eligibility

If both an Employee and the Employee's spouse or civil union partner are Employees of Employers participating in the Trust, each spouse or partner may have separate coverage as an Employee. Either spouse or partner may be covered as a dependent of the other, or one or both may be covered as both an Employee and as a dependent. An Employee may change from coverage as an Employee to coverage as a dependent of his or her spouse or partner, or from coverage as a dependent to coverage as an Employee at any time, provided that there is not a lapse in coverage.

If both a Retiree and the Retiree's spouse or civil union partner are covered as Retirees (or as an Employee in the case of the spouse or partner) of Employers participating in the Trust, each spouse or partner may be covered as a dependent of the other, or one or both spouses or partners may be covered as both a Retiree (or Employee) and as a dependent. A Retiree may

change from coverage as a Retiree to coverage as a dependent, or from coverage as a dependent back to coverage as a Retiree, provided that there is no lapse in coverage and provided further that the Employer from which the Retiree retired continues to participate in the Trust. A mere change in status without a lapse in coverage will not be considered as a late enrollment (which is not permitted for Retirees and dependents of Retirees).

Children may not be covered as dependents of more than one Employee.

Termination Of Coverage

Except as otherwise specified below, coverage under the Plan will terminate on the earliest of the following dates:

- a. with respect to all Covered Persons, the date of termination of the Plan;
- b. the date the Employee's Employer ceases to be a Participating Employer in the Plan;
- c. with respect to Employees, the last day of the month in which your employment with a Participating Employer terminates, unless you are eligible for coverage as a Retiree;
- d. with respect to Employees, the date membership in an eligible class ceases;
- e. with respect to all Covered Persons, the date all coverage or certain benefits are terminated for the Covered Person's particular class by modification of the Plan;
- f. with respect to dependents, the date the Employee's coverage terminates for any reason other than death;
- g. with respect to dependent spouses, the last day of the month in which the spouse is legally separated or divorced from the Employee;
- h. with respect to dependent civil union partners, the last day of the month in which the civil union is legally terminated;
- i. with respect to dependent children, the earliest of:
 - the last day of the month in which the dependent ceases to qualify as a foster child of the Employee or ceases to be a step-child of the Employee due to divorce of the child's parent from the Employee or termination of a civil union between the child's parent and the Employee;
 - the last day of the month in which the dependent reaches age 26 (unless the dependent remains eligible under the rules for dependent veterans or disabled dependent children);
 - the last day of the month in which a dependent veteran reaches age 30 (unless the dependent remains eligible under the rules for disabled dependent children);
 - the last day of the month in which a disabled dependent age 26 or over ceases to be disabled or ceases to be dependent on the Employee for support; or
 - the last day of the month in which an otherwise eligible dependent child age 26 or older marries;
- j. with respect to all Covered Persons, the date the Covered Person becomes a full-time member of the armed forces of any country; or
- k. with respect to all Covered Persons for whom a periodic contribution is required, the due date of a required contribution that has not been made.

Coverage will terminate immediately on the dates and upon the events stated in this section. Coverage may not be rescinded, which means coverage may not be cancelled retroactively for a period during which an individual was enrolled, for any reason other than an act or omission that constitutes fraud (including forgery) or an intentional misrepresentation of a material fact. The Plan will provide 30 days written notice before rescinding coverage due to fraud or intentional

misrepresentation, but the rescission may be given retroactive effect. Termination of coverage for failure to pay required contributions is not a rescission.

Disability Of Employee. If an Employee's employment terminates due to disability, coverage for the Employee and covered dependents may be continued in accordance with the "Continuation of Coverage" provisions, provided all required contributions are made when due. If your disability is certified by Social Security, IMRF or TRS, you and your eligible dependents may continue your regular coverage and will not be required to elect continuation coverage as long as you remain so certified and all required contributions are made when due.

Death Of Employee. If an Employee's employment terminates due to death or in the event of the death of a covered Retiree, regular coverage for the Employee's or Retiree's covered eligible dependents may be continued, provided that the former Employer of the deceased Employee (or Retiree) remains a Participating Employer in the Trust, and the dependents continue to make the contribution normally required for dependent coverage. Except as provided in the Continuation of Coverage provisions, benefits for the deceased Employee's surviving spouse or civil union partner will terminate if the surviving spouse or partner marries or enters into a civil union, and benefits for any eligible dependent child will terminate if the dependent ceases to qualify as an eligible dependent. Benefits for a surviving dependent child (but not for a surviving dependent spouse or civil union partner) will also terminate if the dependent child becomes eligible for Medicare.

Certificate Of Coverage

When your coverage terminates you are entitled to receive a Certificate stating the period you were covered under this Plan. You should submit the Certificate when you enroll in a new insurance plan. If you enroll without a lapse in coverage of more than 63 days, the new plan will be required to count your coverage under this Plan if the new plan has limitations or exclusions for pre-existing conditions. Contact the Claim Services Administrator to ask for a Certificate if you do not receive one. You must notify the Employer if you are terminating a dependent's coverage.

Suspension Of Claims

If your coverage terminates due to the withdrawal of your Employer as a Participating Employer in the Plan, and if your Employer fails to make all required contributions and withdrawal payments to the Trust, your claims must be suspended and payment will not be made until your Employer has satisfied its obligations to the Plan and Trust. If your Employer fails to satisfy its obligation to the Trust, the Employer will be responsible for any pending claims you or your dependents may have.

CONTINUATION OF COVERAGE (COBRA)

VERY IMPORTANT NOTICE

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring that most employer sponsored group health plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This coverage is called "continuation coverage" or COBRA. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the premium for your continuation coverage.

This summary is intended only to summarize, as best possible, your rights and obligations under the law. The law, however, is not clear on some points and is interpreted by Federal agencies and the courts. Therefore, this summary is subject to change without notice as interpretations or changes of the law occur. Both you and your spouse or civil union partner should read this summary carefully and keep it with your records. While the Federal law does not provide continuation coverage rights to civil union partners, the Plan provides the same continuation rights to civil union partners as it is required to provide to spouses.

Qualifying Events

If you are an **Employee** covered by the Plan you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Retirement or other termination of your employment (for reasons other than your gross misconduct); or
2. Reduction in the hours of your employment below the minimum required for eligibility.

If you are the **spouse** or **civil union partner** of an Employee covered by the Plan you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of the Employee;
2. Retirement or termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment with the Employer; or
3. Divorce or legal separation from the Employee, or termination of the civil union; or
4. The Employee becomes entitled to Medicare benefits.

In the case of a **dependent child** of an Employee covered by the Plan, the child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

1. The death of the Employee parent;
2. Retirement or other termination of the Employee parent's employment (for reasons other than gross misconduct) or reduction in the Employee parent's hours of employment with the Employer;
3. Parent's divorce or legal separation or termination of a civil union;
4. The dependent ceases to be a "dependent child" as defined under the Plan; or
5. The Employee parent becomes entitled to Medicare benefits.

A child born or adopted while one or both parents is covered under COBRA continuation coverage may also be enrolled for COBRA coverage.

NOTE: Under this Plan dependents generally do not lose coverage if the Employee dies, Employees and their dependents generally do not lose coverage if the Employee retires and receives a pension from IMRF or TRS, and Retirees and Employees generally do not lose coverage when they become eligible for Medicare. In cases where the event does not

cause loss of coverage, Employees and their dependents do not need to elect COBRA continuation coverage. However, the Employee's death, retirement or eligibility for Medicare will be considered a COBRA qualifying event for purposes of measuring the period during which the Employee's dependents retain COBRA rights. If another event occurs that causes the dependents to lose coverage under the Plan, all coverage from the date of the initial COBRA qualifying event will be counted in determining the maximum COBRA coverage period. For example, if an Employee or Retiree decides to drop Plan coverage due to Medicare eligibility or eligibility for medical benefits under TRS or IMRF, dependents of the Employee or Retiree will lose their coverage. The dependents may elect continuation coverage under these COBRA rules for any remaining portion of the COBRA coverage period if the loss of regular coverage occurs within the maximum COBRA coverage period, measured from the date of the applicable initial qualifying event (death of the Employee or retirement/termination of employment or eligibility for Medicare). See the Maximum Coverage Periods section below. Dependents whose coverage has been continued under the terms of the Plan beyond the maximum COBRA coverage period, measured from the date of the initial qualifying event, may not elect continuation coverage under these COBRA rules.

Notice And Election

The Employee or a family member has the responsibility to notify the Employer of a divorce, legal separation, termination of a civil union or a child losing dependent status under the Plan. You or your family member must give this notice no later than 60 days after the date of the applicable event. **If you fail to give this notice during the 60-day period, you will not be offered the option to elect continuation coverage.**

When the Employer is notified that one of these events has happened, the Employer must notify the Claim Services Administrator. The Employer must also notify the Claim Services Administrator if one of the following events occurs and results in a loss of coverage: the Employee's retirement or other termination of employment, reduction in hours, or death, or the Employee becoming entitled to Medicare. The Claims Services Administrator will then notify you in writing that you have the right to elect continuation coverage.

You must elect continuation coverage within 60 days after your regular Plan coverage ends, or, if later, within 60 days after you are notified of your right to elect continuation coverage. If you do not elect continuation coverage within this 60-day period, you will lose your right to elect continuation coverage.

The Employee and the spouse or civil union partner and dependent children each have an independent right to elect continuation coverage. Thus a spouse or civil union partner or dependent child may elect continuation coverage even if the Employee does not elect it.

Importance Of Continuation Coverage

Failure to elect continuation coverage when you are eligible for such coverage may affect your future rights under federal law, as follows:

1. You may lose the right to avoid having pre-existing condition exclusions applied by other health plans if you have more than a 63-day gap in health coverage. Electing COBRA coverage may help avoid such a gap.
2. You may lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition limitations if you do not elect COBRA coverage for the maximum period available to you.
3. You should keep in mind your special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your regular coverage under the Plan ends because of a qualifying event. You will have the same special enrollment right at the end of your period of COBRA coverage if you elect COBRA coverage for the maximum period available to you.

Type Of Coverage: Premium Payments

If you elect continuation coverage, the Plan must provide coverage that, as of the time coverage is provided, is identical to the coverage provided under the Plan to similarly situated Employees or family members. If the coverage for similarly situated Employees or family members is modified, your coverage will be modified.

You must pay the premium payment for your "initial premium month" and subsequent months to bring your payments current, by the 45th day after you elect continuation coverage. Your initial premium month is the first month after your regular Plan coverage terminates. All future premiums are due on the 1st of the month for which the premium is due, subject to a 30 day grace period.

COBRA premium rates will be determined as follows:

- Employee only: Employee rate plus 2% administration charge;
- Employee and Spouse/Partner: Employee + Spouse/Partner rate plus 2%;
- Employee and Child or Children: Employee + Child or Children rate plus 2%;
- Employee and Spouse/Partner and One or More Children: Family rate plus 2%;
- Spouse/Partner only: Difference between Employee + Spouse/Partner rate and Employee rate plus 2%;
- One or More Children: Difference between Employee + Child or Children rate and Employee rate plus 2%;
- Spouse/Partner and One or More Children: Difference between Family rate and Employee rate plus 2%.

Maximum Coverage Periods

1. **36 months.** If you (a covered dependent spouse or civil union partner or dependent child) lose coverage because of the Employee's death, divorce, legal separation, termination of a civil union or the Employee's becoming entitled to Medicare or because you lose your status as a dependent under the Plan, the maximum coverage period (for the spouse or civil union partner and/or dependent child) is 36 months from the date of the qualifying event.
2. **18 months.** If you (the Employee, the Employee's spouse or civil union partner or dependent child) lose group health coverage because of the Employee's retirement or termination or reduction in hours of the Employee's employment, the maximum continuation coverage period (for the Employee, spouse or civil union partner and/or dependent child) is 18 months from the date of retirement, termination or reduction in hours. There are four exceptions:
 - If an Employee or a covered family member is disabled on the date of retirement, termination or reduction in hours, or becomes disabled within 60 days after such date, the continuation coverage period for the disabled person and all covered family members may be extended to 29 months from the date of retirement or termination or reduction in hours. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act, IMRF or TRS. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act, IMRF or TRS must be provided to the Employer within 60 days after the date of the determination of disability. You may be charged a higher premium for the 19th through 29th months, but not more than 150% of the rate otherwise applicable.
 - If a second qualifying event occurs (for example, the Employee dies or a divorce occurs or the Employee becomes entitled to Medicare) during the initial 18-month or 29-month coverage period, the maximum coverage period for the spouse or civil union partner or dependent child will be 36 months from the date of the Employee's retirement or termination or reduction in hours.
 - If the Employee became entitled to Medicare benefits within the 18-month period preceding the Employee's retirement or termination of employment or reduction in hours,

the maximum coverage period for the Employee's spouse or civil union partner or dependent child may be extended through the end of the 36-month period beginning on the date the Employee became entitled to Medicare benefits.

- If the Employee left employment to assume active military duty, the coverage period for the Employee and the Employee's dependents may be extended to up to 24 months from the date the Employee left employment for military duty, but not later than the last day the Employee had to apply for reemployment in order to preserve the Employee's rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Termination Before The End Of Maximum Coverage Period

Your continuation coverage under this Plan automatically terminates (even before the end of the maximum coverage period) when any one of the following six events occurs:

1. The Employer no longer provides group health coverage to any of its employees.
2. The Employer withdraws from the Trust.
3. The premium for your continuation coverage is not timely paid.
4. After electing continuation coverage you become covered under another group health plan (as an Employee or otherwise), that does not contain any exclusions or limitations with respect to any pre-existing condition you may have, or when any such exclusions or limitations no longer apply to you.

NOTE: By law, your new health plan may be required to count the period you were covered under this Plan toward satisfying any waiting period the new plan requires for covering pre-existing conditions.

5. After electing continuation coverage you become entitled to Medicare.
6. If you became entitled to a 29-month coverage period due to your disability or disability of a covered family member, when there is a final determination under the Social Security Act or IMRF or TRS that you or the family member is no longer disabled.

Other Information

If you have questions about this notice or COBRA, please contact your Employer or the Claim Services Administrator.

If your marital status or civil union status changes, or a dependent ceases to be a dependent eligible for coverage under the Plan terms, or your address or a dependent's address changes, you must immediately notify the Employer.

Certificate of Coverage

When your continuation coverage terminates you are entitled to receive a Certificate stating the period you were covered under this Plan. You should submit the Certificate when you enroll in a new insurance plan. If you enroll without a lapse in coverage of more than 63 days, the new plan will be required to count your coverage under this Plan if the new plan has limitations or exclusions for pre-existing conditions. Contact the Claim Services Administrator to ask for a Certificate if you do not receive one.

DEFINITIONS

This section defines some of the more commonly used terms. To help you better understand the benefits and provisions of your Plan, please take a few moments to review these definitions.

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

Birthing Center means any freestanding health facility, place, professional office or institution that is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a physician and either a registered nurse (R.N.) or a licensed mid-wife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Claim Services Administrator means the person or firm employed by the Plan Administrator to provide consulting services in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

Close Family Member as used in the Plan means a person who ordinarily resides in the Covered Person's household, or who is related to the Covered Person as a spouse or civil union partner, parent, child, brother or sister, whether such relationship is by blood or exists in law (by marriage or civil union).

Complications of Pregnancy means conditions with diagnoses that are distinct from pregnancy, but which are adversely affected by or are caused by a pregnancy. Complications of pregnancy include: acute nephritis, nephrosis, cardiac decompensation, puerperal infection, eclampsia, missed abortion, ectopic pregnancy that is terminated, spontaneous termination of pregnancy occurring during a term of gestation in which there is not a viable birth (this does not include voluntary or elective abortion), or other medical and surgical conditions of comparable severity.

Complications of pregnancy do not include: Cesarean section delivery, false or premature labor, occasional spotting, physician prescribed rest during pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, or similar conditions associated with the management of high risk pregnancy but which do not constitute a diagnostically distinct complication of pregnancy.

Convalescent Nursing Home/Extended Care Facility/Skilled Nursing Facility means only an institution, other than a hospital, which meets all of the following requirements:

- a. maintains permanent and full-time facilities for bed care of 10 or more residents;
- b. has available at all times the services of a physician;
- c. has a Registered Nurse (R.N.) or physician on full-time duty in charge of patient care and one or more Registered Nurses (R.N.'s), Licensed Vocational Nurses (L.V.N.'s), or Licensed Practical Nurses (L.P.N.'s) on duty at all times;
- d. maintains daily medical records for each patient;
- e. is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their illness or injury, and is not, other than incidentally, a rest home or a home for the custodial care for the aged; and
- f. is operating lawfully as a skilled nursing facility/extended care facility in the jurisdiction where it is located.

In no event, however, shall such term include an institution primarily engaged in the care and treatment of drug addiction or alcoholism.

Covered Person means a covered Employee or retired Employee, a covered eligible dependent or a person enrolled for COBRA coverage under the Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, and individual health insurance policy, Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care means that care that provides a level of routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a lay person who does not have professional qualifications, skills or training. Custodial care includes, but is not limited to:

- a. help in walking or getting into or out of bed;
- b. help in bathing, dressing or eating;
- c. help in other functions of daily living of a similar nature;
- d. administration of or help in nursing or applying medications, creams or ointments;
- e. routine administration of medical gasses after a regimen of therapy has been set up;
- f. routine care of a patient, including functions such as changes of dressings, diapers, protective sheets and periodic turning and positioning in bed;
- g. routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters;
- h. routine tracheostomy care; and
- i. general supervision of exercise programs including carrying out maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

Disability/Period of Disability means any period of illness or injury, or multiple illnesses or injuries arising from the same cause, including any and all complications therefrom, which are not separated by complete recovery as certified by the attending physician and return to active full-time employment in case of the Employee; or in the case of a Retiree or dependent, return to the resumption of the normal activities of a person of the same age and sex in good health.

Durable Medical Equipment means equipment that meets all of the following requirements:

- a. it can withstand repeated use;
- b. it is primarily and customarily used to serve a medical purpose;
- c. it would generally not be useful in the absence of an injury or illness;
- d. it is appropriate for home use;
- e. it is not primarily and customarily for convenience;
- f. it provides direct aid or relief of the medical condition;
- g. it is prescribed by a doctor.

Educational in Nature means the primary purpose of any drug, device, medical treatment or procedure is to provide the patient with any training in matters that are other than directly medical.

Eligible Expenses and Covered Charges mean the Usual, Customary and Reasonable (UCR) charges, or the HealthLink network contracted amount, incurred for necessary hospital, surgical, diagnostic and other medical services and supplies that have been directly furnished for the purpose of therapeutic treatment of accidental injury or illness not connected with employment with any employer. Charges must be incurred while the Covered Person is covered under this Plan and shall include only services, supplies and treatment furnished upon the order of a physician acting within the scope of his or her license. An eligible expense or charge shall be deemed to be incurred on the date on which the particular service or supply which gives rise to the expense is rendered or obtained.

Eligible expenses and covered charges are interchangeable terms under this Plan. A covered charge may be reimbursed at the levels set out in the Schedule of Benefits. The Covered Major

Medical Expenses section of this booklet details eligible expenses covered under this Plan. Also see the Limitations and Exclusions section for expenses that are limited or not covered.

Eligible expenses and covered charges only include medical services generally accepted by the medical community of the United States as necessary and appropriate for diagnosis and therapeutic treatment of a medically diagnosed injury or illness; and, when more than one acceptable alternative service is available, benefits shall be paid based on the prevailing charge (UCR) or the network contracted amount for the least expensive, medically acceptable service.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Employee/Retiree means an **Employee** (averaging 20 or more hours per week or such minimum hours per week as may be required by the Employer) of a Participating Employer who is eligible for, and enrolled for benefits under this Plan; or a Retiree as defined. **Retiree** means a person who retired from employment as an eligible Employee of an Employer, was covered under the Plan (or the prior plan of the Employer) at the time of retirement and has maintained continuous coverage under the Plan (or the prior plan of the Employer) since retirement. A Retiree will only qualify for coverage as a Retiree under the Plan if the Retiree is eligible for a pension benefit or disability pension benefit from either the Illinois Municipal Retirement Fund (IMRF) or the Teachers Retirement System (TRS), as determined by IMRF or TRS.

Employer/Participating Employer means individually or collectively, the various public and special education districts and such other similar entities that elect to become Participating Employers in the Egyptian Area Schools Employee Benefit Trust.

Experimental or Investigational means any service, supply, care or treatment that is not properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The determination of whether care or treatment is Experimental or Investigational shall be made by the Administrator in good faith guided by a reasonable interpretation of Plan provisions and the following principles:

- a. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- b. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- c. if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- d. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure;

or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. With respect to an individual, Genetic Information includes information about (1) the individual's own genetic tests, (2) the genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in the individual's family members. Genetic Information also includes any request for or receipt of genetic services (including genetic testing, counseling or education), or participation in clinical research which includes genetic services, by the individual or any family members.

Home Health Agency means an organization, or its distinct part, that meets the following requirements:

- a. its primary purpose is providing skilled nursing and other therapy for, and in the private homes of, persons recovering from an injury or illness;
- b. it is licensed or approved under any state or local standards that apply;
- c. it is run under policies established by a professional staff that includes doctors and registered nurses;
- d. its services are supervised by a doctor or registered nurse;
- e. it keeps clinical records on all patients; and
- f. it does not, except incidentally, provide care or treatment of the mentally ill or care of a custodial nature.

Home Infusion means the intravenous administration of medication or intravenous administration of fluids for nourishment. Common types of home infusion therapy include total parenteral nutrition, chemotherapy, drug therapy (antibiotics), pain management and hydration therapy. Home kidney dialysis treatment is not considered home infusion.

Hospice Care/Program means a program of care that offers 24-hour services to terminally ill patients in the home, on an out-patient basis and/or on a short term inpatient basis, and includes such services and items as nursing care, physical/occupational therapy, medical social services, home health aid, medical supplies, physician services, short-term inpatient care and counseling for the patient and family.

Hospital means an institution licensed as a Hospital and operated pursuant to law for the care and treatment of sick and injured persons. It must maintain organized facilities for medical, diagnostic and surgical care for hospital confined patients, for which a charge is made that the Covered Person is legally obligated to pay, maintain a staff of one or more licensed doctors, provide 24-hour-a-day nursing care supervised by a professional graduate registered nurse (R.N.), have surgical facilities on its premises, or have a contract with another institution with a valid license to provide for surgical services, and be legally operating in the jurisdiction where located.

An institution that specializes in providing care and treatment for patients with Mental Disorders or Substance Abuse disorders is not required to have major surgery facilities if it otherwise qualifies as a hospital under this definition.

Hospital does not include: an institution principally for rest, nursing, long-term, extended or custodial care; sub-acute care; care for the aged; skilled nursing care; or a military or veterans' hospital, soldiers' home or hospital contracted for or operated by the federal government or any of its agencies, for active or former members of the Armed Forces, unless legally required to pay.

Illness/Injury In this Plan, the word "injury" means an accidental bodily harm. The word "illness" means a sickness that impairs a Covered Person's normal function of mind or body; the pregnancy, childbirth and related medical conditions of a covered Employee or covered spouse or

civil union partner of an Employee; or a covered child's functional defect caused by premature birth or congenital malformation or Autism Spectrum Disorders.

Inpatient/Outpatient The term "inpatient" means a person is assigned to a bed in a hospital or skilled nursing facility or rehabilitation facility; the bed shall not be in the outpatient department, and shall be the basis of a room and board charge. Reference to treatment as an "outpatient" means service received while the person is not an inpatient.

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.

Medically Necessary or **Medical Necessity** shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- a. in accordance with generally accepted standards of medical practice;
- b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- c. not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

With respect to mental health services, including treatment for psychiatric illness and substance abuse, in determining the clinical appropriateness of care, the following minimum standards relevant to mental health care must be met:

- a. There is a diagnosis as defined by standard diagnostic nomenclatures (DSM IV or its equivalent ICD-9-CM) and an individualized treatment plan appropriate for the patient's illness or condition; and
- b. There is a reasonable expectation that the patient's illness, condition, or level of functioning will be stabilized, improved, or maintained through ambulatory care, through treatment known to be effective for the patient's illness; and
- c. The mental health services are not primarily for the avoidance of incarceration of the patient.

The fact that a doctor may prescribe, order, recommend or approve of a service or supply does not, of itself, make it "Medically Necessary" or make the charge an eligible expense under this Plan even if it has not been listed as an exclusion.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means a condition or disorder recognized as a mental health condition in accordance with the most current version of the Diagnostic and Statistical Manual of mental Disorders (DSM) and/or the most current version of the International Classification of Diseases (ICD), including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, even if organic origin is believed contributory. This includes ICD-9 diagnoses 290-299 and 300-316.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables for a person of the same height, age and mobility as the Covered Person.

Network Provider means a provider (a hospital, physician, or other service provider) that participates in the HealthLink HMO network and/or the HealthLink PPO network.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Provider means a provider that does not participate in either the HealthLink HMO network or the HealthLink PPO network.

Occupational Therapy means therapy, treatment or equipment that provides or assists in the remediation, restoration and/or compensation for bodily functions lost through illness or injury. Also, the adaptation or modification of equipment or materials to give a Covered Person increased independence.

Outpatient Surgical Facility means a licensed public or private medical facility that has an organized staff of doctors, and permanent facilities equipped and in operation primarily to perform surgery. The facility must provide continuous doctor and registered professional nursing services whenever a patient is in the facility.

“Outpatient surgical facility” includes a facility that is operated by a hospital that provides scheduled, non-emergency and outpatient surgical care. It does not include a hospital emergency room, trauma center, doctor’s office or clinic.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician/Doctor means a person acting within the scope of his license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Doctor of Podiatric Medicine (D.P.M.), or Doctor of Chiropractic (D.C.). The term physician shall also be extended to include a Clinical Psychologist (Ph.D.), Registered Physical Therapist (R.P.T.), Occupational Therapist (O.T.), and Licensed Speech Therapist (L.S.T.), provided they are licensed in the political jurisdiction where practicing, are acting within the scope of their license and are performing services ordered by a Doctor of Medicine or a Doctor of Osteopathy.

Physical Therapy means rehabilitation concerned with restoration of function and prevention of disability following disease, injury, or loss of body part.

Plan Administrator means the Board of Managers of the Egyptian Area Schools Employee Benefit Trust.

Preferred Provider Organization means an organization that has contracted with the Plan to make available medical care to Covered Persons through a network of preferred providers, including HMO Providers and PPO Providers.

Pregnancy means childbirth and conditions associated with pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: “Caution: federal law prohibits dispensing without prescription”; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Preventive Care means health care that is not intended to treat an existing illness, injury or medical condition, such as routine annual physicals and the tests and diagnostic procedures ordered in conjunction with such physicals; well-baby and/or well child care; immunizations; tobacco cessation and obesity weight loss programs. This Plan covers Preventive Care only as described in the Wellness Benefit pages in the Schedule of Benefits or as stated in the Wellness Benefit/Preventive Services section of this booklet.

Preventive Drug means a drug or medication prescribed to help keep a patient from developing a health condition and not to treat an existing illness, injury or medical condition. This includes drugs prescribed for a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (i.e., asymptomatic) or to prevent the

recurrence of a disease from which the person has recovered (for example, cholesterol-lowering medications when used to prevent heart disease and Angiotensin Converting Enzyme (ACE) inhibitors when used to prevent recurrence in recovered heart attack or stroke victims). In addition, drugs or medications used as part of procedures providing Preventive Care services specified in the Internal Revenue Code, including obesity weight-loss and tobacco cessation programs, are also considered Preventive Drugs.

Primary Care Physician means, for purposes of this Plan, a Physician (M.D. or D.O.) who practices medicine in the primary care fields of general practice, family practice, general pediatrics, general internal medicine or gynecology.

Recommended Preventive Services means preventive services recommended in guidelines published by the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) (collectively, the Guidelines). Recommended preventive services include:

- a. Evidence-based preventive items or services that have in effect a rating of "A" or "B" in the current recommendations of the USPSTF for individuals of the patient's age, gender and health risk factors.
- b. Routine vaccines and immunizations recommended by the CDC for individuals of the patient's age, gender and health risk factors.
- c. For infants, children and adolescents, evidence-informed preventive care and screenings recommended by the HRSA.
- d. For women, additional preventive care and screenings, not otherwise addressed by the USPSTF guidelines, recommended by the HRSA.

These Guidelines will change from time to time. Any new service added to the Guidelines will be added to the Plan as a recommended preventive service no later than the first Plan Year that begins one year after the new service is added. A complete list of the current Guidelines can be found at <http://www.healthcare.gov/center/regulations/prevention/recommendations.html>. Contact the Claim Services Administrator for a paper copy of the current Guidelines.

Rehabilitation Facility means a facility which meets all of the following requirements:

- a. it provides care for the treatment of acute injury or illness;
- b. it is licensed as an acute rehabilitation facility;
- c. the care is under the direct supervision of a Physician;
- d. services are specific to an active written treatment plan;
- e. the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care;
- f. it provides 24 hour a day nursing services;
- g. it is not, other than incidentally, a rest home or home for custodial or maintenance care.

Specialist Physician means, for purposes of this Plan, any Physician other than a Primary Care Physician.

Speech Therapy means the study, diagnosis and treatment of defects and disorders of the voice and of spoken and written communication.

Spinal Manipulation means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse means the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting

physical health and/or personal or social functioning. This does not include dependence on tobacco and caffeine.

Temporomandibular Joint Dysfunction Syndrome (TMJ) means a disease or symptoms of the jaw joint(s) and/or symptoms of the associated parts resulting in pain or the inability of the jaw to work properly. Associated parts of the jaw mean those functional parts that make the jaw work.

Urgent Care Center/Facility means a public or private facility, licensed and operated according to the law, which provides immediate care in the case of a medical emergency or accidental injury. Treatment must be administered under the supervision of a recognized Physician or nurse as defined in the Plan and the facility must maintain a relationship with an available pool of specialists for consultation and treatment when necessary. The facility cannot provide any inpatient treatment and cannot be accessed for routine care or as a private practice.

Usual, Customary and Reasonable Charge (UCR) means the normal charges made for similar services by providers of medical services with like experience, education and training, who are practicing in the same geographic area or in an area large enough to provide a reasonable sampling. UCR charges for surgery, diagnostic testing or other services will be considered on a "global" basis rather than on an "unbundled" basis. This means one fee should include and combine all minor procedures essential to the performance of the main procedure, and all tests performed as part of a test panel. Determination of whether or not a charge is UCR will be made by the Claim Services Administrator based on nationally obtained and recognized survey data received from an insurance company which, as a major portion of its business, is involved in the adjudication of health care claims.

Utilization Review/Pre-Certification must be performed on ALL inpatient hospitalizations and Extended Care/Skilled Nursing Facility/Rehabilitation Facility admissions **PRIOR TO THE DATE ADMITTED**, except:

- a. Emergency admissions, for which notification of admission and request for Utilization Review must be made within 24 hours **OR** the next business day; and
- b. admissions for childbirth, for which notification of admission and Utilization Review are required only if the mother requires a hospital stay longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section.

Selected outpatient surgical procedures, ancillary services, including services for Autism Spectrum Disorders, durable medical equipment, diagnostic imaging procedures and specialty infusion drugs also require pre-certification **PRIOR** to services being rendered or equipment purchased. Refer to the Major Medical Expense Provisions section of this booklet for details.

Utilization Review is for the purpose of determining the medical need for and reasonable length of a hospital or facility stay and the medical need for outpatient surgery, ancillary services, durable medical equipment, diagnostic imaging procedures or specialty infusion drugs. Utilization Review does not guarantee coverage for the service if any limitations or exclusions of the Plan apply to that service. Failure to comply with Utilization Review requirements will result in benefit reductions and may result in denial of benefits.

COORDINATION WITH OTHER COVERAGE

Coordination Of Benefits

Many individuals are covered under more than one group health plan. This may afford an opportunity for a person to receive more in benefits than the actual charges for medical care. This "profit" or "over-insurance" possibility is more than unfair -- it pushes up the cost of medical coverage for all of us.

For this reason, nearly all medical benefit plans, including this Plan, have adopted a coordination of benefits provision. This provision is designed to take the unfair profiteering out of multiple coverage, yet enables the individual to be reimbursed for as much of his medical expenses as possible - up to 100% of allowable expenses.

All health plans covering individuals as a group and all group insurance policies are considered in applying this coordination of benefits provision, including group policies purchased through AARP or any other organization.

The Claim Determination Period is the Calendar Year, except the first Claim Determination Period starts the day you first become covered under the Coordination of Benefits provision.

The Following Is An Example Of How The Coordination Of Benefits Provision Works:

Mary Williams is covered under this Plan as a dependent and under the plan of another employer as an employee. Both plans include coordination of benefits provisions.

Mary is hospitalized and undergoes a surgical operation and two claims are filed - one under this Plan and one under the other plan. Assume that the allowable expense for all types of medical expenses totals \$1,000 and that the full benefit allowance, in the absence of other coverage, would be \$700 under this Plan and \$400 under the other Plan. Since the other plan covers Mary as an employee, it will determine its benefits and will pay its full \$400 allowance.

This Plan will pay \$600, which is the remaining allowable expenses actually incurred. If this Plan had paid its \$700 benefit allowance, the total benefit paid would have exceeded the cost of Mary's bills by \$100.

Summary

Allowable expense for medical services rendered\$1,000

Other Plan:

Full Benefit Allowance\$ 400

Benefits Actually Paid\$ 400

(this leaves \$600 of allowable expense which has not been reimbursed)

This Plan:

Full Benefit Allowance\$ 700

Benefits Actually Paid\$ 600

Remainder available for future expenses.....\$ 100

If both the husband and wife or both partners in a civil union are covered under this Plan as "Employees", and one spouse or partner is also covered as a dependent of the other, the Coordination of Benefits provision will apply.

How Coordination Of Benefits Works - When you are covered by more than one health care plan to which the Coordination of Benefits provision applies, the following rules are applied in the order stated to determine which plan will be the first to determine (pay) its benefits:

1. When only one of the plans has a Coordination of Benefits provision, then the plan without such a provision will determine its benefits first.
2. When both plans have a coordination of benefits provision, then:

- the plan which covers the patient as an employee or member will determine its benefits first before a plan which covers the patient as a dependent;
- the plan which covers the patient as an active employee will determine its benefits first before a plan which covers the same individual as a retired employee or former employee or because of entitlement to continuation coverage;
- in the case of a dependent child, the plan of the parent whose birthday falls first in the year will determine its benefits before the plan of the parent whose birthday falls later in the year;
- if none of the above establish an order of benefit determination, then the plan which has covered the patient for the longer period of time will be the first to determine its benefits.

NOTE: If the patient is a dependent child of divorced or unmarried parents, special provisions apply. In such cases, if there is a court decree requiring one parent to provide health coverage, the plan of that parent pays first. Otherwise, the plan of the natural parent who has custody generally pays first; the plan of the step-parent (if any) who is married to the custodial parent pays second; the plan of the non-custodial natural parent pays third. If the parents have joint custody and the court decree does not specify which parent is to provide health coverage, the plan of the parent whose birthday falls first in the year will determine its benefits before the plan of the parent whose birthday falls later in the year.

How Your Benefits Are Paid

The plan which is the first to determine its benefits will pay its benefits without regard to any other coverage. When a plan is not the first to determine its benefits, and there are allowable expenses that have not been paid by the other plan(s), it will then pay its regular benefits up to the amount of the remaining allowable expenses.

Any benefit savings resulting from the application of the Coordination of Benefits provision will be available for future claims. These savings may be applied toward additional allowable expenses, not otherwise payable under another plan, which the Covered Person incurs later in the same Claim Determination Period.

Health Maintenance Organization (Effect On Benefits)

If you or your dependents are covered under a Health Maintenance Organization (HMO) plan, benefits will be payable under this Plan in accordance with the following:

- a. If you are covered under an HMO plan provided by your Employer, no benefits will be payable under this Plan.
- b. If you are covered under an HMO plan provided by a plan sponsor other than your Employer and if this Plan is determined to be primary (first to pay) under the Coordination of Benefits (COB) provision of this Plan, then benefits will be payable only if the HMO provider furnishes an itemized statement for services rendered and benefits are assigned to the HMO provider.
- c. If you are covered under an HMO plan provided by a plan sponsor other than your Employer and if this Plan is determined to be secondary (second to pay) under the COB provisions of this Plan and if you elect to use the HMO facilities and providers, then only those charges that have not been covered by the HMO plan will be eligible under this Plan. You must submit an itemized copy or receipt for any charges made by the HMO that have not been covered by the HMO plan and a copy of your HMO plan of benefits.
- d. If you are covered under an HMO plan provided by a plan sponsor other than your Employer and if this Plan is determined to be secondary (second to pay) under the COB provision of this Plan and if you elect not to use the HMO facilities or providers, then the only expenses that will be eligible under this Plan are those for which you would have had to pay under the HMO plan if you had used the HMO benefits for which you are eligible. You must submit an itemized copy of your medical expenses and a copy of your HMO plan of benefits.

Effect Of Medicare On Benefits

For Active Employees And Their Dependents

Federal law requires Employers to offer to active Employees and their covered dependents who are age 65 and over the same health benefits as are available to younger Employees and dependents. If you are such an individual, and you choose to be covered under this, the Employer's group health plan, the Plan's normal Coordination of Benefits provision will not apply; Medicare will be the secondary payor. This Plan will determine what benefits are covered; the remainder of the expenses may then be submitted to Medicare by you for reimbursement.

If this Plan is the primary payor, your claims should be sent to this Plan first. After this Plan makes its payment, you should then send Medicare a copy of the claim and a copy of this Plan's explanation of what benefits were paid (EOB) so that any balance can be considered for payment under Medicare. It will be your responsibility to follow up with Medicare for payment. You should advise all your physicians that this Plan will be the primary payor, and that this Plan should be billed before billing Medicare.

End Stage Renal Disease (ESRD)

Medicare has special rules if you are eligible for Medicare because you have end stage renal disease (kidney failure). In most cases, this Plan will be primary for the first 30 months you are eligible for Medicare due to ESRD. After 30 months, Medicare will be the primary payor and this Plan will pay secondary.

This Plan's method of paying secondary to Medicare after the 30-month period will depend on whether you are an active Employee (or a dependent of an active Employee) or a retired Employee (or a dependent of a retired Employee) when your claims are incurred. As long as you remain an active Employee or a dependent of an active Employee, this Plan will pay secondary to Medicare under the special Coordination of Benefits rules for Medicare described above. If you are or become a retired Employee or a dependent of a retired Employee, this Plan will pay secondary to Medicare in the manner described below for retired Employees and their dependents. That is, this Plan will reduce its benefit payment by the amount(s) paid by Medicare.

If this Plan is already paying your claims secondary to Medicare when you become eligible for Medicare due to ESRD, an exception to the 30-month Medicare primary rule applies. This exception applies only if you were already eligible for Medicare due to age or disability and you are a retired Employee or a dependent of a retired Employee. In this case, this Plan will continue to pay your claims secondary to Medicare in the manner described below.

For Retired Employees And Their Dependents

In the case of Retirees and their covered, Medicare-eligible dependents, this Plan's normal Coordination of Benefits provision will **not** apply; Medicare will be the primary provider of coverage. If eligible, you must enroll for both Medicare Part A and Part B when you retire. This Plan will **reduce** its benefit payment by the amount(s) paid or payable by Medicare whether or not you are actually enrolled in both Part A and Part B, unless you are not eligible for Medicare.

Example: Mary is covered under this Plan as a Retiree and is eligible for Medicare. Assume that she has a surgical procedure and incurs \$1,000 of expenses. Assume further that Medicare would pay \$750 of these expenses and that this Plan would have paid \$800 if Mary had not been eligible for other coverage. In this example, this Plan will pay \$50.

This Plan's Full Benefit Allowance.....	\$800
Medicare Pays	<u>-\$750</u>
After subtracting what Medicare will pay, This Plan will pay	\$ 50

Because the benefits payable under this Plan are limited, if both the Retiree and spouse or civil union partner are covered by Medicare and they have no other covered dependents, it may be wise to obtain coverage under a Medicare Supplement policy instead of remaining in this Plan.

If Medicare is the primary payor you should send your claims to Medicare first. Make sure you advise your physicians and other providers of service. After you receive payment notification from Medicare, send a copy of the Medicare explanation of benefits and a copy of the bill to this Plan for consideration of any balance not paid by Medicare.

In all cases, it will be your responsibility to follow up with Medicare.

Effect Of Medicaid On Benefits

If you or your dependents are eligible for or are provided medical assistance under any State plan for medical assistance approved under Title XIX of the Social Security Act as in effect on August 10, 1993 (a "State Medicaid Plan"), the fact that you are entitled to such assistance will not be taken into account in determining your benefits under this Plan. Your benefits under this Plan will be paid in accordance with any assignment of rights made by you or on your behalf as required by the State Medicaid Plan, and to the extent payments have been made by the State Medicaid Plan for services for which benefits are payable under this Plan, this Plan will pay in accordance with any State law that provides that the State has acquired your rights with respect to such payment.

Third Party Recovery

This provision applies if you or your covered dependents incur covered expenses for an injury or illness due to another person's act or omission. The Plan is subrogated to any and all amounts paid or payable to you or on your behalf by a third party, including the person or company that caused the illness or injury and any insurance company. This means that the Plan has the right to recover directly from the third party amounts paid by the Plan for that illness or injury and you must notify the third party of the Plan's rights to any recovery. In addition, if you receive any payment directly from a third party by legal judgment, settlement or otherwise after you have received benefits from the Plan, you must reimburse the Plan promptly for expenses paid by the Plan relating to the injury or illness for which the recovery was obtained. This provision applies to any payments made under an automobile policy because of "no fault" automobile laws or uninsured motorist laws.

When this provision applies, the Plan generally will pay its normal benefits only on the condition that you will reimburse the Plan when you receive any recovery. The Plan may require you to sign an agreement agreeing to reimburse the Plan from any payments you receive, to the extent of the benefits paid or payable by the Plan. The Plan has the right to deny benefits until you sign a reimbursement agreement, but your failure to sign such an agreement does not prevent application of this provision. If you receive any payments from a third party and fail or refuse to reimburse the Plan as required, in addition to any other remedies the Plan may have, the Plan may terminate your coverage under the Plan and/or may set-off the reimbursement due the Plan against any pending or future claims, whether or not related to the injury or illness for which you received the payments, otherwise payable by the Plan to or on behalf of the Covered Person and any covered family member.

Insurance Recovery

This provision applies if you or your covered dependents incur covered expenses for illness or injury for which you are entitled to reimbursement for medical expenses under your own automobile insurance, homeowner's insurance or other similar policy. When this provision applies, the Plan will pay its normal benefits only on the condition that you will reimburse the Plan when you receive reimbursement from your insurance company. When you receive payment from your insurance company you must reimburse the Plan promptly up to the lesser of the amount of the expenses paid by the Plan or the amount you receive from your insurance company.

The Plan may require you to sign an agreement agreeing to reimburse the Plan from any insurance payments you receive, to the extent of the benefits paid or payable by the Plan. The Plan has the right to deny benefits until you sign a reimbursement agreement, but your failure to sign such an agreement does not prevent application of this provision. If you receive any insurance payments and fail or refuse to reimburse the Plan as required, in addition to any other

remedies the Plan may have, the Plan may terminate your coverage under the Plan and/or may set-off the reimbursement due the Plan against any pending or future claims, whether or not related to the injury or illness for which you received the payments, otherwise payable by the Plan to or on behalf of the Covered Person and any covered family member.

CLAIM AND APPEAL PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. At the time you receive treatment, show the Employee identification card to your provider. In most cases the provider will file your claim for you. You may also file a claim directly by following the procedures below.

Assignment Of Benefits

Benefits are paid to the Employee unless you specifically request in writing when the claim is submitted that payment be made directly to the provider of services (physician, hospital, etc.).

Most hospitals will require you to sign an "Assignment of Benefits" prior to treatment so that they may be paid directly. Many physicians will also request that you assign benefits directly to them.

NOTE: Network providers will always be paid directly, unless the claim form clearly indicates that the bill has been paid in full.

In the event that payment is made directly to the provider of service, you will receive written notification of the payment and how it was computed. You may also access your claims payment information on the website at www.myMERITAIN.com. If you have questions regarding the claim settlement, please call the Claim Services Administrator, Meritain Health, at (800) 844-7979.

When To File A Claim

You should file a claim as soon as you receive charges for services. Claim forms may be obtained from your Employer or at www.myMERITAIN.com. In situations where charges may be of a nominal nature (office visits, etc.) it is suggested that you accumulate them until they are sufficient to satisfy the deductible. In situations where the deductible has already been satisfied, accumulating small bills will simplify everyone's record keeping by reducing the number of checks issued to you.

All claims relating to payment for a service covered by the Plan must be filed within the 12-month (365 day) period following the date the service is received.

If Your Coverage Terminates

If your coverage under the Plan terminates, all claims must be submitted within 90 days of the date coverage terminated.

Late Submission Of Claims

Claims submitted more than 12 months after the date of service, or more than 90 days after your coverage terminates, will be denied. You can assist the Claim Services Administrator by submitting your claims promptly, and by following the claim filing instructions. A claim will not be considered filed unless and until all required information relating to the service or benefit for which the claim has been filed has been submitted.

How To File A Claim

Sometimes the provider of health care services does not bill the Claim Services Administrator directly, but bills you for such services as:

- physician care;
- blood and blood plasma;
- diagnostic x-ray and laboratory examinations;
- rental of medical appliances or durable medical equipment; or
- ambulance services.

Make sure that your bill from the provider contains all of the following information:

- patient's name;

- description of each service rendered;
- date of each service rendered;
- charge for each service rendered;
- diagnosis (if more than one diagnosis, an indication of which diagnosis refers to each specific service rendered);
- diagnosis and procedures codes; and
- name, address and tax identification number of the provider of service.

Make a photocopy of the billing you receive from the provider for your records, and send the billing (if paid by you, make sure the bill so indicates) with a completed claim form to:

HealthLink
P.O. Box 419104
St. Louis, MO 63141-9104

A separate claim form must be submitted for each family member for whom a claim is being made. The Plan maintains separate payments and deductible records on you and each of your dependents.

Only one claim form from the major provider of service is needed for each disability. It is not necessary to submit another form with billing for subsequent services.

If you have made payment to the provider, be sure the bill is marked paid or is accompanied by a paid receipt.

Please review the claim form carefully and follow the instructions it contains. It is not always necessary to complete every section. You need only complete those sections applicable to the claim being filed. For example, if no accident is involved, you need not complete the accident section; if the claim is for you (the Employee), it is not necessary to complete the dependent section, etc.

Other Group Coverage

Since this Plan contains a Coordination of Benefits provision, it is important that you advise the Claim Services Administrator of any other group health plan covering you or your dependents. You should complete the appropriate section of your claim form in full.

NOTE: When another plan covers the claimant, send exact duplicates of the bills being submitted with a claim form to each carrier or administrator involved to assist them in coordinating benefits without a lengthy delay. If this Plan is paying as the secondary plan, we must be notified of the amount(s) paid by the primary plan before our payment can be made. To help you understand what Coordination of Benefits is and how it affects you, refer to the Coordination of Benefits section in this booklet.

Right Of Physical Examination

The Administrator has the right to have a physician of its choice examine the person with respect to whom benefits are claimed at reasonable intervals during pendency of a claim for benefits under this Plan.

Appealing A Claim Determination

If you feel a claim you have submitted has not been properly settled, you may request the Claim Services Administrator, Meritain Health, to review the claim. You must request this review in writing, stating your name, social security number, Employer, the claimant's name and reasons you feel the claim was improperly settled. You must request this review within 180 days after the date the disputed claim was paid or denied. Written requests may be sent to:

Attn: Egyptian Trust Claims Supervisor
Meritain Health
300 Corporate Parkway
Amherst, NY 14226

The Claim Services Administrator will generally respond within 30 days of the receipt of your letter. The Claim Services Administrator may request additional information from you that may be helpful in re-evaluating the claim. It is your responsibility to provide that information to the Claim Services Administrator or to assist in obtaining the information from a physician or other provider. After the Claim Services Administrator reviews all the relevant information, you will be notified in writing of the final decision on the appeal and the basis on which the decision has been made.

If you still do not feel your claim was properly settled, you may appeal to the Board of Managers of the Trust as the Plan Administrator. Your letter of appeal must state the reasons you disagree with the Claim Services Administrator's decision on your claim. Your letter will not be considered by the Board if you have not first requested and obtained review of your claim from the Claim Services Administrator.

All appeals to the Board of Managers must be made in writing, addressed to:

Appeals Committee
Egyptian Area Schools Employee Benefit Trust
c/o Meritain Health
P. O. Box 2046
Fairview Heights, IL 62208

and must be filed within 180 days of the final decision made by the Claim Services Administrator. Except as stated below with respect to claims involving medical/clinical judgment, all appeals to the Board of Managers will be decided by an Appeals Committee comprised of members of the Board of Managers. The determination of the Appeals Committee will be final, unless the claim qualifies for review under the External Review Procedures described in the next section of this booklet.

Appealing Adverse Pre-certification Or Medical Necessity Determinations

You also have the right to appeal to the Board of Managers if you disagree with an adverse pre-certification, utilization review or medical necessity determination made by HealthLink. However, when appeals involve medical/clinical judgment issues, the Board reserves the right to forward such appeals for review under the External Review Procedures, in which case the Board will defer to the decision made by the external independent review organization. If your appeal is not forwarded directly for external review, you may still request external review if you are not satisfied with the decision of the Appeals Committee. Your letter of appeal must be filed within 180 days of the final decision made by HealthLink and must state the clinical reasons you disagree with HealthLink's determination. Your appeal will not be considered if you have not first completed the Appeal/Grievance Process described in Appendix A, printed at the end of this booklet.

Recovery Of Overpayments/Right Of Offset

If this Plan has paid benefits in error, it has the right to recover any overpayment amounts, either from the provider of service, the Covered Person or other insurance or benefit plan(s), as appropriate. This provision includes any payments made to or on behalf of an individual that should have been paid by another plan or Medicare or should have been compensable under Worker's Compensation coverage. If the amount of the refund is not returned to the Plan Administrator immediately, the Plan may, in addition to any other rights it may have, deduct the amount from future benefits that may become payable by the Plan on behalf of the Covered Person or on behalf of any covered family members.

EXTERNAL REVIEW PROCEDURES

Standard External Review

If you are not satisfied with the results of the Plan's internal appeal process, you may ask the Claim Services Administrator to have your claim considered by a professional review organization that is independent of the Plan. Unless further guidance is issued by the U.S. Department of Health and Human Services, the external review process is available only for adverse benefit determinations that involve either (i) medical judgment (including but not limited to whether care is Medically Necessary, whether the health care setting or level of care is appropriate, or whether a treatment is Experimental or Investigational), or (ii) a rescission of coverage (whether or not the rescission has any effect on a particular claim at that time). The standard external review process applies when the claim does not require expedited review (as described below).

Time for Requesting External Review. You may file a request for standard external review within four months after the date you receive final notice that all internal appeals have been denied. The Claim Services Administrator will review the request within five business days of receipt and will notify you if any additional information is required to proceed with external review. If the Claim Services Administrator determines the request does not qualify for external review (for example, because you do not meet the Plan's eligibility requirements), you will receive a notice explaining the reason the request does not qualify.

Review by Independent Review Organization. If the claim qualifies for external review, the Plan will forward the request and all relevant documents considered in the internal claim and appeal process to an independent review organization (IRO) that is accredited by a nationally recognized accrediting organization. The IRO will notify you in writing that the claim has been accepted for review and will invite you to submit any additional relevant information within 10 days. If you provide additional information, the IRO will forward that information to the Plan. The IRO will review all information that is timely submitted, which may include medical records, recommendations from your physicians, the terms of the Plan and appropriate clinical practice guidelines. If the claim involves a clinical determination, the IRO will have the claim reviewed by a clinical reviewer with appropriate training and experience. Based on all the evidence, the IRO will make an independent decision on the claim and will provide written notice of its decision to you and to the Plan within 45 days after receiving the request for external review. The notice will describe the claim and explain the principal reasons for the decision, including the evidence considered.

Expedited External Review

If a claim involves a medical condition for which the time frame required for a standard external review would seriously jeopardize the life or health of the Covered Person, or would jeopardize the person's ability to regain maximum function, or involves a claim relating to a hospital admission for which the person received Emergency services and has not been discharged, you or your representative may request an expedited external review. Upon receiving the request and determining that the case is eligible for external review, the Plan will immediately forward all relevant documents to the assigned IRO electronically or by facsimile or other expedited method. The IRO will make its decision as expeditiously as the Covered Person's medical condition requires, but in no event more than 72 hours after the IRO receives the request for expedited review. If the initial decision is not in writing, within 48 hours after notifying the parties of its decision the IRO will provide a written notice describing the claim and explaining the principal reasons for its decision, including the evidence considered.

Effect of Decision of IRO

The decision of the IRO is generally binding on all parties, but you and/or the Plan may exercise any rights available under law to request a court to review the decision. If the IRO determines that benefits are payable under the terms of the Plan, the Plan will pay the claim promptly consistent with the IRO's determination, subject to the Plan's right to recover if the Plan seeks judicial review and the court reverses the decision of the IRO. If the Board refers a claim directly for external review without deciding the appeal, the Board will defer to the IRO's determination.

PRIVACY PROTECTIONS

Effective Date

This section of the Plan is effective April 14, 2003. This section, and **Appendix B**, the **Notice of Privacy Practices**, are intended to comply with the privacy requirements under the Health Insurance Portability and Accountability Act ("HIPAA"). Collectively, HIPAA and the related privacy regulations are referred to in this section as the Privacy Rule.

The Privacy Rule requires health plans, health insurance companies and health care providers to protect the privacy of individually identifiable information relating to a person's physical and mental health. Such information is defined in the Privacy Rule as "protected health information." Protected health information created or received by or on behalf of the Egyptian Area Schools Employee Benefit Trust for this Plan is referred to in this section as "PHI."

The Privacy Rule permits the Trust to use and disclose PHI for treatment, payment and health care operations, and for other purposes as permitted or required by the Privacy Rule and other federal and state laws, as described below and in the Notice of Privacy Practices. The Trust will use and disclose PHI only for the purposes and to the extent permitted by the Privacy Rule.

Permitted Uses And Disclosures Of PHI For Payment And Health Care Operations

The Trust may use your PHI for your health care treatment, payment for your health care and health care operations, without your specific authorization.

Payment activities include but are not limited to the following activities necessary to allow the Plan to provide your health care benefits:

- ◆ Determining your eligibility for benefits, coverage, and cost sharing amounts.
- ◆ Coordinating your benefits with other plans if you have other health insurance.
- ◆ Adjudicating your claims (including appeals and other payment disputes).
- ◆ Subrogating claims if a third party may be liable for your injury and expenses.
- ◆ Establishing contribution rates.
- ◆ Billing and collection activities.
- ◆ Claims management, including auditing payments, investigating and resolving payment disputes and responding to provider inquiries about payments.
- ◆ Obtaining reimbursement under a contract for reinsurance.
- ◆ Obtaining reviews for medical necessity or appropriateness of care.
- ◆ Utilization review, including pre-certification of services.

Health care operations include but are not limited to the following activities:

- ◆ Quality assessment.
- ◆ Activities relating to improving health or reducing health care costs, case management, care coordination and disease management.
- ◆ Contacting health care providers and patients with information about treatment alternatives.
- ◆ Rating providers, including accreditation, certification, licensing or credentialing activities.
- ◆ Underwriting and other activities relating to obtaining reinsurance.
- ◆ Conducting or arranging for medical review and legal, actuarial and auditing services.
- ◆ Resolution of internal grievances.
- ◆ Management activities related to implementing and complying with the requirements of HIPAA.

Use And Disclosure Of PHI To And By Business Associates

The Executive Committee and Board of Managers of the Trust make policy decisions, benefit design decisions and set premium rates, but the day to day administration of the Plan is delegated to Meritain Health, the Claim Services Administrator, HealthLink, which maintains the provider network and provides utilization review and case management services, and other service providers to the Trust. Under HIPAA, these service providers are referred to as "Business

Associates." Normally, all of the PHI created or received by or on behalf of the Trust is held by these Business Associates since the Trust itself has no employees or staff. The Trust has contracts with its Business Associates which require the Business Associates to have procedures and policies in place to protect the privacy of your PHI to the same extent that the Trust is required to protect your PHI. Business Associates are not permitted to use or disclose PHI except for the reasons stated in this section and in the Notice of Privacy Practices.

PHI created and received by Business Associates on behalf of the Trust is not disclosed to the Board of Managers which sponsors the Trust, nor to the Employer districts, except as provided in this section.

Use And Disclosure Of PHI As Required By Law

The Trust may use and disclose PHI as required by law. The circumstances in which the Trust may be required by law to disclose PHI are summarized in **Appendix B**, the **Notice of Privacy Practices**.

Use And Disclosure Of PHI When Authorized In Writing

You or your personal representative may sign an authorization form authorizing the Trust to use or disclose your PHI for any other specified purpose. The authorization must specify in writing the person to whom the information may be disclosed, the nature of the information to be disclosed, any restrictions on the disclosure, and an expiration date. An **Authorization to Disclose Health Information** form is included at the end of **Appendix B**. A signed authorization is required for the Trust to disclose PHI created or maintained by or on behalf of this Plan to any other employee benefit plan that is not a health plan, including the life insurance plans offered through the Trust.

Disclosures To School Districts

The Trust and its Business Associates will provide only the following health information to the Employer districts:

- ◆ Summary health information, which is information that summarizes the claims history, claims expenses, or types of claims experienced by the district's employees and dependents, from which individual names, identifying numbers, addresses, telephone numbers, dates (except year), etc. have been deleted. This summary information may be provided to the Employer for the purpose of obtaining premium bids from other carriers or making decisions about terminating participation in the Trust.
- ◆ Information on whether a person is participating in the Plan.

The Trust and its Business Associates will not disclose any individually identifiable health information to the Employer districts without a specific written authorization from the covered individual or a personal representative. **Unless you submit a signed authorization form, the Trust and its Business Associates cannot and will not discuss your claims or disclose any other PHI to the district or any district representative.**

Disclosures To The Board Of Managers

The Trust and its Business Associates will provide only the following health information to members of the Trust's Board of Managers:

- ◆ Summary health information, which summarizes the claims history, claims expenses, or types of claims experienced by the Trust as a whole from which individual names, identifying numbers, employers, addresses, telephone numbers, dates (except year), etc. have been deleted. This summary information may be provided to the Board for the purpose of making changes in the plan of benefits and setting premium rates.
- ◆ The Appeals Committee of the Board of Managers has final responsibility for deciding appeals from covered individuals. All appeals will be handled on a strictly anonymous basis. No individually identifiable information will be disclosed to the Appeals Committee or other members of the Board of Managers in the appeal process unless you choose to participate in

person at the appeal meeting or you submit a signed authorization form asking the Appeals Committee to consider information that identifies you in connection with your appeal.

Disclosures To Officers Of The Trust

If necessary for administration of the Plan, the Trust and its Business Associates may provide individually identifiable PHI to the Chairman and Vice-Chairman of the Board of Managers in the following limited circumstances:

- ◆ Information about members with large claims, as necessary for obtaining quotes from reinsurers and resolving claims with reinsurers.
- ◆ Information in connection with potential claims against the Trust.

The Officers have agreed to ensure that any PHI they receive is not used or disclosed in violation of the HIPAA Privacy Rule.

Responsibilities Of The Board Of Managers

The Board of Managers will maintain the confidentiality of health information in accordance with the HIPAA Privacy Rule and all applicable federal and state laws and regulations. In particular, the Board will observe the following specific requirements of the Privacy Rule. The Board:

- ◆ Will not use or disclose PHI to any third party other than a Business Associate of the Trust or another "covered entity" as defined in the HIPAA Privacy Rule (generally, insurance companies, health plans and health care providers) or as permitted or required by law.
- ◆ Will ensure that any agents to whom the Trust provides PHI agree to the same restrictions and conditions that apply to the Trust with respect to such information.
- ◆ Will not use or disclose PHI for employment-related actions.
- ◆ Will not use or disclose PHI in connection with any other benefit or employee benefit plan of the Trust or any district (except other health plans).
- ◆ Will report to the Trust's Privacy Officer any use or disclosure of PHI that is not authorized by the terms and conditions of this section or is otherwise in violation of applicable law, and will mitigate, to the extent practicable, any harmful effects of any unauthorized disclosure.
- ◆ Will comply with all lawful requests made by the Trust or individuals who are subjects of PHI to permit access to, inspection of, or copies of any PHI in a timely manner.
- ◆ Will make PHI available for amendment and will incorporate any requested amendments to the extent required by the HIPAA Privacy Rule.
- ◆ Will make available any information required to allow the Trust to provide an accounting of disclosures.
- ◆ Will make any internal practices, books, and records related to PHI available to the Secretary of the United States Department of Health and Human Services for purposes of determining the Trust's compliance with the Privacy Rule.
- ◆ Will return all PHI to the Trust or destroy it when it is no longer needed.

The Trust has established administrative and physical safeguards to protect the confidentiality of your PHI and to implement the protections and restrictions set forth in this section. These procedures will be administered by the Trust's Privacy Officer. The Privacy Officer will establish a mechanism for resolving any issues of noncompliance with the terms, conditions and restrictions set forth in the Trust's Privacy Policy.

Rights Of Individuals

You have certain rights to inspect and copy your PHI, to request the Plan to amend your PHI, to request the Plan to restrict access to your PHI, and to request an accounting of most disclosures of your PHI made for purposes other than treatment, payment and health care operations. These rights are explained in the **Notice of Privacy Practices** in **Appendix B**.

For More Information

Please refer to the **Notice of Privacy Practices** in **Appendix B** for additional information about the Privacy Rule and your rights under the Privacy Rule.

GENERAL INFORMATION

Name Of The Plan

Egyptian Area Schools Employee Medical Benefit Plan

Name And Address Of The Plan Administrator

Board of Managers of the Egyptian Area Schools Employee Benefit Trust
c/o Meritain Health
P. O. Box 2046
Fairview Heights, IL 62208

Each Participating Employer selects a representative to serve on the Board of Managers. You may obtain the name and address of the representative of your Employer from your Employer.

Name And Address Of The Person Designated As Agent For Service Of Legal Process

Chairman, Board of Managers
Egyptian Area Schools Employee Benefit Trust
c/o Meritain Health
13 Executive Drive, Suite 19
Fairview Heights, IL 62208

Name And Address Of The Claim Services Administrator

Meritain Health
300 Corporate Parkway
Amherst, NY 14226
(800) 844-7979

Name And Address Of The Trustee

Regions Morgan Keegan Trust
1 South Church Street
Belleville, IL 62220

Collective Bargaining Agreements

Participation in this Plan may be subject to the terms of collective bargaining agreements. You may obtain a copy of any bargaining agreement applicable to you from your Employer.

Funding

Contributions are made to the Plan by the Employers and Employees and are accumulated in a Trust Fund. Benefits are paid directly from the Trust by the Claim Services Administrator. Each Participating Employer determines the contribution, if any, that must be paid by its Employees.

Internal Revenue Service Plan Identification Number And Tax Identification Number

Plan Identification Number: 501; Tax Identification Number: 37-1156166

Plan Year

September 1 – August 31

Termination Or Amendment Of The Plan

The Plan may be canceled or discontinued at any time by the Employer without the consent of a Covered Person. The Plan may also be amended or terminated at any time by the Board of Managers of the Egyptian Area Schools Employee Benefit Trust. In the event the Plan is terminated by the Board of Managers, written notice will be provided to all covered Employees. If any amendment to the Plan affects any rights described in this booklet, new booklets or notices explaining the change will be distributed.

APPENDIX A
HEALTHLINK APPEAL/GRIEVANCE PROCESS FOR
PRE-CERTIFICATION/UTILIZATION REVIEW PROGRAM

AND

MEDICAL NECESSITY DETERMINATIONS

Appeal of adverse pre-certification, utilization review and medical necessity determinations may be made by or on behalf of a member. The right to appeal is provided to all participants in the utilization management programs of HealthLink. The levels of appeal/grievance are: Peer-to-Peer Discussion Standard Appeal/First Level Grievance and Expedited Appeal.

Letters of non-certification include the principal reason(s) for the determination, the instructions for initiating an appeal, and the instructions for requesting a written statement of the clinical rationale, including the clinical criteria used to make the determination. Requests for clinical rationale and/or appeal may be made by the physician, hospital, member or member representative.

Peer-to-Peer Discussion of Adverse Pre-Certification/Medical Necessity Determinations

- Cases not meeting medical necessity criteria are referred to a physician reviewer for certification or non-certification decision.
- After a non-certification determination has been made and communicated to the provider, the attending physician or other ordering provider may request a *peer-to-peer* discussion with the physician reviewer who made the initial decision not to certify.
- The *peer-to-peer* discussion typically will occur within one business day of the request. In the event the initial physician reviewer is not available within the one business day, an alternate physician reviewer will be available to discuss the case and either uphold or overturn the initial decision.
- Differences of opinion may be further addressed through the standard appeal (first level grievance) or expedited appeal process. The appeal process is outlined in letters of non-certification.

Standard Appeal or First Level Grievance

- The *standard appeal/first level grievance process* is available when a patient or provider disagrees with an adverse certification decision. The process to request the appeal is outlined in all non-certification letters and must be submitted in writing directly to HealthLink..
- Requests for appeal will be acknowledged in writing within 10 working days of receipt of the written request. The case is referred to a peer reviewer who was not involved in the original determination.
- An appeal review for pre-service elective or concurrent services will be completed within 15 calendar days after receipt, unless the review cannot be completed in that period. If so, the member and provider are notified in writing on or before the 15th day. The notice will state the reason for the delay. The review must be completed within 15 days thereafter.
- An appeal review for services that have already been rendered will be completed within 30 calendar days after receipt, unless the review cannot be completed in that period. If so, the member and provider are notified in writing on or before the 30th day. The notice will state the reason for the delay. The review must be completed within 30 days thereafter.

- The member and provider are provided an explanation of the decision in writing. The written decision will be issued promptly when the decision is made and should generally be received no later than 5 working days after the end of the applicable review period.

Expedited Appeal

- *Expedited appeals* are available when an adverse decision has been rendered by a HealthLink Physician Advisor or the Medical Director where the time frame of standard appeal procedures would seriously jeopardize the life or health of an enrollee or would jeopardize the enrollee's ability to regain maximum function.
- A request for an *expedited appeal* may be initiated by the patient, patient representative, health care provider or facility. The request may be submitted orally or in writing directly to HealthLink.
- Upon receipt of the request for an *expedited appeal*, the HealthLink nurse reviewer will initiate a physician advisor referral to a peer reviewer who is qualified to render an opinion and who did not make the original non-certification decision. Normally this referral takes place the same day as the request for appeal. The peer reviewer will discuss the case with the attending physician the same day as the request and will issue a certification or uphold the non-certification.
- The peer reviewer will verbally communicate the decision to the attending physician at the time of the discussion. All other parties (facility, member, and Claims Administrator) are notified by the nurse reviewer. Typically, confirming letters are issued and sent by the next business day.
- When non-certification decisions are upheld, the standard appeal/first level grievance process is available.

A grievance register will be maintained by HealthLink of all grievances submitted by or on behalf of a member regarding an adverse determination made pursuant to utilization review.

While the Plan has retained HealthLink to make clinical pre-certification, utilization review and medical necessity determinations for the Plan, the Plan sponsor reserves all rights to final decision-making. After you complete this Appeal/Grievance Process, you may file an appeal with the Board of Managers and may request review by an independent review organization under the Plan's External Review Procedures.

All requests for peer-to-peer discussion and appeal under this Appeal/Grievance Process must be sent directly to HealthLink, not the Claim Services Administrator.

This Appeal/Grievance Process applies only to pre-certification and utilization review and medical necessity determinations made by HealthLink. It does not apply to claims for benefits. If you believe a claim for benefits was not paid properly, you must use the appeal process described under "Appealing a Claim Determination" in the Claim and Appeal Procedures section of this booklet.

APPENDIX B

NOTICE OF PRIVACY PRACTICES

Effective Date: 4/14/03

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this Notice carefully.

The Health Insurance Portability and Accountability Act ("HIPAA") created new federal privacy rights with respect to medical information. The Egyptian Area Schools Employee Benefit Trust ("Trust") is required by law to provide this Notice explaining the Trust's privacy practices and how the Trust may use and disclose your medical information for treatment and payment purposes and for other purposes permitted or required by law. This Notice also describes your rights to obtain access to your medical information maintained on behalf of the Trust.

Definitions

"Member" means any person who receives health care coverage from the Trust, including employees, retirees, surviving spouses or civil union partners, COBRA beneficiaries and eligible dependents.

"Protected Health Information" or **"PHI"** means individually identifiable information created or received by or on behalf of the Trust, whether oral or recorded in any form or medium, that relates to the past, present or future physical or mental health or condition of a Member, the provision of health care to a Member, or the payment for health care provided to a Member.

"Personal Representative" means: (1) a person who has authority under applicable law to make decisions related to health care on behalf of an adult or an emancipated minor; or (2) the parent, guardian, or other person acting *in loco parentis* who is authorized under law to make health care decisions on behalf of an unemancipated minor, except where the minor is authorized by law to consent, on his/her own or with court approval, to a health care service, or where the parent, guardian or person acting *in loco parentis* has assented to an agreement of confidentiality between the provider and the minor.

"Business Associate" means a person or organization which, on behalf of the Trust, performs, or assists in the performance of a function or activity involving the use or disclosure of PHI, or provides administrative, management, consulting, legal, actuarial,

accounting, or financial services involving disclosure of PHI. Business Associates of the Trust include Meritain Health, HealthLink, and the Trust's attorneys and actuaries, among others.

Our Responsibilities

The Trust is required to:

- Maintain the privacy of your health information in accordance with the Trust's Privacy Policy and in accordance with applicable federal and state law;
- Provide you with this Notice of our legal duties and privacy practices, and your rights with respect to information we collect and maintain about you;
- Abide by the terms of this Notice;
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations; and
- Notify you if we are unable to agree to a requested restriction.

We may change the terms of this Notice at any time. We will provide you with a revised copy of the Notice promptly following any material revision to the Notice and upon your request. The Notice will be posted on the Trust's web site.

The Trust reserves the right to make changes in its Privacy Policy effective for all PHI maintained by the Trust. You may request a copy of the Privacy Policy. See "Contact Information" below.

NOTICE OF PRIVACY PRACTICES

How the Trust May Use and Disclose PHI

PHI may be used and disclosed by the Trust and its Business Associates and others outside the Trust for purposes of treatment, payment and health care operations. Your PHI may be disclosed for these purposes without your express consent or authorization.

The following are examples of the types of permitted uses and disclosures of PHI. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by the Trust.

Treatment: The Trust may use and disclose your PHI to coordinate or manage your health care and any related services. For example, the Trust may disclose information to a case manager involved in coordinating your care with providers.

Payment: The Trust may use and disclose your PHI to facilitate and coordinate payment for your health care services. This includes activities such as making determinations of eligibility or coverage and services such as utilization review. For example, the Trust may tell your treating physician whether you are eligible for coverage or what portion of the physician's bill will be paid by the Trust.

Health Care Operations: The Trust may use or disclose your PHI in order to support the Trust's health care operations. "Health care operations" include, but are not limited to, underwriting, premium rating and other insurance activities. For example, the Trust may use PHI to refer you to a disease management program, project future benefit costs, obtain reinsurance or audit the accuracy of its claims processing functions.

Business Associates: The Trust does not have its own employees. Most of the Trust's operations are handled by third party Business Associates which perform various administrative and other services for the Trust. Normally, all of the PHI created or received by or for the Trust is maintained by its Business Associates, and the terms

"Trust" and "we" in this Notice generally mean the Trust and its Business Associates when they are acting on behalf of the Trust. Whenever an arrangement between the Trust and a Business Associate requires the use or disclosure of PHI, we will have a written contract that contains terms that will protect the privacy of your PHI as provided in this Notice. For example, the Trust has contracts with Meritain, HealthLink and other service providers which require these Business Associates to protect the privacy of your PHI to the same extent that the Trust is required to protect your PHI.

Treatment Alternatives and Other Services: The Trust may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about the Trust and the services we offer or to send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Disclosure of PHI to Family Members, Friends, Guardians and Others Involved in Your Care

Unless you object or request additional privacy restrictions or alternative communications that are accepted by the Trust (as explained below under "Your Rights"), the Trust may, in the exercise of professional judgment, disclose to a family member, other relative, or close personal friend, PHI directly relevant to such person's involvement with your care or payment for your care. The Trust may reasonably infer from the circumstances surrounding the request or otherwise utilize professional judgment and experience with common practice to make reasonable inferences of your best interest in disclosing PHI to another person on your behalf.

NOTICE OF PRIVACY PRACTICES

When Written Authorization is Required

The Trust will not use or disclose your PHI for any reasons other than those described above, or as otherwise permitted or required by law as described below. You may, however, authorize the Trust to disclose your PHI to another party.

For example, the Trust will not disclose your PHI to your employer for any reason, unless you give us written authorization to disclose your PHI to the employer. If you want a representative from your employer to contact the Trust or our Business Associates on your behalf about your claims, you must provide a written statement authorizing us to disclose your PHI to that person or organization.

You may obtain an Authorization To Disclose Health Information form from your employer or from the Trust. See "Contact Information" below. A copy is also provided at the end of this Notice. You may revoke this authorization at any time by providing written notice of the revocation to the Privacy Officer, except to the extent that the Trust has taken action in reliance on the authorization.

While the Trust will not disclose individually identifiable health information to your employer without authorization, the Trust may provide certain summary health information to your employer to allow the employer to obtain bids for other health insurance and to decide whether to continue to participate in the Trust. The Trust may also disclose certain summary health information to the Board of Managers of the Trust to allow the Board to establish premium rates, obtain bids for reinsurance, and amend or modify the plan of benefits provided by the Trust. Summary health information means information that summarizes the claims history, claims expenses or types of claims incurred by the Members provided coverage through your employer group or through the Trust as a whole. Summary health information does not include information such as names, addresses, identification numbers, dates of

service or other individually identifying information.

Other Disclosures that May be Made Without Authorization or Opportunity to Object

The Trust may also use or disclose your PHI in the following situations without your authorization:

Required By Law: We may use or disclose PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information for the purpose of controlling disease, injury or disability.

Communicable Diseases: If authorized by law we may disclose PHI to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a government agency charged with overseeing the health care system for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect.

Food and Drug Administration: We may disclose PHI to the FDA as required to report adverse events, product defects or problems; track products; enable product recalls; make repairs or replacements; or conduct post-marketing surveillance.

Legal Proceedings: In accordance with applicable federal and state law, we may disclose PHI in the course of any judicial or administrative proceeding, in response to an

NOTICE OF PRIVACY PRACTICES

order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: In accordance with law, we may also disclose PHI for law enforcement purposes.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law; to a funeral director in order to permit the funeral director to carry out his/her duties; or to appropriate parties for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or to allow law enforcement authorities to identify or apprehend an individual.

Military and National Security: When the appropriate conditions apply, we may use or disclose PHI of Members who are Armed Forces personnel for activities deemed necessary by appropriate military authorities. We may also disclose PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others authorized by law.

Workers' Compensation: We may disclose PHI as authorized to comply with workers' compensation laws and other similar programs established by law.

Inmates: We may disclose PHI of an inmate in a correctional facility to the facility if the facility represents the PHI is necessary for certain permitted purposes.

Required Uses and Disclosures: Under the law, we must make disclosures of PHI when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the privacy requirements of HIPAA.

Your Rights

Following is a statement of your rights with respect to your PHI and how you may exercise these rights.

Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical information maintained for the Trust. This includes medical and billing records, but does not include psychotherapy notes.

To inspect and obtain a copy of your PHI, you must complete the Inspection and Copy Request Form and submit the form to the Trust's Privacy Officer. See "Contact Information" below. If you request a copy of the information, we will charge a fee for the costs of copying, mailing or other supplies associated with your request.

The requested information will generally be provided within 60 days. The Trust may ask for a single 30 day extension if the Trust is unable to comply with the deadline.

We may deny your request to inspect and copy in certain limited instances. If you are denied access to your medical information, the Trust will provide you with a written denial setting forth the basis of the denial, a description of how you may exercise your review rights and a description of how you may file a complaint.

Right to Amend: If you feel that medical information the Trust has about you is incorrect or incomplete, you may ask us to amend the information.

To request an amendment, you must complete the Correction/Amendment

NOTICE OF PRIVACY PRACTICES

Request Form and submit the form to the Privacy Officer. See "Contact Information" below.

The Trust generally has 60 days after receiving the Amendment Request Form to act on the request. The Trust is entitled to a single 30 day extension in the event the Trust is unable to comply with the deadline.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by or for the Trust, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Trust;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

If your request is denied the Trust will provide you with a written denial that explains the basis of the denial. You may submit a written statement disagreeing with the denial and you may require the Trust to include the statement, or if no statement is filed, a copy of your Amendment Request Form and the Trust's written denial, with any future disclosures of the PHI.

Right to an Accounting of Disclosures:

You have the right to request an accounting or list of certain disclosures of your PHI. You may request an accounting only of disclosures the Trust has made to others for reasons other than treatment, payment or health care operations.

To request an accounting you must complete the Accounting of Disclosures Request Form and submit it to the Privacy Officer. See "Contact Information" below. Your request must state a time period which may not be longer than 6 years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. We may charge you for the costs of

providing an additional list during any 12 month period.

The Trust will attempt to comply with your Accounting of Disclosures Request within 60 days. The Trust will be permitted an additional 30 days to comply with the request as long as the Trust provides you with a written statement explaining the reasons for the delay and the date by which the accounting will be provided.

Right to Notice of a Breach: You have the right to be notified if we become aware of any unauthorized access, use or disclosure of your PHI if the PHI was not secured or encrypted in a method approved by the U.S. Department of Health and Human Services. We have a duty to notify you if we discover a breach of your unsecured PHI.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you may ask that we not disclose information to your spouse.

To request such restrictions on the use or disclosure of your PHI, you must complete the Additional Restrictions Request Form and submit the request to the Privacy Officer. See "Contact Information" below.

We are not required to agree with your request. If we do agree, we will comply with your request.

You also have the right to request a health care provider not to disclose your PHI to the Plan, provided that the PHI pertains solely to health care services for which you have paid the provider in full out-of-pocket. The provider must comply with your request if the provider has been paid in full.

NOTICE OF PRIVACY PRACTICES

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must complete the Confidential Communication Request Form and submit the request to the Privacy Officer. See "Contact Information" below. We will not ask you the reason for your request and will accommodate all reasonable requests.

Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before being given access to your PHI. Proof of such authority may include:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as conservator or guardian; or
- A parent of a minor child.

The Trust retains discretion to deny access to your PHI to a personal representative in certain circumstances.

Complaints

If you believe your privacy rights have been violated, you may submit your complaint in writing by mail or by fax to the Privacy Officer for the Trust at:

Attention: Privacy Officer
Egyptian Area Schools
Employee Benefit Trust
P.O. Box 2046
Fairview Heights, IL 62208
Fax: (888) 525-2799

You also have the right to file a written complaint with the Secretary of the United States Department of Health and Human Services or with the Illinois State Attorney General.

The Trust will not intimidate, threaten, coerce or discriminate against you for filing a complaint or otherwise exercising legal rights set forth in this Notice and/or the Trust's Privacy Policy.

Contact Information

You may obtain copies of the Trust's Privacy Policy and the Forms referred to in this Notice from:

Egyptian Area Schools
Employee Benefit Trust
c/o Meritain Health
P. O. Box 2046
Fairview Heights, IL 62208
Telephone: (866) 588-2431
Fax: (888) 525-2799

This Notice of Privacy Practices will also be posted on the Trust's web site at:

www.egtrust.org.

Forms:

- Authorization to Disclose Health Information
- Inspection and Copy Request Form
- Correction/Amendment Request Form
- Accounting of Disclosures Request Form
- Additional Restrictions Request Form
- Confidential Communication Request Form
- Member Complaint Form

Privacy Regulations

The Trust's use and disclosure of PHI is regulated by federal and state law, including HIPAA. The HIPAA privacy regulations are set forth in the United States Code of Federal Regulations at 45 CFR Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information contained in this Notice and the regulations.

EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

By signing this authorization, I authorize the Egyptian Area Schools Employee Benefit Trust ("Trust") and its Business Associates to use or disclose certain protected health information (PHI) about me to or for the person or persons listed below.

This authorization permits the Trust to disclose to _____
(1)

the following individually identifiable health information (Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.): _____

(2)

I understand that this authorization may include information relating to: (1) Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection; (2) Psychiatric care (but not psychotherapy notes); (3) Treatment for alcohol and/or drug abuse; and (4) Genetic testing, if any, except as stated here (Specify any restrictions): _____

(3)

This authorization will expire on: _____
(4) (Specify Expiration Date or a Defined Event)

I understand that if my information is disclosed in accordance with this authorization, the person or persons who receive the information may disclose it to others and the information may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the Trust has acted in reliance on this authorization. My written revocation must be submitted by mail or fax to the Trust's Privacy Officer at:

Attention: Privacy Officer
Egyptian Area Schools Employee Benefit Trust
P. O. Box 2046
Fairview Heights, IL 62208
Fax: (888)525-2799

I understand that the Trust will not condition my enrollment or eligibility for benefits upon my granting this authorization, unless the authorization is to make determinations about my eligibility for enrollment or for underwriting determinations. This authorization is not for the use or disclosure of psychotherapy notes.

(a) _____
Signature of Member or Legal Guardian
Authorizing Release of PHI

(b) _____
Authorized Recipient's Relationship
to Member

(c) _____
Member's Name

(d) _____
Date

(e) _____
Print Name of Member or Legal Guardian (5)

INSTRUCTION TO COMPLETE HIPAA AUTHORIZATION FORM

Because the federal government provides special protections for health information, this authorization is required by privacy regulations that are a part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable laws. The Trust is required to abide by the HIPAA Privacy Regulations. This form needs to be completed by each member and the member's covered dependents age 18 and above in order for the Trust or Meritain to disclose any information to a member of your family, a relative, a close friend, the HR department, or any other person you identify.

- (1) *This authorization permits the Trust to disclose to:* Please insert all names of individuals or organizations to whom the Trust and/or Meritain can disclose protected health information. This can be a family member, friend, the school's bookkeeper, etc.
- (2) *The following individually identifiable health information:* You can limit the information being disclosed to a specific date, level of detail, origin of information, etc. If you are not limiting the information, please mark "all information available."
- (3) *I understand that this authorization may include information relating to:* You can again restrict what information is being released. If you do not want a specific diagnosis disclosed, please list here. If there are no restrictions please mark "no restrictions."
- (4) *This authorization will expire on:* You can limit the length of time the authorization is available for use. If there is no limitation, please indicate "indefinitely." Again, you have the right to revoke this authorization at any time.
- (5) *Authorizations:*
 - (a) *Signature of Member or Legal Guardian Authorizing Release of PHI.* A form must be completed and signed by each individual age 18 and above, including the employee and/or spouse or civil union partner in order for us to release any information to the person listed on line (1). For dependents under the age of 18, the legal guardian (typically the parent) must complete a separate form for the under age 18 dependent.
 - (b) *Authorized Recipient's Relationship to Member.* Indicate the relationship to the person listed on line (a) and/or (c), i.e., spouse, civil union partner, mother, father, employer contact.
 - (c) *Member's Name.* The individual, spouse or dependent child whose PHI information is being released. (Member is any individual covered by the Plan. This could be the employee, spouse or civil union partner or dependent child.)
 - (d) *Date.* The date of the authorization.
 - (e) *Print Name of Member or Legal Guardian.* Please print the name of the person whose signature is listed on line (a).

Therefore, by completing this form, we will be able to release your PHI to any entity/person indicated on line (1).