EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST
BOARD OF MANAGERS

2011/2012 APPROVED CHANGES

A. APPROVED PREMIUMS – Effective September 1, 2011

Premiums for 2011-12 will be:

	Platinum Plan		**Gold Plan**		**Silver Plan**		**Bronze Plan**	
	Current	**2011-12**	Current	**2011-12**	Current	**2011-12**	Current	**2011-12**
Employee	$536	**$632**	$484	**$571**	$418	**$493**	$356	**$420**
EE + Spouse	$1,106	**$1,305**	$998	**$1,178**	$866	**$1,022**	$732	**$864**
EE + Children	$1,068	**$1,260**	$963	**$1,136**	$835	**$985**	$719	**$848**
Family	$1,191	**$1,405**	$1,073	**$1,266**	$932	**$1,100**	$791	**$933**

B. Approved Medical Benefit Changes – Effective September 1, 2011

- **Increase the Office Visit Copay for Specialist Physicians to $40.** The Board of Managers approved increasing the office visit copay for all specialists. The copay will remain at $25 for primary care physicians, including general and family practice physicians, internists, pediatricians and gynecologists. All other physicians are considered specialists will have a copay of $40.
- **Increase Copay and Member Coinsurance for Emergency Room Visits.**
    - **Copay – All Plans:** The Board of Managers approved increasing the ER copay from $200 to $300 in all Tiers. (The ER copay is waived if the patient is admitted, but the patient will pay the hospital admission copay instead.)
    - **Coinsurance – Platinum, Gold and Silver Plans:** The Board of Managers approved increasing the member coinsurance from 10% to 15% and decreasing the Plan coinsurance for ER visits from 90% to 85% in all Tiers. (ER visits in the Bronze Plan are currently paid at 80%.)
- **Increase Copay for Inpatient Hospital and Outpatient Surgery Services by $100.** The Board of Managers approved increasing the per admission or per procedure copay for inpatient hospital admissions and outpatient surgical procedures from $150 to $250 for HealthLink Network providers (Tiers 1 and 2) and from $450 to $550 for Non-Network providers (Tiers 3 and 4). (Maximum 3 copays per calendar year.)
- **Pre-certification of Additional Services and Certain Chemotherapy Drugs.** The Board of Managers approved adopting HealthLink's complete standard list of Services Requiring Pre-Certification. HealthLink has recently expanded the list of services, supplies and procedures that HealthLink recommends for pre-certification of medical necessity. The list now includes certain chemotherapy drugs, whether administered inpatient or outpatient. These drugs are reviewed to determine whether there is medical

evidence to support the use of the proposed drug therapy for the patient's type of cancer and condition.

- **Consult A Doctor™.** The Board of Managers approved adopting the Consult A Doctor program. Consult A Doctor provides members with unlimited access to experienced state-licensed physicians by telephone or e-mail. Doctors are available to provide advice around the clock, including weekends, holidays or after business hours, and can prescribe medications for common conditions such as allergies, bronchitis, cold/flu, headaches, respiratory and sinus infections, stomach ache/diarrhea, urinary tract infections and many other conditions. The program is not intended to substitute for a patient's own physicians, but provides an alternative to urgent care or emergency room care when the patient is traveling or cannot reach his or her physician. The managers believe this program will be very beneficial to members and may result in cost savings to the Trust by avoiding unnecessary office visits and ER visits.
- **Health Care Reform Recommendations.** As described below, the federal Health Care Reform law will require a number of changes in the Plan. Most of the changes are not optional. However, in connection with the required changes, the Board of Managers approved three changes noted below:
    - **Alcohol and Substance Abuse Treatment:** Substitute inpatient hospital day limits and outpatient visit limits for the current dollar limits that must be eliminated under the new law.
    - **Eliminate all Wellness Benefits in Tier 4 Non-Network.**
    - **$100 Calendar Year Benefit for Routine Diagnostic Lab and X-ray Services.**

  These changes are explained in part D below.

C. Change Required by the Illinois Civil Union Act – Effective June 1, 2011

- **Coverage of Civil Union Partners and their Children.** Illinois has enacted a civil union law that allows same sex and opposite sex partners to register as civil union partners. In addition, a same sex marriage or domestic partnership or civil union that was legally entered into under the laws of another state, whether or not the relationship is considered a marriage under federal law, will be recognized by Illinois as a civil union. An eligible employee's civil union partner will be eligible for coverage and the same benefits under the Plan as an employee's legal spouse. The employee will be required to provide a certificate of civil union or other documentation issued under the applicable state law.

  Children of an employee's civil union partner will also be eligible for coverage under the Plan to age 26.

  Districts should be aware that an employee's civil union partner and his or her children may not be tax dependents of the employee for federal tax purposes. If they are not dependents as defined in the Internal Revenue Code, the employer is required by federal law to report the value of coverage provided by the employer for such individuals as taxable income to the employee. Districts should consult their own attorneys about the proper tax treatment of coverage provided to civil union partners and their children.

D. Changes Required by Federal Health Care Reform Law – Effective September 1, 2011

- **Coverage of Dependent Children to Age 26.** A child of an eligible employee will be eligible for coverage to age 26, regardless of the child's marital status, student status, residency, or dependency on the employee for support. During the open enrollment period this fall employees may enroll any child of the employee up to age 26. (As required by Illinois law, an employee's unmarried child age 26 to age 30 will be eligible for coverage if the child is an Illinois resident who was discharged from active or reserve duty in the U.S. Armed Forces or National Guard.) Districts should consult their attorneys about the proper tax treatment of coverage provided to adult children who do not qualify as dependents of the employee for federal tax purposes.

- **Overall Lifetime Dollar Limit on Benefits.** The $5 million lifetime limit on all benefits paid on behalf of any one person under the Plan will be eliminated. There will no longer be any dollar limit on the total amount of benefits the Plan may pay for any one person.

- **Pre-existing Condition Exclusions.** All pre-existing condition exclusions will be eliminated for all covered individuals.

- **Benefits for Alcohol and Substance Abuse Treatment.** The current lifetime and annual dollar limits on treatment for alcohol and substance abuse must be eliminated.

  The Board of Managers approved substituting the same hospital day limits and outpatient visit limits that apply for treatment of mental disorders, as follows:

  Inpatient Alcohol and Substance Abuse treatment:
  Current: $25,000 lifetime limit on all alcohol and substance abuse treatment.
  Substitute: The Plan will cover up to a total of 50 lifetime days of inpatient hospital care for treatment of all alcohol and substance abuse and mental disorders.

  Outpatient Alcohol and Substance Abuse treatment:
  Current: $5,000 annual limit on outpatient treatment.
  Substitute: The Plan will cover up to a total of 52 outpatient visits per calendar year for treatment of all alcohol and substance abuse and mental disorders.

  This will require the Trust to continue to opt out of full compliance with the federal Mental Health Parity law. The Trust is permitted to do this because it is a nonfederal governmental plan. The Trust will notify CMS and Plan participants before September 1, 2011 that the Trust is opting out of the parity requirements for another year.

- **100% Benefit for Recommended Preventive Services Provided In-Network.** As required by federal law, under the Wellness Benefit the Plan will pay 100% of the cost of certain services provided by a HealthLink Network physician or other HealthLink provider if the services are preventive services recommended under guidelines published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration (the Guidelines). The 100% benefit will include routine physical exams, some routine screening tests, immunizations and counseling to promote health or prevent health problems, as prescribed in the Guidelines. When provided by a

Network provider, all preventive services recommended by the Guidelines will be paid by the Plan without any deductibles, copays or coinsurance.

Non-Network Preventive Services. Wellness services provided by Tier 3 Non-Network providers will continue to be covered by the Plan subject to the same deductibles and coinsurance (if any) as under the current Wellness Benefit. The Board of Managers approved amending the Plan to eliminate all Wellness Benefits for services provided by Tier 4 Non-Network providers. The rationale is that in the Metro St. Louis area members can choose from many HealthLink providers so there is no need for a Tier 4 Non-Network benefit for routine non-emergency services.

$100 Calendar Year Benefit for Routine Diagnostic Lab and X-ray Services. Under the current Wellness Benefit the Plan provides a benefit of up to $500 per calendar year that may be used for routine diagnostic laboratory and x-ray testing and the HPV and Shingles vaccines. Effective September 1, 2011, all laboratory tests and immunizations that are recommended preventive services under the Guidelines (including the HPV and Shingles vaccines at appropriate ages) will be covered at 100% without any annual dollar limit. Some services are covered under the Guidelines only if the patient meets certain criteria, including age, gender and health risk factors. The Guidelines do not recommend for all patients all of the routine lab tests that are commonly prescribed. The Board of Managers approved allowing a benefit of up to $100 each calendar year that can be used for any routine diagnostic laboratory and x-ray testing that is not otherwise covered as a recommended preventive service for the patient under the Guidelines.

Preventive Drugs Required under the Guidelines. The Guidelines include as recommended preventive services the following drugs:

- **Aspirin** prescribed to prevent cardiovascular disease for men age 45 to 79 with certain health risk factors and for women age 55 to 79 years with certain health risk factors.
- **Oral fluoride supplementation** prescribed for children from birth to age 5.
- **Iron supplementation** prescribed for children from birth to 12 months of age.
- **Folic acid supplementation** prescribed for women of child bearing age.

If prescribed by a physician these drugs will be covered under the prescription drug benefit. Over the counter (OTC) versions of these drugs will be added under the OTC $0 copay program with a prescription.

- **Internal and External Claim Review Procedures.** The Plan will have more detailed procedures to allow participants to appeal claims they believe were wrongly decided. The new procedures will include the right to request an external review from a professional independent review organization (IRO) after all internal appeals are completed. The IRO must be completely independent of the Plan and the employers.