Egyptian Area Schools Employee Medical Benefit Plan

Plan Document
and
Summary Plan Description for Plan HDHP
(formerly the Bronze Plan)
An HSA Qualified High Deductible Health Plan

Originally Effective: January 1, 2008

Amended and Restated Effective: September 1, 2013

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ESTABLISHMENT OF THE PLAN

The Board of Managers of the Egyptian Area Schools Employee Benefit Trust (the "Trust" or "Plan Sponsor") has adopted this amended and restated Plan Document and Summary Plan Description effective as of September 1, 2013 for the Egyptian Area Schools Employee Medical Benefit Plan (hereinafter referred to as the "Plan" or "Summary Plan Description"), as set forth herein. The HDHP Plan was originally adopted by the Plan Sponsor effective as of January 1, 2008. By signing the Adoption Agreement, each Participating Employer (the "Participating Employer"), has authorized the Plan Sponsor to adopt and amend the Plan from time to time. The Plan Sponsor has adopted this Plan for the exclusive benefit of the eligible Employees, and Retirees, and their eligible Dependents of the Participating Employers.

A list of Participating Employers may be obtained by visiting the Trust website at www.egtrust.org.

The Plan is not a contract of employment between you and the Trust or any Participating Employer and does not give you the right to be retained in the service of your Trust or any Participating Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses.

Adoption of this Plan Document and Summary Plan Description
The Plan Sponsor hereby adopts this HDHP Plan Document and Summary Plan Description (SPD) as the written description of the Plan. This HDHP Plan represents both the HDHP Plan Document and the Summary Plan Description. This HDHP Plan Document and SPD amends and replaces any prior statement of the health care coverage contained in the HDHP Plan or any predecessor to the HDHP Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this HDHP Plan Document and Summary Plan Description to be executed as of the date set forth below.

Board of Managers of the Egyptian Area Schools Employee Benefit Trust c/o Meritain Health, Inc.

Dated:_____ By:_____

Name:_____

Title:_____

GENERAL OVERVIEW OF THE PLAN

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 Covered Persons 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 document 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 (Physician or Hospital), not by where you live.

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

Note: Certain limits apply when you use Non-Network Providers outside the **Designated Area. Designated Area** means the states of Illinois, Missouri, Indiana, Kentucky, and Arkansas.

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 Provider 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.

This Plan Is Not An HMO. The Plan simply has a contract with HealthLink which allows Covered Persons to receive services from Network Providers for reduced or discounted fees. 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, the most current information about providers may be found on HealthLink's website at www.healthlink.com. You may also contact a Care Coordinator at (855) 452-9997 who will assist you.

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:

(1) Emergency room Physicians;

(2) Inpatient Hospital professional fees for radiology, pathology or anesthesiology;

(3) 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.

A current list of Network Providers is available, without charge, at www.healthlink.com or through the Trust website at www.egtrust.org. If you do not have access to a computer at your home, you may contact the Care Coordinators at (855)452-9997.

You have a free choice of using any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Network Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Network Provider.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Network Provider or a Non-Network Provider. These payment levels are also shown in the Medical Schedule of Benefits.

Copay
A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible, Coinsurance or Out-of-Pocket Maximum.

Deductible
A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Medical Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. When selecting family coverage, the entire family Deductible must be satisfied by one individual or collectively before benefits will be paid at the Coinsurance rate.

Out-of-Pocket Maximum
An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The individual Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied, by one individual or collectively, before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year. When the family reaches the family Out-of-Pocket Maximum, the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Network Providers than for Network Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Precertification penalties.

(2) Charges over Usual and Customary Charges for Non-Network Providers.

(3) Coinsurance for all Mental Disorders/Alcohol and/or Substance Use Disorders.

(4) Coinsurance for treatment outside the Designated Area.

(5) Charges for transplants outside the Network service area.

(6) Charges for surgical procedures for morbid obesity outside the Network service area.

(7) Charges for chiropractic care

(8) Expenses this Plan does not cover.

(9) Amounts in excess of the Lifetime or Calendar Year maximums.

(10) Charges for services by Tier 4 providers.

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Network Providers and any penalties for failure to comply with requirements of the Medical Management Program section of the Plan or any other penalty that is otherwise stated in this Plan. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact a Care Coordinator at (855) 452-9997.

Integration of Deductibles and Out-of-Pocket Maximums
If you use a combination of Network Providers and Non-Network Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid will not exceed the amount shown for Non-Network Providers. In other words, the amount of the Deductible expense and Out-of-Pocket Maximum you pay for both Network Providers and Non-Network Providers will be combined and the total will not exceed the amount shown for Non-Network Providers during a single Calendar Year.

Medical Expense Audit Bonus
The Plan offers an incentive to all Covered Persons to encourage examination and self auditing of eligible medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. The Covered Person is asked to review all medical charges and verify that each itemized service has been received and the bill does not represent either an overcharge or a charge for services never received. This self auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Covered Person to avoid unnecessary payment of healthcare costs.

In the event a self audit results in elimination or reduction of benefits paid, 50% of the amount saved will be reimbursed directly to the Employee (subject to a $10 minimum payment and a $250 maximum payment per Hospital stay or Outpatient facility charge), provided the savings are accurately documented, and satisfactory evidence is submitted to the Third Party Administrator (e.g., a copy of the incorrect bill and a copy of the corrected billing).

This self audit credit is in addition to the payment of all other applicable Plan benefits for legitimate medical expenses.

This credit will not be payable for expenses in excess of the Usual and Customary Charges or expenses that are not covered under the Plan, regardless of whether benefits paid are reduced.

Copay For Hospital Admissions And Outpatient Surgery
You must pay a Copay for each new Hospital admission and each outpatient surgical procedure performed at a Hospital or Ambulatory Surgical Facility, but not more than three Copays per Covered Person per Calendar Year. The amount of the Copay 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 Copay for readmission. If a Covered Person has three or more Hospital admissions and/or surgical procedures in the same Calendar Year, the Copay will be waived for any additional Hospital admissions or surgical procedures in the same Calendar Year. You must contact the Third Party Administrator to request this waiver. These Copays can be used to satisfy the Calendar Year Deductible amount or the annual Out-of-Pocket Maximum.

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 Lab Card Program Works:

(1) When your Physician orders lab work for you, show your Meritain Health ID Card with the Lab Card logo. Tell your Physician 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 Physician's office collects your specimens and calls a participating testing facility for pickup. If your Physician 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 Physician (usually within 24 hours).

For questions about the Lab Card program and Quest Diagnostics, please contact the Care Coordinators at (855) 452-9997.

Consult-A-Doctor
The Plan provides coverage for telephone consults or e-mail consults provided by a Consult-A-Doctor Physician for non-emergent care. Common examples of when to use Consult-A-Doctor for non-emergent medical care include but are not limited to the following: 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 utilize this service, please visit www.MyDrConsult.com directly or you may visit www.egtrust.org to hyperlink to Consult-A-Doctor. If you do not have internet service available, please call 1-800-362-2667 to utilize this service. If a prescription is requested, 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 the Consult-A-Doctor program. For any questions with respect to the Consult-A-Doctor benefit, please contact the Care Coordinators at (855) 452-9997. Coverage under this benefit does not include telephone or e-mail consults from your regular Physician; it only includes coverage for telephone or e-mail consults to the extent the Physician who is consulted participates in the Consult-A-Doctor program. The Consult-A-Doctor benefit is not available in the State of Oklahoma.

ABOUT THE HDHP PLAN

Plan HDHP (formerly Bronze) 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 Plan HDHP, 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, this 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 document the terms Plan and Schedule of Benefits refer to Plan HDHP and the Schedule of Benefits for Plan HDHP. 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 Care Coordinators at (855)452-9997.

ABOUT HEALTH SAVINGS ACCOUNTS

If you are enrolled in Plan HDHP 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 Plan HDHP without establishing an HSA, but you may not contribute to an HSA unless you are enrolled in a qualified HDHP such as this 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 2014, up to $3,250 may be contributed to an HSA on behalf of an eligible individual for individual coverage and up to $6,450 for family coverage. An account owner may contribute an additional $1,000 for 2014 if the account owner will reach at least age 55 in 2014.

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 Plan HDHP. 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.

MEDICAL MANAGEMENT PROGRAM

Introduction
The Plan incorporates a "Care Coordination" program managed by *Coordinated Health/Care*. This program includes a staff of Care Coordinators who receive a notification regarding most healthcare services sought by Covered Persons, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Persons obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and for early identification of complex medical conditions. The Care Coordinators are available to Covered Persons and their providers for information, assistance, and guidance, and can be reached toll-free by calling:

Care Coordinators: 1-855-452-9997

Process of Care Requirements
In order to receive the highest benefits available in the Plan, Covered Persons must follow the Care Coordination Process outlined in this section. In some cases, failure to follow this process of care can result in significant benefit reductions, penalties, or even loss of benefits for specific services. The process of care generally includes:

(1) Designating a coordinating Physician (Primary Doctor)

(2) Review and coordination process, including:

  (a) Referrals from a Primary Doctor for all visits to Specialist Physicians

  (b) Pre-certification of certain procedures

  (c) Utilization Review

  (d) Concurrent Review of hospitalization and courses of care

  (e) Case Management

As described below, referral and pre-certification authorizations are generally requested by the providers on behalf of their Covered Persons.

Overview

Designated Coordinating Physician
Upon enrollment, all Covered Persons are asked to designate a coordinating Primary Doctor for each member of their family. While such designation is not mandatory, it is strongly recommended. **To ensure the highest level of benefits, and the best coordination of your care, all Covered Persons are encouraged to designate an in-network Primary Doctor to be their coordinating Physician.**

The care coordination process generally begins with the "coordinating Physician," who is a Primary Care Doctor who maintains a relationship with the Covered Person and provides general healthcare guidance, evaluation, and management. The following types of physicians can be selected by Covered Persons as their coordinating Physician or Primary Doctor:

(1) Family Medicine

(2) General Practice

(3) Internal Medicine

(4) Pediatrician (for children)

(5) OB/GYN

OB/Gyn are normally considered to be specialists and not Primary Doctors, as they typically do not provide general care regarding all body systems and family conditions, comprehensive preventive screening and care of non-OB/Gyn-related symptoms and conditions. Most OB/Gyn's state that they are a specialist and NOT a Primary Doctor, and do not wish to be considered a Primary Doctor. For instance, you may ask your OB/Gyn if they want to treat sore ankles, chest pain, or chronic joint pain; generally, the OB/Gyn will say no, and they are therefore not a Primary Doctor. However, if a patient's OB/Gyn wishes to serve as their Primary Doctor and agrees to provide comprehensive care for all body systems and preventive screening, Coordinated Health/Care will list this physician as the patient's Primary Doctor and accept referral notifications from the OB/Gyn to other specialists.

Covered Persons are encouraged to begin all healthcare events or inquiries with a call or visit to a Primary Doctor, who will guide patients as appropriate. In addition to providing care coordination and submitting referral and pre-certification requests, the Primary Doctor may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the Primary Doctor to provide ongoing healthcare guidance.

If you have trouble obtaining access to a Primary Doctor, the Care Coordinators may be able to assist you by providing a list of available Primary Doctors and even contacting Primary Doctors offices on your behalf. Please contact the Care Coordinators at 1 (855) 452-9997.

Use of Network Providers
The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize "network" providers. Specific benefit levels are shown in the Schedule of Benefits.

Review and Coordination Process
The Care Coordination process includes the following components:

(1) Referrals for Specialty Care

It is recommended that the Covered Person begin every healthcare event with a call or visit to a Primary Doctor. If and when a Primary Doctor refers the patient to a specialist, he/she will submit a notification of this referral to Coordinated Health/Care. The member ID Card alerts the Primary Doctor that "the patient receives the best benefits and/or coordination when you submit a notification that you are referring the patient to a specialist." Referral notices can be submitted by any Primary Doctor, including Non-Network Providers. (Please note: an office visit to a Non-Network Primary Doctor would be covered at the Non-Network benefit level.) The referral will be authorized for a certain time period, number of visits, or number of units, as requested by the Primary Doctor. During the authorized period, further referrals are not required for additional visits or treatments associated with the initial referral.

The Schedule of Benefits specifies the increased copay or coinsurance that applies for specialty services that are received without an authorized specialty referral in place.

The Primary Doctor is responsible for submitting the referral notice with all required information to the Care Coordinators, who will process the referral and notify the Primary Doctor's office upon authorization. While the referral process is initiated by the Primary Doctor, the Covered Person is ultimately responsible for ensuring that the referral authorization is in place before the specialty visit. Whenever possible, notice of this referral is sent to the Covered Person; however, Covered Persons can verify that the referral is in place by calling the Care Coordinators at 1 (855) 452-9997 or visiting the website on your ID card. Referral submissions will not be accepted after the specialty service has been received. Please refer to Emergency Admissions and Procedures for additional information regarding those circumstances.

OB/Gyn Office Visits: As noted above, OB/Gyn specialists are generally not considered to be Primary Doctors. However, to ensure open and unhindered access to OB/Gyn care, all office visits to OB/Gyn specialists receive the same benefit level as a Primary Doctor Office Visit. Covered Persons do not have to obtain a referral from a Primary Doctor to see their OB/Gyn specialist or receive the highest level of benefits for an Office Visit to an OB/Gyn.

(2) Pre-certification of Certain Procedures

To be covered at the highest level of benefit and to ensure complete care coordination, the Plan requires that certain care, services and procedures be pre-certified before they are provided. Pre-certification requests are submitted to the Care Coordinators by a specialty Physician, designated Primary Doctor, other Primary Doctor, or other healthcare provider. Provider offices have been provided with materials and education regarding this referral process and your Plan identification card includes instructions. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the need for the pre-certification request and to ensure that the care, service and/or procedure meet Plan criteria. If a pre-certification request does not meet Plan criteria, the Care Coordinators will contact the Covered Person and healthcare provider and assist in redirecting care if appropriate. The following services require pre-certification:

(a) Autism Spectrum Disorders

(b) Dialysis

(c) DME – all rentals and any purchase over $500

(d) Home Health Care

(e) Hospice Care

(f) Inpatient and Skilled Nursing Facility Admissions

(g) MRI/MRA and PET scans

(h) Occupational, Physical and Speech Therapy

(i) Oncology Care and Services (chemotherapy and radiation therapy)

(j) Organ, Tissue and Bone Marrow Transplants

(k) Outpatient Surgeries

(l) Prosthetics

(m) Residential Treatment Facility Admissions

(n) Routine patient care provided in connection with a clinical trial

(o) Specialty Infusion Drugs

Penalties For Not Obtaining Pre-Certification
A non-notification penalty is the amount you must pay if notification of the service is not provided prior to receiving a service. Failure to obtain pre-certification 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 for the services listed above.

Utilization Review
The Care Coordinators will review each pre-certification request to evaluate whether the care, requested procedures, and requested care setting all meet utilization criteria established by the Plan. The Plan has adopted the utilization criteria in use by the Coordinated Health/Care program. If a pre-certification request does not meet these criteria, the request will be reviewed by one of the medical directors for Coordinated Health/Care, who will review all available information and if needed consult with the requesting provider. If required, the medical director will also consult with other professionals and medical experts with knowledge in the appropriate field. He or she will then provide, through the Care Coordinators, a determination as to whether the request is approved, denied, or allowed as an exception. In this manner, the Plan ensures that pre-certification requests are reviewed according to nationally accepted standards of medical care, based on community healthcare resources and practices.

Concurrent Review
The Coordinated Health/Care program will regularly monitor a hospital stay, other institutional admission, or ongoing course of care for any Covered Person, and examine the possible use of alternate facilities or forms of care. The Care Coordinators will communicate regularly with attending Physicians, the Utilization Management staff of such facilities, and the Covered Person and/or family, to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). Such concurrent review, and authorization for Plan coverage of hospital days, is conducted in accordance with the utilization criteria adopted by the Plan and Coordinated Health/Care.

Case Management
Case Management is ongoing, proactive coordination of a Covered Person's care in cases where the medical condition is, or is expected to become catastrophic, chronic, or when the cost of treatment is expected to be significant. Examples of conditions that could prompt case management intervention include but are not limited to, cancer, chronic obstructive pulmonary disease, multiple trauma, spinal cord injury, stroke, head injury, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, high risk pregnancy, and premature birth.

Case Management is a collaborative process designed to meet a Covered Person's health care needs, maximize their health potential, while effectively managing the costs of care needed to achieve this objective. The case manager will consult with the Covered Person, the attending physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provides the most appropriate health care and services in a timely, efficient and cost-effective manner.

If the case manager, Covered Person, and the Claim Services Administrator all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, the Care Coordinator may alter or waive the normal provisions of this Plan to cover such alternative care, at the benefit level determined by the Claim Services Administrator.

In developing an alternative plan of treatment, the case manager will consider:

(1) The Covered Person's current medical status

(2) The current treatment plan

(3) The potential impact of the alternative plan of treatment

(4) The effectiveness of such care and

(5) The short-term and long-term implications this treatment plan could have

If an alternative plan of treatment is warranted, the Care Coordinators will submit this plan to the Claims Services Administrator for prior review and approval.

The Plan retains the right to review the Covered Person's medical status while the alternative plan of treatment is in process, and to discontinue the alternative plan of treatment with respect to medical services and supplies which are not covered charges under the Plan if:

(1) The attending physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment

(2) The goal of the alternative care of treatment has been met

(3) The alternative plan of care is not achieving the desired results or is no longer beneficial to the Covered Person

Chronic Condition Management
Chronic Condition Management (also referred to as Disease Management) is specialized support and coordination for Covered Person's with lifelong, chronic conditions such as diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and asthma. Chronic Condition Management is a collaborative process that designed to help Covered Persons with such conditions self-manage based on care pathways with

respect to such disease state, including but not limited to assisting Covered Persons in understanding the care pathway, assisting Covered Persons in setting goals, facilitating dialog with physicians if there are complications or conflicts with the Covered Person's care, evaluating ways to eliminate barriers to successful self-management and generally maximize their health. Covered Persons who are identified from claims, biometrics or other sources will be assessed for level of risk for each disease state and may be contacted proactively by a Chronic Condition Case Manager (also referred to as Disease Manager). Covered Persons whose information indicates they are high risk will be contacted by a Chronic Condition Case Manager for an assessment and ongoing assistance and will be asked to update their care pathway information bi-annually. Covered Persons who are low or moderate risk may request assistance of a Chronic Condition Case Manager and will also be asked to update their care pathway information on a bi-annual basis. Participation in chronic condition care management is voluntary, but participants may receive various prescription medications and/or supplies at a reduced cost or may be entitled to benefits that non-participants do not receive.

General Provisions for Care Coordination

Authorized Representative
The Covered Person is ultimately responsible for ensuring that all referrals and pre-certifications are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual referral and pre-certification process will be executed by the Covered Person's Physician(s) or other providers. By subscribing to this Plan, the Covered Person authorizes the Plan and its designated service providers (including Coordinated Health/Care, the Third Party Administrator, and others) to accept healthcare providers making referral and pre-certification submissions, their authorized representative in matters of Care Coordination. Communications with and notifications to such healthcare providers shall be considered notification to the Covered Person.

Time of Notice
The referral and pre-certification notifications must be made to Coordinated Health/Care within the following timeframe:

(1) **Within 5 to 7 business days**, before a scheduled (elective) Inpatient Hospital admission

(2) By the next business day after, an emergency Hospital admission

(3) Upon being identified as a potential organ or tissue transplant recipient

(4) **At least three business days** before receiving any other services requiring pre-authorization

"Emergency" Admissions and Procedures
Any Hospital admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the patient's health is considered an emergency for purposes of the utilization review notification.

Maternity Admissions
A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process complies with all state and federal regulations regarding utilization review for maternity admissions. The Plan will not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require prior notification or authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is Not a Guarantee of Payment of Benefits
The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of referral and pre-certification notices for specialty visits, procedures, hospitalizations and other services, indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not guarantee that the service is a covered benefit, that the Covered Person is eligible for such

benefits, or that other benefit conditions such as co-pay, deductible, co-insurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

Result of Not Following the Coordinated Process of Care
Failure to comply with the Care Coordination "process of care" may result in reduction or loss in benefits. The Penalties for Not Obtaining Pre-certification section specifies applicable penalties. Charges you must pay due to any penalty for failure to follow the care coordination process do not count toward satisfying any deductible, co-insurance or out-of-pocket limits of the Plan.

Appeal of Care Coordination Determinations
Covered Persons have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The appeal process is detailed in the Claims and Appeal Procedures section within this document.

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility
An eligible Employee who works on average 20 or more hours of work per week (or such minimum hours per week as may be required by the Participating Employer) will be eligible to enroll for coverage once he/she completes a waiting period as designated by the Participating Employer from the date he or she completes at least one hour of service with the Participating Employer. Participation in the Plan will begin as determined by each Participating Employer following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Participating Employer. A Retiree who immediately prior to retirement was considered an Employee and was covered under the Plan will also be considered an Eligible Employee.

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 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:

(1) **Certified Personnel:** a person required to have a teaching certificate for the position of employment that the person holds with the Employer;

(2) **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

(3) **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.**

You are not eligible to participate in the Plan if you are an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Dependent Eligibility
Your Dependent is eligible for participation in this Plan provided he/she is:

(1) Your Spouse.

(2) Your Civil Union Partner (as determined under Illinois law).

(3) Your Child from birth until the end of the month in which he/she attains age 26.

(4) Your 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.

(5) Your Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26 or age 30. Your Child must be unmarried and primarily dependent upon you for support. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity, within 31 days of the child's 26th or 30th birthday, as applicable.

(6) A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO).

The below terms have the following meanings:

“Child” means your natural born son, daughter, stepson, stepdaughter, legally adopted child (or a child placed with you in anticipation of adoption), Eligible Foster Child or a child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a child for whom you are the Legal Guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors). The term “Child” shall include the children of your Civil Union Partner.

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced. Also, 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.

Effective as of June 1, 2011, the state of Illinois enacted a civil union law. This law allowed unrelated individuals of the same or opposite sex 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, is to be recognized by Illinois as a civil union. The Employee will be required to submit an affidavit of civil union or other documentation issued under the applicable state law to the Participating Employer. A civil union partner after the civil union with the Employee has legally terminated will not be considered an eligible Dependent.

The Plan Administrator reserves the right to require such evidence as it deems necessary that a Civil Union satisfies the above eligibility requirements.

“Eligible Foster Child” shall mean an individual who is placed with you by an authorized placement agency.

“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 an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

“Spouse” means a person of the opposite or same sex recognized as the covered Employee's husband or wife under the laws of the state where you live.

The Plan Administrator may require documentation proving a legal marital relationship.

Excluded as Dependents are:

(1) a spouse legally separated or divorced from the Employee;

(2) a civil union partner after the civil union with the Employee has legally terminated; and

(3) 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.

Each Participating Employer is responsible for verifying that its Employees, Retirees and their Dependents satisfy the eligibility requirements to participate in the Plan. The Employer may be required to submit evidence of eligibility to the Third Party Administrator/Claims Services Administrator at any time.

When you and your Spouse are both Covered Employees

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.

This Plan will coordinate benefits following the guidelines as described in the "Coordination of Benefits" section of the Plan.

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

Court Ordered Coverage for a Child
Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Employer shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Employer receives a QMCSO, the Employer shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Employer determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Employer will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Plan.

Retiree Eligibility
You are eligible for coverage under this Plan as a Retiree (a former Employee classified as either a Certified Personnel or Educational Support Personnel) if you retired from employment as an eligible Employee of the Participating Employer and were covered under the Plan (or the prior plan of the Participating Employer) as of the date of your retirement. A Retiree will only qualify for coverage 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. You may also elect to continue coverage for your Spouse or civil union partner and any eligible Dependents.

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).

Dependent children may not be covered as dependents of more than one Employee (or Retiree).

Retirees and their eligible Dependents are not permitted to enroll in the Plan after retirement. A covered Retiree is not permitted to enroll new dependents acquired after retirement.

For further details regarding Retiree continuation of coverage options, refer to the "COBRA Continuation Coverage" section of the Plan.

If you decide to enroll yourself and your eligible Dependents in Retiree coverage, you must enroll by completing all required election and enrollment forms and submitting them to your Human Resources Department within 31 days after your retirement date. Participation in the Plan will continue for you and any eligible Dependents as of your date

of retirement provided all required election and enrollment forms are properly submitted to your Human Resources Department.

You are required to pay the cost of Retiree coverage for yourself and any eligible Dependents in accordance with the policies and procedures established by your Employer. The amount of any required contribution will be communicated to you prior to the date of your retirement. You may check with your Human Resources Department for this information.

Timely Enrollment
Once you have completed any applicable waiting period as designated by your Participating Employer, and you and your eligible Dependents are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to your Human Resources Department. You will have 31 days from the date first eligible to enroll for coverage. Coverage will become effective on the date you become eligible. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you fail to complete and submit the appropriate election and enrollment forms described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Qualifying Change in Status.

If you enroll in the Plan you cannot drop coverage for yourself or any Dependent until the next annual open enrollment period unless you experience a Special Enrollment Event or a Qualifying Change in Status.

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 Human Resources Department or the Third Party Administrator/Claims Services Administrator for additional information.

Annual Open Enrollment Period
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 Special Enrollment Event or a Qualifying Change in Status, as described later in this document. 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 Special Enrollment Event or 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 Special Enrollment Event or 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 plan options with different Schedules of Benefits. The five plan options are Plan A (formerly Platinum), Plan B (formerly Gold), Plan C (formerly Silver), the High Deductible Health Plan – HDHP (formerly Bronze) and Plan E (formerly Copper). Each Participating Employer will decide which plan option or plan options will be available to its Employees. An Employer may offer only one plan option or may offer up to four plans options. If an Employer selects Plan E (formerly Copper) option it cannot offer any other plan option to its Employees.

If your Employer offers more than one plan option, you must select and enroll in the plan option you want during an open enrollment period. All covered family members must enroll in the same plan option. You cannot change between plan options outside of the 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 option, you may move from a higher plan option to a lower plan option (from Plan A to Plan B, C or HDHP, or from Plan B to Plan C or HDHP or from Plan C to HDHP) by making an election during any open enrollment period. The change to the lower plan option will be effective as of September 1 or October 1 of the same year.

If your Employer offers more than one plan option and you want to move to a higher plan option (from Plan B to Plan A, or from Plan C to Plan A or B, or from the HDHP to Plan A, B or C) you must give one year advance notice that you intend to change plan options. This notice must be given in writing to your Employer during an open enrollment period. The change to the higher plan option 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 option for 12 months before you can change to a different plan option.

Exceptions: There is one exception to the rule that changes between Plans may not be made outside the annual open enrollment period.

An Employer may change from offering its Employees a choice between several different Plans to offering only one Plan, or from offering only one Plan to offering only one different Plan, effective as of January 1 of any year. In either case, 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 of the change. Thereafter, decisions to enroll in or drop coverage can only be made during the normal annual open enrollment period unless you have a Special Enrollment Event or a Qualifying Change in Status.

Special Enrollment Event

A Special Enrollment Event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each Special Enrollment Event is more fully described below:

(1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted a written statement to your Human Resources Department when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:

(a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

(b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

(c) Employer contributions ceased for the other health 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.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you must enroll your Dependent in the same benefit option as you are currently enrolled in under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 31 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the day following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

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.

(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

Information about States that offer premium assistance and contact information is available from the U.S. Department of Labor at (866) 444-3272 or at: http:www.dol.gov/ebsa/chipmodelnotice.doc.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the day following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, entering into a civil union, birth, adoption or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to your Human Resources Department within 31 days after the date you acquire such Dependent, except for the birth or adoption of a child as indicated below.

(a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable).

(b) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable).

(c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of birth if you are awarded physical or legal custody of a newborn child within 10 days of the date of birth. Otherwise, coverage for an adopted child will be effective as of the day of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable).

(d) Coverage for a newly acquired Dependent due to birth or adoption (or placement with you in anticipation of adoption) will be extended as follows:

(i) **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.

(ii) **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.

Note: 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 the birth of a child, you must enroll yourself and/or the other Dependents within 31 days of the birth.

(4) **Insurance Exchange Open Enrollment Periods.** A Covered Person who elects to enroll in an insurance plan through the insurance exchange during an exchange open enrollment period will be permitted to drop this coverage as of December 31. An Employee who was previous enrolled in an insurance plan through the insurance exchange will be permitted to drop that coverage and enroll in this Plan effective January 1. For the first exchange open enrollment period in 2014 only, coverage may be added or dropped effective January 1, February 1, or March 1, 2014. The Employer will be responsible for confirming that the Employee's decision to enroll in or drop coverage through this Plan corresponds to the Covered Person's decision to drop or add coverage purchased through the exchange.

Qualifying Change In Status

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Qualifying Change in Status. If a Qualifying Change in Status occurs you may make a new election under the Plan provided your new election is consistent with the Qualifying Change in Status. You must submit the appropriate election and enrollment forms to your Employer's Human Resources Department within 31 days after the Qualifying Change in Status along with written proof of the event. A Qualifying Change in Status includes the following:

(1) A change in your legal marital status, including divorce, legal separation, annulment or entering into a civil union;

(2) The death of your Spouse, Dependent Child or civil union partner;

(3) Termination of a civil union;

(4) Termination or commencement of employment by you, your Spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan, including a strike or lockout;

(5) A reduction or increase in your hours of employment or those of your Spouse, civil union partner or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;

(6) Your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;

(7) A change in the place of residence or work of you, your Spouse or your Dependent Child;

(8) The annual TRS insurance plan open enrollment period for Retirees and their eligible Dependents;

(9) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child;

(10) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;

(11) A change due to you, your Spouse, civil union partner or your Dependent Child gaining coverage under another employer's plan; or

(12) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including a plan maintained by the employer of your Spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 31 days after the Qualifying Change in Status.

A Change in Status does not allow you to change to a different Plan option (the Plan A option, Plan B option, Plan C option or HDHP Plan option) outside the open enrollment period.

Restatement 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:

(1) Coverage lapsed during a period the Employee was on an approved leave of absence from the Employer;

(2) 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

(3) 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 one of the following reasons:

(1) The birth of a child of the Employee;

(2) Placement of a child with the Employee for adoption or foster care;

(3) A serious health condition that makes the Employee unable to perform his or her job;

(4) 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;

(5) “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

(6) “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.

TERMINATION OF COVERAGE

Termination of Employee Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) The date the Employer ceases to be a Participating Employer;

(3) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(4) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained under the Continuation of Coverage under USERRA section;

(5) The end of the month you cease to be eligible for coverage under the Plan;

(6) The date coverage or certain benefits are terminated for your particular class by modification of the Plan;

(7) The date you terminate employment or cease to be included in an eligible class of Employees;

(8) The end of the month in which your employment ends with a Participating Employer, unless you are eligible for coverage as a Retiree;

(9) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and

(10) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) The date the Plan discontinues coverage for Dependents;

(3) The date coverage terminates for the Employee for any reason except death;

(4) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(5) The date the Dependent Spouse, civil union partner of an Employee or a child of a civil union partner reports to active military service;

(6) The end of the month in which a Dependent Spouse or civil union partner ceases to be a Dependent as defined by the Plan;

(7) With respect to Dependent Spouses, the end of the month in which the Spouse is legally separated or divorced from the Employee;

(8) With respect to civil union partners, the end of the month in which the civil union partner is legally terminated;

(9) With respect to Dependent children, the earlier of:

(a) The end of the month in which the Dependent child 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;

(b) The end of the month in which the Dependent child reaches age 26 (unless the child remains eligible under the rules for dependent veterans or disabled dependent children);

(c) The end of the month in which a dependent veteran reaches age 30 (unless the dependent remains eligible under the rules for disabled dependent children);

(d) The end of the month in which a disabled Dependent child age 26 or older ceases to be disabled or ceases to be dependent on the Employee for support;

(e) The end of the month in which an otherwise eligible Dependent child age 26 or older marries;

(10) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and

(11) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Termination of Retiree Coverage
Coverage under the Plan will terminate for you, your civil union partner and any Dependents on the earliest of the following dates:

(1) The date in which a required contribution has not been paid;

(2) The date the Plan terminates or no longer provides Retiree coverage;

(3) The end of the month in which a Dependent no longer satisfies the eligibility requirements as a Dependent under the terms of the Plan;

(4) The date you no longer qualify as a Retiree;

(5) The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) performs an act, practice or omission that constitutes fraud;

(6) The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) makes an intentional misrepresentation of a material fact.

Retirees and their 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. When a Retiree terminates Retiree coverage under this Plan, the Retire is never allowed to re-enroll at a later date.

Retroactive Termination of Coverage
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Continuation of Plan Coverage due to an Approved Leave of Absence or Disability
Medical coverage may continue for you and your Dependents in the event of your disability or an approved leave of absence as follows:

(1) 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. 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.

(2) In the event of an approved leave of absence, you and your eligible Dependents may continue regular coverage during the approved leave 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.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)
The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by the Participating Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws
To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Continuation of Coverage under USERRA
You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to your Human Resources Department within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Participating Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA. You must submit the appropriate documentation to your Employer when USERRA coverage terminates or changes.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Participating Employer. Your Participating Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

Certificates of Creditable Coverage

The Plan generally will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage under the Plan. In addition, a Certificate of Creditable Coverage will be provided upon request at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

SURVIVOR BENEFIT

Survivor Benefit for Employees or Retirees
In the event of death of an Employee or Retiree, coverage will continue for the Spouse, civil union partner and any eligible Dependents who were covered at the time of the Employee's or Retiree's death, provided that the former Employer of the deceased Employee or Retiree remains a Participating Employer in the Trust, until the earlier of the following:

(1) The date such Spouse or civil union partner remarries or civil union partner enters into a civil union.

(2) The date a required contribution has not been paid;

(3) The date a Dependent child becomes eligible for Medicare.

(4) The date the Dependent fails to satisfy the eligibility requirements for Dependent coverage under the Plan.

If your surviving Spouse and/or any eligible surviving Dependents decide to continue their enrollment in coverage under the Plan, they must enroll by completing all required election and enrollment forms and submitting them to your Human Resources Department within 31 days after the date of your death. Participation in the Plan will continue for your surviving Spouse, civil union partner and any eligible surviving Dependents as of the date of your death provided all required election and enrollment forms are properly submitted to your Human Resources Department. The cost of Plan coverage under this survivor benefit will be communicated to you by the Employer.

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.

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or

(2) Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

(1) **Acupuncture:** Services by a licensed Doctor of Medicine, Doctor of Osteopathic Medicine or Acupuncturist.

(2) **Allergy Services:** Allergy testing, serum and injections.

(3) **Ambulance Service:** 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 Third Party Administration prior to services being rendered.

(4) **Ambulatory Surgery Center:** Services and supplies provided by an Ambulatory Surgery Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(5) **Anesthetics:** Anesthetics and their professional administration.

(6) **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. 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.

The following terms have the following meanings:

(a) **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.

(b) **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:

(i) Psychiatric care.

(ii) Psychological care.

(iii) 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.

(iv) 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.

(c) **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.

All services for treatment of Autism Spectrum Disorders must be precertified as Medically Necessary.

(7) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced. Administration of these items is included.

(8) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(9) **Chemotherapy:** Services and supplies related to chemotherapy, except for high-dose chemotherapy related to a non-covered transplant procedure. **Please note the precertification requirements and penalties for Chemotherapy.**

(10) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(11) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

(12) **Consult-A-Doctor:** The Plan provides full coverage for telephone consults or e-mail consults provided by a Physician for non-emergent care. Common examples of when to use Consult-A-Doctor for non-emergent medical care, include but are not limited to the following: 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 utilize this service, please visit www.MyDrConsult.com. If you do not have internet service available, please call 1-800-362-2667 to utilize this service. If a prescription is requested, 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 the Consult-A-Doctor program. For any questions with respect to the Consult-A-Doctor benefit, please contact the Care Coordinators at 1-855-452-9997. Coverage under this benefit does not include telephone or e-mail consults from your regular Physician; it only includes coverage for telephone or e-mail consults to the extent the Physician who is consulted participates in the Consult-A-Doctor program. The Consult-A-Doctor benefit is not available in the State of Oklahoma.

(13) **Contraceptives:** Contraceptive procedures and medications other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a Preventive Service).

(14) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) For the correction of a Congenital Anomaly for a Dependent Child.

(b) Any other Medically Necessary Surgery related to an Illness or Injury.

(c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

(iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

(iv) Prosthetic devices include breast prostheses and bras.

(v) Coverage for post-mastectomy care including:

(A) Inpatient Hospital care following a mastectomy, for a length of stay as determined by the attending Physician to be Medically Necessary.

(B) Post-discharge Physician office visit or in-home nurse visit within 48 hours of discharge.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(15) **Dental Care:** Expenses for any care or treatment of teeth, gums or alveolar process will not be considered eligible unless such expenses are for:

(a) Reduction of fractures of the jaw or facial bones;

(b) Surgical correction of harelip, cleft palate or protruding mandible;

(c) Removal of stones from salivary ducts;

(d) Bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;

(e) Freeing of muscle attachments;

(f) 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);

(g) Emergency medical services related to an Injury to sound, natural teeth.

(16) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of

diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

(17) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program or under Durable Medical Equipment.

(18) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care.

The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of the Lab Card Program, benefits will be payable as shown in the Medical Schedule of Benefits. When a Physician orders laboratory work, the Covered Person should present the Lab Card or Employee identification card with the Lab Card logo on it and verbally request to use the Lab Card Program. The Physician will then collect the specimen and send it to Quest Diagnostics. Any Physician can collect specimens and call Quest Diagnostics Lab Card Client Services at (800) 646-7788 for courier pick-up and supplies. In the event the Physician does not participate with the Lab Card Program, simply take the test orders to an approved Lab Card collection site for the draw. Collection site locations can be found by calling Lab Card Client Services or by going to the website at www.labcard.com.

The Lab Card Program covers routine outpatient testing. The Lab Card does NOT cover: (a) testing ordered during hospitalization; (b) lab work needed on an emergency or STAT basis; (c) testing done at another laboratory; or (d) time sensitive esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(19) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary.

(b) The equipment will be provided on a rental basis; however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price).

(c) Benefits will be limited to standard models as determined by the Plan.

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair or motorized scooter.

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered.

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

(g) Expenses for diabetic equipment when Medically Necessary and prescribed by a Physician as follows:

(i) Blood glucose monitors;

(ii) Blood glucose monitors for the legally blind;

(iii) Cartridges for the legally blind; and

(iv) Lancets and lancing devices.

Please note the pre-certification requirements and penalties for Durable Medical Equipment.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(20) **Emergency Services:** The Plan will pay the greatest of the following amounts for Emergency Services received from Non-Network Providers:

(a) The amount negotiated with Network Providers for Emergency Services provided, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Network Provider. If there is more than one amount negotiated with Network Providers for the Emergency Services provided the amount paid shall be the median of the negotiated amounts, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Network Provider; or

(b) The amount for the Emergency Services calculated using the same method the Plan generally uses to determine payments for services provided by a Non-Network Provider (such as Usual and Customary Charge), excluding any Copay or Coinsurance that would be imposed if the service had been received from a Network Provider; or

(c) The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Services, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Network Provider.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(21) **Foot Care:** Treatment for the following foot conditions: (a) toenails when at least part of the nail root is removed; (b) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will also be covered, as well as the initial purchase, fitting and repair of custom-fitted foot orthotics when determined to be Medically Necessary by the attending Physician are covered by the Plan. Routine foot care is covered for the treatment of diabetes.

(22) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary, including but not limited to:

(a) Diagnostic testing where the patient is showing symptoms of disease, and those symptoms correspond to a medically recognized genetic disorder;

(b) 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;

(c) 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;

(d) 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.

(23) **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit.

Please note the pre-certification requirements and penalties for Dialysis.

(24) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Part-time or intermittent home nursing care;

(b) Part-time or intermittent services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW);

(d) Physical, occupational or speech therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each four hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, custodial care, private duty nursing, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Please note the pre-certification requirements and penalties for Home Health Care.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(25) **Home Infusion Therapy:** Services, supplies and equipment necessary for home infusion therapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(26) **Hospice Care:** Hospice care on either an inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) 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 of no longer than 10 consecutive days.

(e) Procedures necessary for pain control and acute and chronic symptom management.

(f) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical and speech therapy.

(g) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

Please note the pre-certification requirements and penalties for Hospice Care.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Please note the pre-certification requirements and penalties for Inpatient Hospital Services.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(28) **Infertility Treatment:** 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 childbearing age.

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

(a) The Covered Person has attempted but has been unable to attain or sustain a successful pregnancy through reasonable, less costly medically appropriate infertility treatments;

(b) 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:

(a) Medical costs of oocyte or invasive sperm retrieval

(b) Invitro fertilization

(c) Uterine embryo lavage

(d) Embryo transfer

(e) Artificial insemination

(f) Gamete intrafallopian tube transfer

(g) Zygote intrafallopian tube transfer

(h) Low tubal ovum transfer

(i) Other medically recognized techniques that are not considered Experimental or Investigational at the time the treatment is provided.

The following are non-covered expenses:

(a) Costs associated with cryopreservation and storage of egg, sperm or embryo

(b) Experimental treatments

(c) Fertility treatment for a person who has undergone a voluntary sterilization procedure

(d) Fertility treatment for a person who is beyond normal child-bearing age.

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

(29) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(30) **Maternity:** Expenses Incurred by an Employee, Dependent Spouse or a civil union partner for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center.

(d) One amniocentesis test per Pregnancy.

(e) Up to two ultrasounds per Pregnancy (more than two only when it is determined to be Medically Necessary).

(f) Elective induced abortions.

Maternity expenses are considered as any other illness under the Plan for covered Employees and covered spouses or civil union partners of Employees. Charges include preventive prenatal and breastfeeding support as identified under the preventive services section. 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. However, no deductible will apply to the inpatient hospital facility charges for the baby. **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 except as otherwise covered as a preventive service under the Covered Major Medical Expenses section of the Plan. (Please refer to the Preventive Services benefit.)

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a mother or newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(31) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, dressings, orthotics and custom made orthopedic shoes and other Medically Necessary supplies when ordered by a Physician.

(32) **Mental Disorders, Alcohol and/or Substance Use Disorders**: Treatment of Mental Disorders of any type, regardless of cause or origin, including but not limited to ICD9 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.

Benefits include services for the following:

(a) inpatient and outpatient services, limited to the Lifetime Maximum day limits for inpatient services and the Calendar Year maximum visit limits for outpatient services stated in the Medical Schedule of Benefits;

(b) 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);

(c) both in and outpatient Physicians visits are limited to one per day;

(d) services must be rendered by a provider covered under the Plan.

All inpatient services, including treatment in a Rehabilitation Facility, must be precertified by the Care Coordinators at (855) 452-9997.

Important Note: Group health plans sponsored by State and local governmental employers such as public school districts must generally comply with Federal law requirements in Title XXVII of the Public Health Service Act. However, such employers are permitted to elect to exempt a plan from certain requirements for any plan that is "self-funded" rather than provided through a health insurance policy. The Plan Sponsor has elected to exempt this Plan from some requirements of the Mental Health Parity Act and Addiction Act which generally prevents plans from having more restrictive benefits for mental health and substance abuse disorders than for other covered medical and surgical conditions. This exemption will continue in effect through August 31, 2014, and may be renewed for subsequent Plan years.

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

(a) prescription drugs (considered under the prescription drug benefit);

(b) laboratory tests for prescribed drug levels when performed by an independent lab;

(c) surgical procedures and related expenses;

(d) electroshock therapy and related anesthesia provided by an independent anesthesiologist;

(e) 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;

(f) charges for diagnosis and treatment of Autism Spectrum Disorders (subject to the annual limit stated in the Medical Schedule of Benefits).

(33) **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:

(a) The Covered Person meets the requirements for morbid obesity stated in the Definitions;

(b) 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

(c) the patient or physician provides evidence that conventional weight reduction methods have failed.

Limitations on Benefits:

(a) Network Provider: Considered as all other covered surgical procedures.

(b) Non-Network Provider: Considered at 50%, after the Deductible, 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 Care Coordinator 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.)

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(34) **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:

(a) Attention-Deficit/Hyperactivity Disorder

(b) Chronic Fatigue Syndrome

(c) Idiopathic Environmental Intolerance (casual connection between environmental chemicals, foods and/or drugs).

(35) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(36) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed Occupational Therapist under the recommendation of a Physician for therapeutic treatment of a covered Illness or Injury which will improve a body function. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits. **Please note the pre-certification requirements and penalties for occupational therapy.**

(37) **Outpatient Pre-Admission Testing:** Outpatient pre-admission testing performed within 72 hours of a scheduled Inpatient hospitalization or Surgery. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(38) **Pain Medication and Pain Therapy:** Charges for pain medication and pain therapy related to the treatment of breast cancer, or otherwise when medically appropriate.

(39) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed 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. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits. **Please note the pre-certification requirements and penalties for physical therapy.**

(40) **Physician Services:** Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office for the same or related diagnosis. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, allergy shots, cast application and minor Surgery.

(b) Diagnostic x-ray and laboratory services performed or ordered during the office visit or performed or read at a later date and/or at another facility will not be considered as part of the office visit and will be payable as shown in the Medical Schedule of Benefits.

(c) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

For surgical assistance by an Assistant Surgeon, the eligible charge will be 25% of the Usual and Customary Charge for the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(41) **Prescription Drugs:** 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.**

Please refer to the Wellness Benefit / Preventive Services section under covered Eligible Medical Expenses with respect to Preventive Drug coverage.

(42) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (the “Task Force”) with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children

With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes. A maximum of 5 screenings for gestational diabetes shall be covered in pregnant women.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to one screening every three Plan Years.

(D) Counseling annually for sexually transmitted infections (including for the human-immune-deficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to two counseling sessions per Plan Year.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include sterilization implant (Essure) and surgical sterilization (Sterilization) either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as Preventive

Services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Preventive Service Covered Expense.

(G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested within 60 days (electric) or 12 months (manual) from the baby's date of birth, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last three Calendar Years.

(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding within the first 12 months from the baby's date of birth

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: http://www.hrsa.gov/womensguidelines. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

You may also contact the Care Coordinators 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 By Non-Network Providers. 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, Copay 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 Copay. 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 Care Coordinators.

(v) Preventive Drugs

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 drug benefit with no member Copay: famotidine (Pepcid), omeprazole 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% under the prescription card benefit with no member copayment if the patient meets the stated conditions. You must submit a prescription written for the OTC or generic drug.

(1) 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.

(2) Generic oral fluoride supplements when prescribed for children from birth to age 5.

(3) OTC and generic iron supplements when prescribed for children from birth to 12 months of age.

(4) OTC generic folic acid supplements when prescribed for women of child bearing age.

Preventive Contraceptives. A Preventive Drug is a list of Prescription Drugs, FDA approved contraceptive devices and FDA approved over-the-counter medications (including over-the-counter emergency contraceptives) when prescribed by a Physician, which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. The term "Preventive Drug" does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the-counter emergency contraceptives) regardless of whether or not such items are prescribed by a Physician. Please contact the Care Coordinators for a complete listing of the Preventive Drugs covered under this Plan and any restrictions on the available drugs. You may also view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Care Coordinators.

(b) Routine Care

Routine care as required by the guidelines, including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, pap smears, mammograms, breast exams, colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness. The first mammogram, pap smear, and PSA test in a Calendar Year will be treated as a preventive service and paid at 100%.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(43) **Prosthetic Devices:** Artificial limbs, eyes or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan, but no more than every 5 years for normal wear. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. **Please note the pre-certification requirements and penalties for prosthetic devices.**

(44) **Pulmonary Therapy:** Pulmonary therapy under the recommendation of a Physician.

(45) **Qualified Clinical Trial Expenses:** Expenses for routine patient care provided in connection with a Covered Person's participation in a Qualified 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 cancer or another 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:

(a) 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);

(b) Items or services required for the provision of the investigational item or service (such as administration of a non-covered chemotherapy drug);

(c) 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;

(d) 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 a Qualified Clinical Trial.

Routine patient care to be provided in connection with a Qualified Clinical Trial must be precertified 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.

(46) **Radiation Therapy:** Radium and radioactive isotope therapy treatment.

(47) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(48) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(49) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the newborn's expense. However, no Deductible will apply to the Inpatient Hospital facility charges for the baby.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

There are no benefits available for charges related to the pregnancy of a Dependent child or complication of pregnancy of a Dependent child except as otherwise covered as a preventive service under the covered Eligible Medical Expenses section of the Plan. (Please refer to the Preventive Services benefit.)

(50) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(51) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care. **Please note the pre-certification requirements and penalties for Skilled Nursing Facility.**

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(52) **Speech Therapy:** Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary to restore loss or impairment of normal speech due to an Illness, Injury or Surgery or therapy to correct a Congenital Anomaly, an Illness that is other than a learning or Mental Disorder or to treat a diagnosed Autism Spectrum Disorder. Speech therapy for developmental delay or to change voice sound will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits. **Please note the pre-certification requirements and penalties for speech therapy.**

(53) **Sterilization:** Elective sterilization procedures, including tubal ligation or vasectomy (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(54) **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.

(55) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

(56) **Total Parenteral Nutrition (TPN):** Expenses 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.

(57) **Transplants:** Charges for cornea, bone, homographs 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:

(a) Network Provider Facility: Transplant services rendered at a Network Hospital with organ/tissue transplant facilities will be considered at the benefit levels stated in the Medical Schedule of Benefits, plus transportation costs and room and meals for one designated support person not to exceed $50.00 per day. Please contact the Care Coordinator at (855) 452-9997 for a list of available transplant facilities.

(b) Non-Network Facility: Transplant services rendered at a Non-Network hospital will be considered at 50%, after the deductible, limited to a maximum benefit per procurement of $50,000 (including all related therapy, treatment and drugs). (Note: If the Care Coordinator 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) 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.

(b) 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 Expense.

(c) If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits.

(d) If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately.

(e) 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:

(a) Charges for services relating to obtaining or implanting non-human or artificial organs;

(b) Experimental or Investigational transplant procedures;

(c) High-dose chemotherapy related to a non-covered transplant procedure;

(d) With respect to heart transplant, expenses of the donor will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits

(58) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility for treatment of accidental Injuries, emergency conditions and/or other non-routine care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(59) **Wigs:** Purchase of a scalp hair prosthesis when necessitated by hair loss due to chemotherapy or radiation.

ALTERNATIVE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternative treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) **Adoption:** Expenses related to adoption will not be considered eligible.

(2) **Artificial Insemination:** Expenses for artificial insemination, in-vitro fertilization or embryo or fetal implants, or other assisted reproduction techniques will not be considered eligible, except as specified under Infertility Treatment under Eligible Medical Expenses.

(3) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(4) **Claims:** Expenses for services or supplies that were provided more than 12 months prior to the date the charges are submitted to the Plan for payment will not be considered eligible.

(5) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(6) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible.

(7) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.

(8) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

(9) **Counseling:** Expenses for religious, marital, family, bereavement or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(10) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Hospice Care benefits. 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.

(11) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses. Removal of impacted teeth will not be considered eligible.

(12) **Exercise Programs:** Exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(13) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs or medicines, except charges for routine patient care provided in connection with an approved clinical trial, which are determined to be Experimental and/or Investigational will not be considered eligible.

(14) **Foot Care:** Expenses Incurred for the treatment of corns, calluses or toenails will not be considered eligible unless charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral-vascular disease and as specified under Eligible Medical Expenses.

(15) **Foot Orthotics:** Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace), arch supports or for the exam, prescription or fitting thereof will not be considered eligible, except as specified under Eligible Medical Expenses.

(16) **Gambling Addiction:** Expenses for services related to gambling addiction will not be considered eligible.

(17) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents). (For treatment in Veteran Administration facilities, the law generally requires the Plan to provide benefits for a covered individual who does not have a service-connected disability.)

(18) **Hair Loss:** Expenses for hair loss or hair transplants will not be considered eligible, except as specified under Eligible Medical Expenses.

(19) **Hearing Exams/Aids:** Expenses for routine hearing examinations, hearing aids (including the fitting thereof) and supplies will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan**.**

(20) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(21) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

(22) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(23) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(24) **Massage Therapy:** Expenses for massage therapy will not be considered eligible, except when part of an overall patient treatment plan and the services are provided by an eligible provider.

(25) **Maternity:** Maternity expenses Incurred by a Dependent other than an Employee's Spouse will not be considered eligible except as otherwise covered as a preventive service as specified under the Eligible Medical Expenses section of the Plan.

(26) **Medical Expenses:** Expenses for any services, supplies, charges or expenses which are not included under Eligible Medical Expenses will not be considered eligible.

(27) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(28) **Missed Appointments:** Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible. This exclusion does not apply to telephone consultations provided as part of the Consult-A-Doctor program as described in the Eligible Medical Expenses section of the Plan.

(29) **Morbid Obesity:** Expenses for non-surgical treatment of Morbid Obesity will not be considered eligible.

(30) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Plan to be primary.

(31) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(32) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(33) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(34) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(35) **Obesity:** Surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible**,** except as specified under Eligible Medical Expenses or as otherwise covered as a preventive service under the Plan.

(36) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(37) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(38) **Outside the United States (U.S.) or Outside the Designated Area:** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible, unless the charges are Incurred while the Covered Person is traveling on business or pleasure.

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 Condition 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.

(39) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication obtained without a prescription will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan or as described in the Prescription Drug Card Program section.

(40) **Plan Maximums:** Charges in excess of Plan maximums will not be considered eligible.

(41) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(42) **Private Duty Nursing:** Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Hospice Care benefits.

(43) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

(44) **Refractive Errors:** Expenses for radial keratotomy, lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(45) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(46) **Rhinoplasty:** Expenses related to rhinoplasty, Blepharoplasty or brow lift performed for non-cosmetic reasons will not be considered eligible, 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 will not be considered eligible.

(47) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(48) **Routine Care:** Expenses for routine care, including x-ray, laboratory tests, vaccinations and immunizations will not be considered eligible, except as specified under Eligible Medical Expenses.

(49) **Self-Inflicted Injury:** Expenses for Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury will not be considered eligible. This exclusion will not apply if self-inflicted Injuries result from a medical condition (physical or mental) or act of domestic violence and the benefits for such Injuries are normally covered under the Plan.

(50) **Services to Lessen Patient's Disability**: Expenses related to services that cannot reasonably be expected to lessen the patient's disability and to enable the patient to live outside of an institution will not be considered eligible, except as specifically covered under Hospice Care.

(51) **Sex Transformation:** Expenses in connection with sex transformation will not be considered eligible.

(52) **Sleep Disorder:** Expenses for treatment, services and supplies for sleep disorders unless Medically Necessary will not be considered eligible.

(53) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(54) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.

(55) **Travel:** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.

(56) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible, except to the extent the charge is covered by a contract with a Network provider.

(57) **Vaccinations, Inoculations and Immunizations:** Expenses for vaccinations, inoculations and immunizations will not be considered eligible, unless they are recommended preventive services. See the Preventive Services and Routine Care section under Eligible Medical Expenses.

(58) **Vision Care:** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following cataract Surgery. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(59) **War:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(60) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(61) **Worker's Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

This exclusion does not apply if the Covered Person is not actually covered by Worker's Compensation or similar law unless such coverage is required by applicable law but was not in force for the Covered Person.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG CARD PROGRAM

Deductible
Under the HDHP 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 Plan.) A list of the most common drugs that are often prescribed as Preventive Drugs is attached to your HDHP Plan Schedule of Benefits.This list may also be found on 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.

Copays
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 HDHP Plan, Prescription Drug Copays 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 HDHP Plan will pay the entire cost of your covered Prescription Drug expenses for the remainder of the year.

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to:

(1) Legend drugs.

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

(3) Insulin and insulin syringes.

(4) Compound prescriptions of which at least one ingredient is a legend drug in a therapeutic amount.

(5) Diabetic supplies (test strips).

(6) Injectable medications and syringes.

(7) Growth hormones.

(8) Fluoride products.

(9) Imitrex.

(10) Bee sting kits.

(11) Acne treatments.

(12) Prenatal vitamins.

(13) Fertility drugs (with prior authorization only).

(14) Birth control pills and other prescription contraceptives (excluding IUDs and implants which are covered under the medical benefit).

(15) Diet control/weight management drugs.

(16) Retin-A/Differin (prior authorization required after age 24).

(17) Prescription strength vitamins (with prior authorization only).

(18) Preventive Over-the-Counter (OTC) and generic drugs (including those that are considered Preventive Drugs) for patients who meet the requirements stated below under Preventive Drugs.

(19) Smoking cessation products are limited to two cycles per Calendar Year (168 days = two cycles of treatment, 12 weeks per cycle).

(a) Zyban or Chantix (limited to 168-day supply in one Calendar Year of treatment).

(b) Nicotine replacement products - Nicotine patch, gum & lozenges (limited to 168-day supply in one Calendar Year of treatment).

(c) Over-the-counter (OTC) medications require a prescription from your Physician.

Please note Prescription Drugs are subject to the cost-sharing provisions described in the Prescription Drug Schedule of Benefits unless the Prescription Drug qualifies as a Preventive Drug (as described below).

Exclusions:

(1) Biological serums (immunological vaccines).

(2) Cosmetic agents.

(3) Non-Drug items, such as stockings or devices, even if a prescription is required.

(4) Experimental drugs or drugs required to be labeled “Caution – Limited by Federal Law to Investigational Use”.

(5) Over the Counter (OTC) drugs (except as stated above).

(6) Hair growth stimulants.

(7) Refills obtained more than one year after the original prescription date or prior to 75% of completion of the projected usage.

(8) Medical devices/supplies (unless listed as covered).

(9) Diagnostic agents (test kits).

(10) Syringes and needles (except for insulin and other covered injectables).

(11) Impotence treatments.*

(12) Vitamins, except prenatal vitamins and prescription strength vitamins for which the patient has obtained prior authorization.

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

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply. To purchase more than a 30-day supply of any drug you must use a retail pharmacy in CVS Caremark’s Maintenance Drug Network (MDN) or the Home Delivery program.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Maintenance Drugs

Certain drugs that patients take for chronic medical conditions are classified by CVS Caremark as maintenance drugs. A list with the most common maintenance drugs is available on the CVS Caremark website at www.caremark.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 a Maintenance Drug Network (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 Copays if you choose to use MDN pharmacies instead of Home Delivery.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the CVS Caremark Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Care Coordinators at (855) 452-9997.

Dispense As Written
If the Covered Person chooses a Preferred or Non-Preferred Drug rather than the Generic equivalent when there is a Generic equivalent available and the Physician has allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic Drug and the Preferred or Non-Preferred Drug. The Covered Person's share of the Prescription Drug cost does not apply toward the Plan's Out-of-Pocket Maximum.

Specialty Pharmacy Program
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 CVS Caremark 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 CVS Caremark. Self-administered injectable drugs available under the prescription drug card program will not be reimbursed under the Eligible Medical Expenses section of the Plan.

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 CVS Caremark and the Trust’s website. You may also contact the Care Coordinators with questions about step-therapy.

Injectable drugs
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.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Preferred Drug: Any Brand Name drugs that do not appear on the list of Preferred Drugs.

Preferred Drug: A list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. CVS Caremark and the Care Coordinators will have a list of Preferred Drugs available. The list is also on the Trust website at www.egtrust.org.

Prescription Drug: Any of the following: (a) 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"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

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 Copay: Famotidine (Pepcid), omeprazole OTC (Prilosec OTC), Lansoprazole OTC (Prevacid OTC); ranitidine (Zantac). You must submit a prescription written specifically for the OTC drug.

Preventive Drug means a list of Prescription Drugs, FDA approved contraceptive devices and FDA approved over-the-counter medications (including over-the-counter emergency contraceptives), when prescribed by a Physician, that have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. The term "Preventive Drug" includes, but is not limited to the following:

(1) 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.

(2) Generic oral fluoride supplements when prescribed for children from birth to age 5.

(3) OTC and generic iron supplements when prescribed for children from birth to 12 months of age.

(4) OTC generic folic acid supplements when prescribed for women of child bearing age.

Preventive Contraceptives. Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age and limited to contraceptives that are considered Generic Drugs unless no equivalent Generic Drug is available and the Preferred or Non-Preferred Drug is otherwise covered under the Prescription Drug Card Program**.**

The term "Preventive Drug" does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the counter emergency contraceptives) regardless of whether or not such items are prescribed by a Physician.

Please contact the Care Coordinators for a complete listing of the Preventive Drugs covered under this Plan and any restrictions on the available drugs. You may also view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Care Coordinators at (855) 452-9997.

NOTE: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age.

To the extent the above does not cover any Preventive Drug or contraceptive device required to be covered by the U.S. Department of Health Human Services (HHS) or under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such Preventive Drug or contraceptive device to the extent required by the HHS and/or such guidelines.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

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.

Qualified Beneficiary
In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

A civil union partner of an Employee, generally is not entitled to continue coverage under COBRA; however the Trust has chosen to extend COBRA-like coverage to civil union partners and to the child of a civil union partner. COBRA-like coverage is identical to a continuation of coverage under COBRA offered to a Spouse or civil union partner and any Dependent child of an Employee.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event
If you are a covered Employee, you, your Spouse or civil union partner and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

(1) Your hours of employment are reduced below the minimum required to maintain eligibility; or

(2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse or civil union partner and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse or civil union partner and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse or civil union partner may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse or civil union partner and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

(1) Your spouse/parent-Employee dies;

(2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or

(3) You/your parents become divorced or legally separated or a civil union is terminated.

Your Spouse or civil union partner and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse or civil union partner and/or Dependent Child provide notice of the qualifying event to your Human Resources Department and elect to enroll in COBRA within 60 days following

the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Human Resources Department and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

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**.**

Extension of 18-Month Continuation Coverage Period

If you, your Spouse or civil union partner or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Human Resources Department within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice. In any event, notice must be given to your Human Resources Department prior to the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Human Resources Department within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse or civil union partner and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Human Resources Department within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement

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 Third Party Administrator. The Employer must also notify the Third Party 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 notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse, termination of a civil union, or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

(1) Name and address of the covered Employee or former employee;

(2) Name and address of your Spouse, former Spouse or civil union partner and any Dependent Children;

(3) Description of the qualifying event; and

(4) Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

(1) Name of person deemed disabled;

(2) Date of disability determination; and

(3) Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the COBRA Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or civil union partner may obtain a copy by requesting it from the COBRA Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Meritain Health, Inc.
P.O. Box 27158
Lansing, MI 48909-7158
Fax No.: (716) 319-5736
(800) 925-2272

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.

Payment for COBRA Continuation Coverage
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%.

Termination of COBRA Continuation Coverage
COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

(1) The date your Employer withdraws from the Trust or ceases to provide any group health plan coverage.

(2) The date on which the qualified beneficiary fails to pay the required contribution.

(3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first). However, a qualified beneficiary who becomes covered under a group health plan which has a Pre-Existing Condition limit that affects that individual will be allowed to continue COBRA continuation coverage for the length of the pre-existing condition or to the COBRA maximum time period, if less.

(4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Additional Information
Additional information about the Plan and COBRA continuation coverage is available from your Employer or the COBRA Administrator, who is identified on the General Plan Information page of this Plan.

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

Current Addresses
In order to protect your family's rights, you should keep your Employer and the COBRA Administrator informed of any changes in the addresses of family members.

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 Third Party Administrator to ask for a Certificate if you do not receive one.

CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Preferred Provider Network and the Medical Management Program Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

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

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges;

(6) The name of the Plan;

(7) The name of the covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. However, a request for pre-certification of a Hospital admission or other service for which the Plan requires pre-certification is considered a claim. Presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Third Party Administrator within 12 months following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are four (4) different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient

information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Plan will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan needs additional time to process a claim, the Plan may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the Plan requires you to obtain approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Plan will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan needs additional time to process a claim, the Plan may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the denial;

(2) A reference to the Plan provision on which the denial is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim and an explanation of why the additional material or information is necessary;

(4) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal);

(6) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

(7) If the adverse determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than three days after the oral notification.

Internal Review of Initially Denied Claims
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

Second level appeals will be reviewed by the Trust’s Appeals Committee.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initially denied claims (including all relevant information) and for review of an adverse determination of a first level must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 1380
Amherst, NY 14226-1380

Deadline for Internal Review of Initially Denied Claims

(1) Urgent Care Claims. The Plan provides for one level of appeal for urgent care claims. The reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives your request for review of the initial adverse determination.

(2) Pre-Service Claims. The Plan provides for two levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(3) Post-Service Claims. The Plan provides for two levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims

Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

(1) A description of the Plan's decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal);

(6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request; and

(7) If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

Any notice of adverse determination will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods

For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of a denied claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination
For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review requirement, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Denied Claims
If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan is a non-federal governmental plan and has elected to use the federal external review process that applies to ERISA-governed, self-funded Plans, as described below.

The Federal external review process (including the expedited external review process described later in these procedures) is <u>not</u> available for review of all internal adverse determinations. Specifically, Federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. The Federal external review process is available only for:

(1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is experimental or investigational), as determined by the external reviewer; and

(2) A rescission of coverage.

For any adverse determination for which external review is available, the Federal external review requirements are as follows:

(1) You have four months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Coordinated Health/Care
1215 Polaris Parkway
Columbus, OH 43240-2037
(855) 452-9997

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review
You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

(b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 365 days after the final review/appeal decision by the Plan has been rendered (or deemed rendered).

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Coordinated Health/Care. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Third Party Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this Plan.

Excess Insurance
If at the time of Injury, Illness, disease or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

(1) Any primary payer besides the Plan;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third-party;

(4) Worker's Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses
"Allowable expenses" shall mean any Medically Necessary, Usual and Customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

(1) If you are covered under an HMO plan provided by your Employer, no benefits will be payable under this Plan.

(2) 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.

(3) 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.

(4) 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.

Other Plan
"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

(1) Group, blanket or franchise insurance coverage;

(2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

(3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;

(4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

(5) Coverage under any Health Maintenance Organization (HMO); or

(6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

Order of Benefit Determination
For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

(1) A plan without a coordinating provision will always be the primary plan;

(2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.

(3) Active/laid-off or Retirees: The plan which covers a person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

(4) Dependent children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(5) Dependent children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

(a) The plan of the parent with custody pays first;

(b) The plan of the spouse of the parent with custody (the step-parent) pays next;

(c) The plan of the parent without custody pays next; and

(d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

(6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery
Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

(1) In error;

(2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

(3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;

(4) With respect to an ineligible person;

(5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or

(6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage
You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid
In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare

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	-$750
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.

Medicare and COBRA
For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE
The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist and medical payment provisions (collectively "coverage").

(2) The Covered Person, his or her attorney and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from anyone or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.

(3) In the event a Covered Person settles, recovers or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

(4) If there is more than one party responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may elect to seek reimbursement, at its discretion.

Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

(3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) If the Covered Person fails to file a claim or pursue damages against:

(a) The responsible party, its insurer or any other source on behalf of that party;

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

(c) Any policy of insurance from any insurance company or guarantor of a third party;

(d) Workers' Compensation or other liability insurance company; or,

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

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

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

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

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

Excess Insurance

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

(1) The responsible party, its insurer or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers' Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

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

Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply.

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

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

(b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;

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

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

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

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

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

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

Offset
Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person satisfies his or her obligation.

Minor Status
(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation
The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights. The Plan Sponsor may amend the Plan at any time without notice.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one or two Assistant Surgeons. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

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 a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Certificate of Creditable Coverage means a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Civil Union Partner is defined in the Eligibility for Participation section of the Plan.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance has the same meaning as set forth in the General Overview of the Plan section of this Plan.

Complications of Pregnancy means condition(s) (when the Pregnancy is not terminated) whose diagnosis is distinct from Pregnancy but which is adversely affected by Pregnancy or caused by Pregnancy; such as, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity.

Complications of Pregnancy also include an ectopic Pregnancy which is terminated or spontaneous termination of Pregnancy which occurs during a period of gestation when a viable birth is not possible; and pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of Pregnancy).

Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness and similar conditions, which, although associated with the management of a difficult Pregnancy, are not medically classified as distinct Complications of Pregnancy.

Concurrent Review means the Medical Management Program Administrator will review all Inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay has the same meaning as set forth in the General Overview of the Plan section of this Plan.

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) The Usual and Customary Charge or the HealthLink network contracted amount.

(3) For prescription drug expenses, any prescription drugs or medicines eligible for coverage under the Prescription Drug Card Program.

Covered Person means, individually, a covered Employee or Retiree and each of his or her Dependents or a person enrolled for COBRA coverage under the Plan.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

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

Dependent is a Covered Person, other than the Employee or Retiree**,** who is covered by the Plan pursuant to the terms and conditions set forth in the Eligibility for Participation section of the Plan.

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 prescribed by a Physician that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

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.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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.

Emergency Services means, with respect to an Emergency Medical Condition:

(1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

Employee is defined in the Eligibility for Participation section of the Plan.

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.

Enrollment Date means the earlier of first day of coverage or, if there is a waiting period, the first day of the eligibility waiting period.

Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Third Party Administrator as set forth below.

The Third Party Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Third Party Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Third Party Administrator will be final and binding on the Plan. In addition to the above, the Third Party Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

(2) 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, then it is deemed to be Experimental and/or Investigational; or

(3) 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 or is the subject of the research, Experimental, study, Investigational or other 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, then it is deemed to be Experimental and/or Investigational; or

(4) 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, then it is deemed to be Experimental and/or Investigational.

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, service, 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.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(1) The named drug is not specifically excluded under the General Limitations of the Plan; and

(2) The named drug has been approved by the FDA; and

(3) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(4) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment, except for routine patient care described under Qualified Clinical Trial Expenses.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Third Party Administrator.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Foster Child is defined in the Eligibility for Participation section of the Plan.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the 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. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility); and (2) establishing contribution or premium amounts for coverage under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

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 means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, at least two of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

Illness means a bodily disorder, disease, physical sickness, Pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special life saving equipment which is immediately available at all times; (3) at least two (2) beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Leave of Absence means a Leave of Absence of an Employee that has been approved by the Employer, as provided for in the Employer's rules, policies, procedures and practices.

Legal Guardian is defined in the Eligibility for Participation section of the Plan.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits or the applicable covered expenses section of the Plan.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Medical Management Program Administrator means Coordinated Health/Care, 1215 Polaris Parkway, Columbus, OH 43240-2037.

Medically Necessary/Medical Necessity means treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) "Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Morbid Obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

Network Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide discounted or reduced cost health care services to Plan enrollees.

Non-Network Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide discounted or reduced cost health care services to Plan enrollees.

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

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 material to give a Covered Person increased independence.

Participating Employer means any employer that has, with the consent of the Plan Sponsor, adopted this Plan pursuant to a participation agreement by and between the Plan Sponsor and the employer for the exclusive benefit of its Employees and their eligible Dependents.

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.

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

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist and Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the Egyptian Area Schools Employee Medical Benefit Plan.

Plan Administrator means the Plan Sponsor.

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

Plan Year means the period from September 1 - August 31 each year.

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.

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

Prescription Drug means any of the following: (a) 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,” (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Primary Care Physician means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

Qualified Clinical Trial is defined as a Phase I, Phase II, Phase III or Phase IV clinical trial which is conducted for prevention, detection or treatment of cancer or other life-threatening conditions and meets any of the following requirements:

(1) A trial that is federally funded or approved by at least one of the following agencies: (i) the National Institutes of Health (NIH); (ii) the Centers for Disease Control and Prevention (CDC); (iii) the Agency for Health Care Research and Quality (AHCRQ); the Centers for Medicare and Medicaid Services (CMS); (v) a cooperative group or center of any of the above agencies, or the Departments of Defense (DOD), Veterans Affairs (VA), or the Department of Energy (DOE).

(2) A study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

(3) A study or drug trial that is exempt from investigational new drug application requirements.

For this purpose a life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Expenses incurred in connection with a Qualified Clinical Trial are not covered by the Plan except as provided in Eligible Medical Expenses.

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).

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) 24 hour nursing services are available; and (8) the confinement is not for Custodial Care or maintenance care.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by two or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Specialist means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g. cardiologist, neurologist, etc.) and for the purpose 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.

Spouse is defined in the Eligibility for Participation section of the Plan.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

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.

Third Party Administrator means Meritain Health, Inc., 300 Corporate Parkway, Amherst, NY 14226.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Customary Charge (U&C) means, with respect to Non-Network Providers, charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience. Limitations for Usual and Customary Charges are not applicable to Network Providers.

PLAN ADMINISTRATION

Delegation of Responsibility
The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions
The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

(1) To administer the Plan in accordance with its terms;

(2) To determine all questions of eligibility, status and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a Third Party Administrator to pay claims;

(9) To perform all necessary reporting as required by Federal or State law;

(10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

(11) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

(12) To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. **Any Employer may terminate its**

participation in the Plan and thereby terminate the coverage of its eligible Employees, Retirees and their Dependents.

The Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate by operation of law, as a result of changes in law which are required to affect provisions in the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment Of Benefits
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in the Plan's QMCSO procedures.

Clerical Error
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan
The Participating Employers are responsible for funding the Plan. The required monthly contribution for coverage will be determined from time to time by the Board of Managers. Each Participating Employer will determine the portion of the monthly contribution, if any, required to be paid by its Employees and Retirees.

Interpretation of this Document
The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this Plan applies to eligible or covered Employees and Retirees and, where appropriate in context, their covered Dependents.

No Contract of Employment
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of employment or to be consideration for or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Trust or any Participating Employer or to interfere with the right of the Trust or Participating Employer to discharge any Employee at any time.

Release of Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Worker's Compensation

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

(1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify your Employer immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

HIPAA PRIVACY PRACTICES

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:

(1) Determining your eligibility for benefits, coverage, and cost sharing amounts.

(2) Coordinating your benefits with other plans if you have other health insurance.

(3) Adjudicating your claims (including appeals and other payment disputes).

(4) Subrogating claims if a third party may be liable for your injury and expenses.

(5) Establishing contribution rates.

(6) Billing and collection activities.

(7) Claims management, including auditing payments, investigating and resolving payment disputes and responding to provider inquiries about payments.

(8) Obtaining reimbursement under a contract for reinsurance.

(9) Obtaining reviews for medical necessity or appropriateness of care.

(10) Utilization review, including pre-certification of services.

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

(1) Quality assessment.

(2) Activities relating to improving health or reducing health care costs, case management, care coordination and disease management.

(3) Contacting health care providers and patients with information about treatment alternatives.

(4) Rating providers, including accreditation, certification, licensing or credentialing activities.

(5) Underwriting and other activities relating to obtaining reinsurance.

(6) Conducting or arranging for medical review and legal, actuarial and auditing services.

(7) Resolution of internal grievances.

(8) 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, Inc., the Third Party Administrator, HealthLink, which maintains the provider network, Coordinated Health/Care, which 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 A**, 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 A**. 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:

(1) 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.

(2) 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:

(1) 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.

(2) 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:

(1) Information about members with large claims, as necessary for obtaining quotes from reinsurers and resolving claims with reinsurers.

(2) 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:

(1) 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.

(2) 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.

(3) Will not use or disclose PHI for employment-related actions.

(4) 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).

(5) 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.

(6) 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.

(7) Will make PHI available for amendment and will incorporate any requested amendments to the extent required by the HIPAA Privacy Rule.

(8) Will make available any information required to allow the Trust to provide an accounting of disclosures.

(9) 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.

(10) 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 A**.

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

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions
To enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

(3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and

(4) Report to the Plan any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

Health Information Technology for Economic and Clinical Health (HITECH) Act
The Plan will comply with all applicable requirements of final regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.

The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

GENERAL PLAN INFORMATION

Name of Plan:	Egyptian Area Schools Employee HDHP Medical Benefit Plan
Plan Sponsor: **(Named Fiduciary)**	Board of Managers of the Egyptian Area Schools Employee Benefit Trust c/o Meritain Health, Inc. 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.
Plan Administrator:	Board of Managers of the Egyptian Area Schools Employee Benefit Trust c/o Meritain Health, Inc. P.O. Box 2046 Fairview Heights, IL 62208
Plan Sponsor EIN:	37-1156166
Plan Year:	September 1 - August 31
Plan Type:	Welfare benefit plan providing medical and prescription drug benefits. 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.
Plan 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 Third Party Administrator. Each Participating Employer determines the contribution, if any, that must be paid by its Employees.
Third Party Administrator:	Meritain Health, Inc. 300 Corporate Parkway Amherst, NY 14228 (800) 844-7979
COBRA Administrator:	Meritain Health, Inc. P.O. Box 27158 Lansing, MI 48909-7158 (800) 925-2272 Fax No.: (716) 319-5736
Medical Management Program Administrator:	Egyptian Area Schools Coordinated Health/Care 1215 Polaris Parkway Columbus, OH 43240-2037 (855) 452-9997 www.egtrust.org
Prescription Drug Program Card Administrator:	Scrip World/CVS Caremark P.O. Box 52010 Phoenix, AZ 85072-2010 (866) 475-7589 www.caremark.com

Agent for Service of Legal Process:	Chairman, Board of Managers Egyptian Area Schools Employee Benefit Trust c/o Meritain Health, Inc. P.O. Box 2046 Fairview Heights, IL 62208
Trustee:	Regions Bank 10950 Lincoln Trail Fairview Heights, IL 62208
Opt-Out Provision:	The Plan Sponsor has elected to opt-out of the following requirements under Title XXVII of the Public Health Service Act: Parity in the application of certain limits to Mental Disorder and Substance Use Disorder benefits.

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.

APPENDIX A – 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, 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, Coordinated Health/Care 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.

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, Coordinated Health/Care 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 communi-cations 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 involve-ment 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.

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 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 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.

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 Communi-cation 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
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.
(5)

(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

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, Meritain or Coordinated Health/Care 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 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, 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 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).

INSIDE BACK COVER - BLANK

(THIS WILL NOT PRINT)


MERITAIN
HEALTH